2012 UPDATE TO COMMUNITY BENEFIT PLAN

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A MEMBER OF:

PROVIDENCE LITTLE COMPANY OF MARY SERVICE AREA

2012 ANNUAL UPDATE TO COMMUNITY BENEFIT PLAN

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1. *Charity Care policy*
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I. EXECUTIVE SUMMARY

Overview

The Hospital Community Benefit Program (HCBP), commonly referred to as "SB 697," is a result of a State law passed in 1994. This legislation states that private not-for-profit hospitals such as Providence Little Company of Mary Medical Center, Torrance and Providence Little Company of Mary Medical Center, San Pedro "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status.

Senate Bill 697 requires that non-profit hospitals throughout California conduct a triennial community needs assessment and develop a three year Community Benefits Plan based on the findings. This annual Update describes progress towards measureable objectives established by the 2010 needs assessment adopted by the Providence Little Company of Mary governing board.

A summary of the 2010 needs assessment findings are on the Providence Little Company of Mary web site. Every year, Providence Health & Services, Southern California Region and the Providence Little Company of Mary Foundation report on the impact of community outreach programs by telling the stories of individuals and summarizing the programmatic result of the relevant programs sponsored by Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance (PLCM).

The two PLCM Medical Centers share a common geography for their community benefit plan because of their close proximity to each other. The PLCM Service Area is composed of 14 distinct communities, commonly referred to as the South Bay region of Los Angeles County. Charity care expense, the unpaid cost of Medi-Cal and hospital based programs are directly linked to each Medical Center, consistent with Catholic Health Association community benefit guidelines. Community outreach programs [to underserved communities] are allocated 50% to each Medical Center, unless a specific program operates in a single community that is geographically linked to a specific Medical Center.

Like most areas of Los Angeles County, communities of wealth and poverty are geographically adjacent. In the PLCM Service Area (South Bay region of Los Angeles County) these disparities and the Providence Mission have lead us to implement community outreach programs in "high need" communities, based on multiple public and private data sources. To the greatest extent possible, we use zip code specific data trends to identify communities with the greatest need and consult with stakeholders within those communities to help us identify the greatest health needs that are susceptible to improvement within the context of PLCM expertise:

As People of Providence, we reveal God's love for all,
Especially the poor and vulnerable,
through our compassionate service.

The Providence Mission statement directs special attention ***for the poor and vulnerable.*** This statement of organizational purpose reaffirms our commitment to underserved communities and simultaneously creates new challenges based in the reality that no single organization can met all

of the health care needs of high need communities. Accordingly, we work in collaboration with non profit organizations and public entities that share our purpose.

Data and Community Input Considered in 2010 Needs Assessment Process

The 2010 Community Benefit needs assessment included review of quantitative and qualitative data, as follows:

- Demographics and health access data, by PLCM zip code, from Thomson Reuters,
- Health status survey results from L.A. County Department of Public Health (County) for Service Planning Area (SPA) 8 (South Bay) and local Health Districts within the SPA,
- Community Needs Index database to confirm communities with greatest need.
- Local health status/medical home interviews of residents from the six underserved communities where PLCM targets community, using 2007 results for comparison.
- Local survey of Stakeholder representatives from schools, public health, CBO's to facilitate prioritization of community health needs.

In collaboration with our partners, outreach programs and services sponsored by the Medical Centers will continue to focus on the most underserved communities in the PLCM Service Area, for both children and adults. Our process was to seek out input from a broad range of community stakeholders, including the Los Angeles County, Department of Public Health, more than 25 local organizations with whom we partner in underserved communities and interviews of adults who live and work in high need communities.

2010 Needs Assessment Findings.

The 2010 triennial needs assessment used multiple public and private data sources to identify existing disparities across the PLCM Service Area. These five data sources confirm that access to low cost or free primary care, preventive education (physical activity and diabetes education) and linkage to low cost community services are the areas of greatest need across underserved communities in the PLCM Service Area. Within these three categories, the data sources and stakeholder input was analyzed to develop a consensus about where community outreach resources should be targeted. The governing board reaffirmed that available community outreach resources should be directed to high need communities and adopted the community needs assessment. The consensus that emerged was that improvements in access to primary care for children and adults is the top priority, followed by primary prevention for children (physical activity), secondary prevention programs for adults (diabetes education) and linking residents to low cost or free health and social services. Finally, a number of emerging topics were identified as deserving further study and possible inclusion in the Community Benefit Plan.

Measurable Objectives

The 2010 Community Benefit Plan set forth a single goal, with four objectives and multiple benchmarks to be accomplished over the next three years. This Update report describes our progress during 2012 towards achieving these three year objectives. Overall, a similar pattern has emerged during prior cycles: namely, a majority (55%) of our 18 benchmarks were accomplished in the first year of the plan (2011) and 72% (13 of 18) were met in this second

year (2012) of the Plan. We anticipate that we will continue to improve in 2013 and get even closer to the objectives set forth in the 2010 Community Benefit Plan.

The four Measureable Objectives set forth in the 2010 Community Benefit Plan are linked to a single goal, adopted by the governing board. The progress towards benchmarks during 2012 is detailed in Section 3 of this Update. The goal and measurable objectives are as follows:

GOAL: As people of Providence, we partner with community stakeholders, reach out to high need communities and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health education programs.

Objectives

1. Increase access to low cost/free primary care services.
2. Strengthen/expand physical activity and self-care disease management programs.
3. Analyze and pilot new approaches to emerging health care service delivery needs.
4. Measure PLCM Community Benefit Expenditures and Encounters

Community Benefits Expense. This report includes a separate section of accounting of all Community Benefit expenditures, based on the three categories of community benefit expense established by the Catholic Health Association: 1) charity care, 2) unpaid costs of government programs (Medi-Cal) and 3) community benefit services, which includes outreach to underserved communities, subsidized health services, training of the health professions and programs for the broader community.

Total Community Benefit expenditures for 2012 were $67,234,121. This includes charity care expense of $15,954,711, Community Benefit Services in the amount of $16,275,964 and Unpaid Costs of Medi-Cal in the amount of $35,003,446. Even in the face of the economic downturn, we have successfully sustained a consistent $3 Million operating budget for community outreach programs in underserved communities through contributions from the two Medical Centers, Providence Little Company of Mary Foundation and, by attracting new and continuing grants and contracts from private foundations and government entities.

It should be noted that PLCM excludes the Unpaid Costs of Medicare from its Community Benefit calculations and does not publicly report them, but includes them in this report as required by OSHPD regulations. For 2012, unpaid costs of Medicare were $10,880,967.

The number of individual impacted by PLCM Community Benefit programs in 2012 was 93,323 including 15,971 individuals who received services through the charity care program, 53,890 who were impacted by Community Benefit Services program, and 23,462 who received care through the Hospitals' Medi-Cal program.

II. MISSION

A. Incorporating Mission Philosophy into Community Benefit

The Mission of the Little Company of Mary Sisters is reflected in the historical significance of their name: that small group of women who stood with Mary at the foot of the cross as her son Jesus lay dying. From the beginning, the Sisters' commitment to the poor and vulnerable has manifested itself through outreach to underserved communities and care of the sick and dying. In 1982, Little Company of Mary Hospital voluntarily adopted a social accountability budget and, when the organization expanded during the 1990's to include San Pedro Hospital, the commitment to return the value of the tax exemption continued.

During the 1990's, the Sisters recognized that their diminishing numbers threatened to undo core mission commitments and they decided, in 1998, to become a Member of the Providence Health System. During the transition years, the Sisters retained their Mission statement and, when PHS merged with Providence Services in 2006, the Sisters finalized the transfer of assets and joined in the creation of Providence Health and Services; the governing board that oversees the two PLCM Medical Centers adopted the new Mission statement. Today, Providence Little Company of Mary Medical Centers, San Pedro and Torrance, are part of Providence Health & Services, Southern California and are fully aligned with both the Mission and Core Values of the Seattle based Providence Health & Services.

MISSION

As People of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

The new Providence Mission statement did not alter our focus on reaching out to the underserved, but a subtle difference guides our measurable objectives. While the Mission of the Sisters of Little Company of Mary always affirmed ***meeting the health care needs of our communities***, the new Mission statement is more inclusive because in a world of separateness, the Mission does not discriminate on a social level (*As people of Providence we reveal God's love for **all**)* and specifically directs special attention ***for the poor and vulnerable.*** This statement of organizational purpose reaffirms the organization's commitment to underserved communities and simultaneously creates new challenges that address health disparities in the most economically disadvantaged communities and neighborhoods of the South Bay.

B. Allocation of Community Outreach Resources Reflect the Mission

Central to our community based outreach is the notion that diversity of language and culture is an asset and that disparities can be reduced through collaboration, advocacy among stakeholders and resources targeted to communities with the greatest need. The 2010 needs assessment describes the continuing process for determining which communities within the Service Area have the greatest need, bringing together quantitative and qualitative information to identify specific disparities, and in collaboration with community partners, develop a three year plan that describes our priorities, measurable objectives and specific benchmarks that help us determine the impact of community benefit outreach programs.

While our Mission commands special attention to the poor and vulnerable, the Community Benefit Plan also addresses other programs that benefit the broader community. Using guidelines developed by the Catholic Hospital Association[1], our Community Benefit expenses fall into three broad areas: 1) Services for the Broader Community,) Programs for the Poor and Vulnerable, and 3) Health Professions Education. PLCM tracks community benefit expenses throughout the year, as part of its operating commitments.

Community Benefit Services are managed by multiple Hospital Departments, as follows:

Subcategories of Community Benefit Services	**Managed By:**
Services for the Broader Community	Hospice & Emergency Depts; Solutions Center
Community Based Programs for Poor and Vulnerable	Community Health Department
Medical Center Programs for Poor and Vulnerable	Social Work Department
Health Professions Education	Education Department

C. Collaboration Guides Program Development

PLCM plays an active role in collaborating with many schools and community organizations throughout the Service Area. For PLCM, collaboration is a process and includes relationship building, capacity building, and strengthening partnerships with community stakeholders that share our values. In 2012, the Community Health Department was composed of 48 employees (36 of whom are full time), who deliver program services in underserved communities and work with community partners to:

- Collect ongoing information about community health needs through, surveys, focus groups and program evaluations which document program effectiveness, support program development and further inform the community needs assessment.

- Build new relationships and strengthen existing relationships with local public schools (Hawthorne, Los Angeles, Lawndale and Torrance Unified School Districts), health care safety net providers (Department of Family Medicine, Harbor UCLA Medical Center, South Bay Family Health Care Center, Wilmington Community Clinic, Harbor Community Clinic, Northeast Community Clinic, St. John's Well Child and Family Center, etc.) and CBO's (Wilmington YMCA, San Pedro YWCA, Toberman Neighborhood Center, Boys and Girls Club of Los Angeles Harbor, Richstone Family Center, Masada Homes, Training and Research Foundation, etc) and churches across the PLCM Service Area that are located in high need communities (Holy Family, St. Joseph's, Mary Regina, Sts. Peter and Paul, Faithful Central Bible Church, Islamic Center of Hawthorne, Harbor Christian Church, First United Methodist of San Pedro) .

[1] *A guide for Planning and Reporting Community Benefit,* Catholic Health Association of the United State, St Louis, MO, 2012

- Work together on projects that develop capacity and sustain identified priorities in underserved communities (Instant Recess, Healthy Kids Express, Lawndale After school programs).

A critical component of successful collaboration is the ability to provide resources that document high need communities or neighborhoods, that community Stakeholders have long suspected but do not have the data to confirm their beliefs. These information sources, which we share with local stakeholders, further informs gaps in the safety net and promotes development of non-duplicative resources and services to address those gaps.

PLCM staff expertise functions to strengthen existing community capacity (resources) through the delivery of program services located in underserved communities. At the same time, we have a long term objective to strengthen existing community infrastructure through our own work and by encouraging other community partners to take the next step in building a network of services in underserved communities. We call this idea "capacity building" which simply means that PLCM will take the lead, when we have the expertise, to develop, stabilize and hand over programs to community partners that meet the needs of residents. These successes do not come quickly but when they are achieved they strengthen the bonds between PLCM and community organizations. Four examples of community capacity building that have occurred since 2001:

Program	PLCM Role	Handover Date/Partner	Current Status
Lawndale After School	Wrote State funding for multi-year, after school program at 6 sites, 5 days a week.	May 2001; Lawndale School District/ Richstone Family Center	All 6 sites currently operating
Retinal Telemedicine	Lead agency for screening PPP patients for retinopathy at 3 clinic sites	December 2004; Dept. of Family Medicine Harbor UCLA Medical Center	Camera operates in Wilmington
Healthy Kids Express	Set up mobile clinics in four Hawthorne schools	December 2007; van donated to local FQHC (SBFHC)	FQHC operates
Energy Boosters Project	Wrote federal grant for school district to assure continued improvement in school day physical activity levels	October 2010; PLCM continues as a partner in implementation	All 6 sites up and operating

D. Strengthening Communities through Prevention & Collaboration

Too often, hospitals limit community outreach programs to acute health care problems. The inevitable result is that underlying unhealthy behaviors never get the attention needed to create a positive change in the health of communities. When the intervention is limited to "fixing" a medical problem, the opportunity to prevent unhealthy behaviors is lost.

PLCM seeks to balance the clear need for community outreach related to access to medical care services with the need for skills based prevention services that create health improvements in underserved communities. The challenge is to design a program with stakeholder input, implement a successful intervention, sustain it, achieve measurable results and, as new resources

are found, expand to as many high need communities as resources will permit. Our ability to accomplish this result is directly linked to successful results.

Our Community Benefit Plan relies upon the PLCM Medical Centers and the PLCM Foundation to provide the initial funding to test out pilot projects that address identified community needs, develop them to a level of established effectiveness, and then extend them more broadly in partnership with other funding partners, typically private foundations and government entities. This cycle has repeated itself many times in the last 15 years. Between 1998 and 2008, the operating budget of the Community Health Department, which is organized to provide community outreach in underserved communities, increased 100% and has been sustained since 2008 in the range of $3-3.5 Million annually.

Three programs illustrate the cumulative effect of the community health improvement process, over time, and demonstrate the value of sticking with the priorities identified in the needs assessment.

Access to Low Cost or free pediatric care. In 1995, ***Partners for Healthy Kids*** **(PFHK)**, a mobile pediatric clinic, began to provide free acute and preventive medical care to uninsured children at elementary schools in four underserved communities: San Pedro 90731, Wilmington, Gardena and Lawndale. Following the closure of a hospital in Hawthorne and in partnership with a local foundation and FQHC, a plan was developed in 2005 for PLCM to start up multiple school site clinics in the Hawthorne School District and transition it to the FQHC partner after financial feasibility was demonstrated. By 2007, the FQHC was operating the mobile clinic in Hawthorne on its own, under the name *Healthy Kids Express.* In 2008, a large federal grant from the Centers for Medicare and Medicaid Services (CMS) allowed us to initiate intensive outreach and assistance throughout the South Bay to parents whose children are eligible for Healthy Families or Medi-Cal health insurance. One of the factors cited in the grant award was the long term track record of the mobile clinic. As more children are enrolled throughout the region, it has further strengthened the FQHC's ability to sustain viability of the *Healthy Kids Express* clinic in Hawthorne. Most recently, in 2012, the Health Services Resource Administration (HRSA), provided us an ACA grant to purchase a replacement mobile clinic. Plans are in place to donate the old clinic to another partner school district once the new clinic is put into service in 2014.

Childhood Obesity. Early in 2001, PLCM recognized that the childhood obesity epidemic needed a practical solution that would increase physical activity in children. PLCM developed multiple pilot programs during the school day, after school, with parents and through a community coalition. Each of these pilots was initially funded by the Medical Centers; as positive outcomes were achieved it attracted federal grants in 2003 and 2005 and a large demonstration project funded in 2007 and Three separate projects were consolidated into a single program which has become known as **COPA (Creating Opportunities for Physical Activity)** Today, COPA is on site at 15 public and private elementary schools in five separate communities and has three interrelated components: a "peer coach" teacher training model, after school physical activity modules and family night activity events. Two characteristics were critical to sustaining progress: core funding from the Hospitals' allowed the ideas to be tested and evaluated, continuing government and private grants that allowed for further piloting and expansion, and financial support from the School Districts when school finances are stable.

Access to Primary Care and Diabetes Management for Uninsured Adults. The final illustration is a Medical Center sponsored initiative to address two of the three needs assessment priorities: improved access to low cost primary care for uninsured adults and self care management of chronic conditions (ie. Diabetes). In the South Bay, 130,000 adults are uninsured and there are significant disparities in the prevalence of diabetes in underserved, low income communities.

Our initial effort started in 2000 with the implementation of a diabetes management program for Samoans, a population small in numbers but with one of the highest diabetes prevalence rates of any ethnic group in Los Angeles County. A Public Private Partnership clinic in Carson was the hub of a diabetes screening, treatment and education program, in collaboration with Samoan churches. L.A. Care, a Medi-Cal HMO, funded the educational interventions which led to the development of a promotora/community health worker support model. Local Samoans were recruited, trained and employed to provide a range of information and support services to improve patient outcomes. Over time, this Healthy Living Project was expanded to Latinos and conducted in the native language of participants. Promotoras recruited and tracked participants and facilitated physical activity and nutrition support groups.

This initial success lead to the idea of starting a primary care clinic that incorporates skills-based education and linkage to low cost health related services into a single primary care practice, as a way to meet the needs of uninsured working adults. As the result of a non profit hospital closure in Hawthorne , a significant increase in the amount of non urgent care in the Providence Emergency Department closest to Hawthorne and a local family foundation, this concept became a reality, in December 2007, with the opening of the Vasek Polak Health Clinic in Hawthorne. This Clinic uses a low cost, fixed price services delivery approach, a self care education model subsidized by grants and free advanced diagnostics through the Medical Center charity program. A large classroom was built into the Clinic design and there has been dramatic and sustained growth in new patients, total patients, and financial support from private foundations for outreach, education and core operating support from the Medical Centers all of which are critical factors to sustaining the clinic and assuring its long term success. In 2011, 4,560 adults used the Clinic as their medical home.

As the Vasek Polak Clinic grew larger it quickly became apparent that there was a significant need to help uninsured adults learn to better manage diabetes. While it is well established that there are significantly higher prevalence rates of diabetes in low income populations and specific ethnic groups, there are few available solutions to teach uninsured adults how to ***live*** with their condition. With support from a local private Foundation and the Medical Centers, a pilot program, Get Out and Live (GOAL), was developed to implement a successful self care management program developed by Stanford University. We have added three additional group visit classes to the Stanford curriculum and each cohort enrolled in GOAL meets with a clinician to address areas of common concern, with time set aside for individual questions and review of lab results. In 2012, this initiative documented significant pre-post reductions in patient A1C levels, improvements in blood pressure, cholesterol and self efficacy scores for a group of 162 patients who completed the nine week classroom sequence. Also, in 2012, this curriculum was modified for the population of adults ***at risk*** of diabetes at churches in Hawthorne and Wilmington and we would anticipate reporting on those results in the next Update.

E. Benefits for the Broader Community & Health Professions Training

The Medical Centers sponsor four separate longstanding programs that benefit the broader community: Hospice Bereavement, free community health education lectures, a paramedic base station and the cost of employees who facilitate support groups for adults with chronic illnesses, on an ongoing basis. In recent years, both Hospitals have initiated nurse training programs that provide hands-on support and Hospital based experience for students enrolled in registered nurse training programs at two local community colleges. Consistent with Catholic Health Association guidelines, we track the value of employee time spent preceptoring students who are enrolled in a broad range of health professions training programs, for the following disciplines: Registered Nurses/Nurse Practitioners, Pharmacy, Radiology, Radiation Oncology, Respiratory, Physical, Occupational and Speech Therapy, Social Work/Case Management, Laboratory, Pharmacy, Community Health, Dietetics, Ultrasound, Psychology and Hospice.

F Governing Board Involvement in Community Benefit Planning and Oversight

The PLCM Board of Directors oversees the Community Benefit Plan through regular board reports, the adoption of the triennial Community Benefit Plan and annual presentations on progress towards measurable objective. The Board appoints one of its members to chair the Mission Committee, a group of 25 internal and external stakeholders that meets six times a year that includes representatives from health and social services agencies in the South Bay, physicians, interfaith clergy, and individuals with expertise in charity care, foundations, community-based primary care and health education. The Chair of the Mission Committee attends all meetings of the Board of Directors and arranges for staff reports on specific programs.

III. PROGRESS TOWARDS ESTABLISHED MEASUREABLE OBJECTIVES IN 2012

The purpose of establishing measurable benchmarks linked to objectives set forth as part of the 2010 PLCM triennial needs assessment and Plan is to challenge ourselves to make a difference in the high need South Bay communities that experience significant disparities in access, prevalence of chronic illnesses and levels of physical activity, particularly in children. These high need communities in the South Bay, identified in our 2010 needs assessment, are the focus of our community outreach.

Establishing Benchmarks

This process of committing to three year benchmarks was established and approved by the governing board, for the first time, based on the 2007 needs assessment findings and community benefit plan. In the first cycle, beginning in 2008, our success rate towards accomplishing our benchmarks was 52% (ie. 11 of 21 benchmarks accomplished). This success rate increased significantly in the second year, to 71.5% (15 of 21 benchmarks accomplished); in the third year the success rate increased to 81% (17 of 21 benchmarks accomplished). These results are a good yardstick by which to measure the strength of the three year benchmarks (ie. realistic but not too easy to accomplish and continuing year-to-year improvement in results). At the same time, the expectation is NOT that all benchmarks will be achieved because many factors can thwart a three year plan. By sticking with the same benchmarks for a three year period, the continuous improvement process is reinforced for our community partners, Medical Center officials and the 40+ PLCM employees working in community settings. All of these Stakeholder are engaged in a collaborative process and successful results on benchmarks reflects close working relationships built on trust and respect among Stakeholders.

Summary of benchmark accomplishments in 2012

The Providence Little Company of Mary 2010 triennial needs assessment established four measurable objectives with 18 specific benchmark that cover three calendar years: 2011-13. Benchmarks represent key performance indicators that provide evidence as to the likelihood that the objectives will be accomplished, as originally set forth in the 2010 Plan. The 2011 first year success rate was 55% (10 of 18 benchmarks accomplished. For 2012, the rate of success has increased to 72% (13 of 18 benchmarks accomplished). The purpose of this section of the Annual Update is to report on the progress towards these objectives. The next two pages set forth the original 2010 objectives. The rest of this Section reports the actual accomplishments, comments on progress during 2012 and, as appropriate, strengthens the benchmark where actual experience and future projections suggest that a higher benchmark is appropriate.

The following chart documents the actual accomplishments in 2012, provides analysis of benchmarks that were accomplished, provides comments on those that have not yet been accomplished and revises one benchmark **UPWARDS** based on clear trends(# FQHC patients receiving XRay interpretations through Medical Center. In the 2011 Update, three benchmarks were revised **UPWARDS** and were sustained at the new level in 2012 (# children enrolled in

subsidized health insurance, increase in charity care expense and increase in charity care participants) . None of the benchmarks were revised downwards in 2012 or in 2011.

Measurable Objectives Adopted in 2010

The Providence Little Company of Mary 2010 Community Benefit Plan adopted by the governing board, includes a single goal, with four measurable objectives, each of which has multiple benchmarks, or indicators, which collectively are expected to help us accomplish specific objectives:

GOAL: As people of Providence, we partner with community stakeholders, reach out to high need communities and build a path to better health, for children and adults, through improved access to primary care and involvement in skills-based health education programs.

Objective 1. Increase access to low cost/free primary care services.

Benchmarks

- Improve access to health care for uninsured children by providing free medical care to 2,800 children, including coordination of specialty/ancillary referrals for 250 children **(2 benchmarks).**
- Offer weekly clinics at 9 schools each week; pilot an alternate schedule that allows the clinic to add 10 new school clinics, at schools in the same four communities served by the mobile clinic on a twice a year basis to accommodate immunizations, Medi-Cal outreach and specialized medical clinics**(2 benchmarks).**
- Enroll/renew 600 children annually in subsidized health insurance programs.
- Improve access to primary care through a low cost, fixed price, midlevel practitioner service delivery model and increase, by 10%, the number of uninsured adults who utilize the Vasek Polak Health Clinic as their medical home.
- Sustain access to x-ray services for 500 patients at Inglewood FQHC clinic by providing low cost interpretation of on site X-rays.

Objective 2. Strengthen/expand physical activity & self-care disease management programs.

Benchmarks

- Provide ongoing school day physical education training to 150 teachers and 4,200 children in high need communities **(2 benchmarks).**
- Provide after school physical activity programs throughout the school year for 500 children and their adult family members

- Arrange 25 collaborative health and physical education learning events for children and adults in high need communities across the Service Area by involving PLCMSA employees, community based organizations and Community Health staff to organize, plan and implement events.
- 150 uninsured/underinsured adults will complete at least one of the following multi lesson diabetes management programs: self care management, group visits, physical activity/nutritional practices workshop or group visit protocol at the Vasek Polak Health Clinic or at community partner sites using PCLM curriculum.
- Increase physical activity levels 5%, on a pre-post basis, across all physical activity programs using at least one of the following methods: pedometer, accelerometer Fitnessgram, SOFIT observation or self-report.

Objective 3. Analyze and pilot new approaches to emerging health care service delivery needs, after consultation with internal and external Stakeholders.

Benchmarks:

- Explore feasibility and parameters of expanding scope of community outreach services to include one or more of the following:
  - Mental health education Project for children and/or adults
  - Patient navigator Project for seniors
  - Expansion of low cost, fixed price, mid-level practitioner primary care model
  - Strengthen ongoing needs assessment process through the development of academic internships with local School of Public Health

Objective 4. Measure PLCM Community Benefit Expenditures and Encounters

Benchmarks

- The number of individuals impacted by charity care programs will increase 5% over three years **[baseline = 4,733]**;
- The number of individuals impacted by community based outreach programs will increase 5% over 3 years **[baseline = 23,920].**
- Increase charity care expense by 5% over three years, through improved screening**[baseline =$3,770,000].**
- Using CHA guidelines, increase community based outreach expense (non billed/ negative margin) by 9% over 3 years **[baseline = $6,270,000]**

Progress Towards Three Year Benchmarks

MEASUREABLE OBJECTIVES **Objective 1. Increase access to low cost/free primary care services.**		
3 Year Benchmarks established by 2010 Community Benefit Plan	***Progress towards Objective***	
	2012 ACTUAL	***Comment***
Improve access to health care for uninsured children by providing free medical care to 2,800 children, including coordination of specialty/ancillary referrals for 250 children.	2,564 123	The number of mobile clinic patients decreased, as anticipated, because new Tdap immunization requirements for ***all*** middle school & high school students were accomplished in 2011. Further, the success of CHIP enrollment of eligible children in subsidized health insurance reduces demand for medical visits on the mobile clinics. Access to LAC DHS specialty clinics remains difficult. PLCM staff is seeking changes that would allow PFHK to utilize the E-Consult referral process through Harbor UCLA Medical Center. Both benchmarks will remain the same. The 2013 needs assessment will further review PFHK performance data and look at both the scope of services provided and the potential for expansion related to chronic medical conditions (ie. Asthma, obesity), with linkage to safety net clinics.
Offer weekly clinics at 9 schools each week; pilot an alternate schedule that allows the clinic to add 10 new school clinics, at schools in the same four communities served by the mobile clinic on a twice a year basis to accommodate immunizations, Medi-Cal outreach and specialized medical clinics.	**10** **10**	Partners for Healthy Kids, a mobile school based health clinic, provides weekly clinics at nine elementary/middle schools in the Los Angeles Unified School District communities of Wilmington, San Pedro and Gardena, as well as the Lwndale School District. Beginning in September 2012, the mobile clinic began weekly clinics at a new Wilmington K-8 Span School, Harry Bridges. Additional schools were added to the clinic schedule for the purpose of providing immunizations. Lawndale Elementary School District (Billy Mitchell, Smith School, Green Elementary and Addams Middle) LAUSD (Harry Bridges Span School, Halldale, Harbor City Elementary, San Pedro HS) and Hawthorne School District DO, York Elementary and Port of Los Angeles HS (charter) **On track to accomplish benchmarks**

Improve access to primary care through a low cost, fixed price, midlevel practitioner service delivery model and increase, by 10%, the number of uninsured adults who utilize the VP Health Clinic as their medical home	**19.8%**	The number of patients seen at Vasek Polak Health Clinic increased from 3,869 in 2010 to 4,637 in 2012. **On track to sustain and accomplish benchmarks**
Sustain access to x-ray services for 500 patients at Inglewood FQHC clinic by providing interpretation of on site X-rays	**923**	Existing arrangements provide low cost readings, storage and retrieval of X-rays for Inglewood FQHC. **BENCHMARK REVISED UPWARD TO 700.**
Bold Statistics indicate 2010 Implementation Plan benchmark accomplished this year.		

MEASUREABLE OBJECTIVES
Objective 2. Strengthen/expand physical activity and self-care disease management programs.

3 Year Benchmarks established by 2010 Community Benefit Plan	***Progress towards Objective***	
Benchmarks	***2012 ACTUAL***	***Comment***
Provide ongoing school day physical education training to 150 teachers and 4,200 children in high need communities.	**172** **4,644**	**On track to sustain and accomplish both benchmarks**
Provide after school physical activity programs throughout the school year for 500 children and their adult family members	**518**	**On track to sustain and accomplish benchmarks**
Arrange 25 collaborative health and physical education learning events for children and adults in high need communities across the Service Area by involving PLCMSA employees, community based organizations and Community Health staff to organize, plan and implement events.	17	Staff participated in six different type of school wide events (Walk-to-School, Family Night, bike Rodeo, Nutrition Night, Jogo-thon, Fitness gram testing) at 17 different events in the underserved communities of Hawthorne, Lawndale and Wilmington. **On track to accomplish benchmark**
150 uninsured/underinsured adults will complete at least one of the following multi lesson diabetes management programs: self care management, group visits, physical activity/nutritional practices workshop or group visit protocol at the Vasek Polak Health Clinic or at community partner sites using PCLM curriculum	**162**	All 4 program components. 162 adults completed 9 week program. Average A1C reduction for the group, was 1.52%. A1C levels were reduced for 80.3% of participants. Improvements also noted in self reports of health, reduction in % with High blood pressure and cholesterol and improvement in self efficacy scores. **On track to accomplish benchmark**

Increase physical activity levels 5%, on a pre-post basis, across all physical activity programs using at least one of the following methods: pedometer, accelerometer Fitnessgram, SOFIT observation or self-report.	**9.5-26.6%**	External evaluation of the 2011-12 school found an increase in physical activity, by grade level, ranging from 9.5% to 26,6%, using the Fitnessgram Pacer test. **ON track to accomplish benchmark.**
Bold Statistics indicate 2010 Implementation Plan benchmark accomplished this year.		

MEASUREABLE OBJECTIVES
Objective 3. Analyze and pilot new approaches to emerging health care service delivery needs, after consultation with internal and external Stakeholders.

	Progress towards Objective	
3 Year Benchmarks established by 2010 Community Benefit Plan	***2012 ACTUAL***	***Comment***
Explore feasibility and parameters of expanding scope of community outreach services to include one or more of the following: o Mental health education Project for children and/or adults o **Patient navigator Project** o Expansion of low cost, fixed price, mid-level practitioner primary care model o Strengthen needs assessment process through the development of academic internships with local School of Public Health	**YES**	Patient navigator project implemented at PLCM-San Pedro Medical Center that intervenes with patients who do not have a medical home and have repeated ER non urgent care visits. Further planning related to bullet #3 and #4 will continue during 2013 Benchmark remains the same.
Bold Statistics indicate 2010 Implementation Plan benchmark accomplished this year		

MEASUREABLE OBJECTIVES
Objective 4. Measure PLCM Community Benefit Expenditures and Encounters

	Progress towards Objective	
3 Year Benchmarks established by 2010 Community Benefit Plan	***2012 ACTUAL***	***Comment***
The number of individuals impacted by charity care programs will increase 5% over three years **[baseline = 14,199]**;	**15,971** **12.4%**	As a result of 2010 changes in charity care procedures that increased the number of charity care accounts, the original benchmark revised upward in 2011 Update. The revised is 14,199 individuals impacted by charity care programs[original benchmark was 4,733]. For 2012, there was a 12.4% increase in the number of patients **BENCHMARK ACCOMPLISHED**

The number of individuals impacted by community based outreach programs in underserved communities will increase 5% over 3 years **[baseline = 23,920].** 2011--21002	22,683	The number of people in underserved communities impacted by PLCM outreach programs increased from 21,002 in 2011 to 22,683, an 8% increase. **On track to accomplish benchmarks**
3 Year Benchmarks Established by 2010 Community Benefit Plan	**Actual 2012**	**Comment**
Increase charity care expense by 5% over three years, through improved screening**[baseline =$12,395,824].**	**28.7%**	As noted in the 2011 Update, changes in charity care identification methods resulted in a revised charity care benchmark, from $3,770,000 to $12,395,824. For 2012, total charity care expense was $15,954,711, a increase of 28.7% over the revised benchmark **Benchmark accomplished and sustained**
Using Catholic Healthcare Association guidelines, increase community based outreach expense (non billed/ negative margin) by 9% over 3 years **[baseline = $6,270,000]**	1.0%	Community outreach expense increased 3% over 2011, which had fallen below the benchmark established by the 2010 Plan. While Medical Center contributions increased it was not enough to offset the impact of external grant reductions in 2011. Original benchmark remains the same.
Bold Statistics indicate 2010 Implementation Plan benchmark accomplished this year		

IV. Community Benefit Expenditures during 2012

PLCM Community Benefit activities are reported to the local community in three broad expenditure categories: 1) charity care, 2) Community Benefit Services and 3) Unpaid Costs of Medi-Cal[2]. For OSHPD reporting purposes, we also identify the unpaid costs of Medicare but they are not publicly reported. The chart below, which summarizes all community benefit for the 2012 documents a 28% increase in charity care, a 15% increase in community benefit services using guidelines established by the Catholic Health Association and a 103% increase in Medi-Cal shortfall, attributable to the provider tax:

Component of Community Benefit Program	2012 Expense
Charity Care	$12,395,824
Community Benefit Services	$14,062,499
Unpaid Costs of Medi-Cal	$35,003,446
TOTAL	**$67,234,121**
Unpaid Cost of Medicare	$10,880,967

Charity Care. In 2012, charity care increased 28.5%, from $12,395,824 in 2011 to $15,954,711. This increase reflects the increase in the number of uninsured (primarily adults) and the continuing effects of the economic recession. The most recent charity care policy is included at the end of this report.**(See Attachment 1--Charity Care Policy)**

Unpaid Costs of Medi-Cal. In the three calendar years preceding 2011, the increase in unpaid costs of Medi-Cal went from $19,948,000 in 2008 to $30,397,00 in 2010. In 2011, the Medi-Cal shortfall dropped back to $17,199,914 due primarily to provider tax adjustments for California hospitals that resulted in offset to Medi-Cal shortfall, as well as regulatory changes that resulted in more Medi-Cal patients being assigned to HMO's.During 2012, Medi-Cal shortfall increased to $35,003,446. This 104% increase is due to reduced revenue received as a result of the provider tax and an increase in the rate of Medi-Cal reimbursement.

Community Benefit Services. This category includes community based outreach programs provided to poor and vulnerable, Medical Center based programs that benefit the poor and vulnerable, services that benefit the broader community and health professions education. For 2012, this amounted to $16,275,964 in accordance with guidelines established and published by the Catholic Healthcare Association. A detailed list of all items counted towards Community Benefit Services is provided at the end of this report. **(See attachment 2. Detail of programs and services counted towards Community Benefit Services.)**

Comparison of expenses within Community Benefit Services subcategories. Community Benefit services category is composed of seven subcategories: 1) Services to the broader community (community lectures & Call Center referrals, Gathering Place, medical library, etc.), 2) Community Health Education--persons in poverty (physical activity in schools, self care management for adults with diabetes, health insurance outreach and enrollment and domestic violence education) and 3) Community Based Clinical Services--persons in poverty (mobile

[2] OSHPD issued guidance in 2006 notifying hospitals to report Medicare shortfall. Medicare shortfall is not publicly reported as a community benefit expense.

pediatric clinic, specialty access and asthma testing), 4)Health Care Support Services--persons in poverty (Case management of uninsured/ underinsured, Post Discharge expense, Taxi & Transportation, etc) and 5) Subsidized Health Services (Vasek Polak Clinic, Women and Children's Clinic and hospice care for children), 6) Health Professions education (Nursing Institute, preceptorships, CPE.) and 7) Financial and In Kind Contributions.

Expense for *Community based programs for people in poverty* increased slightly, .001%, from $2,503,359 in 2011 to $2,505,157. This recent trend is a reflection of the economic downturn which caused significant reductions in state and federal grants for early childhood education programs. The Medical Centers have sustained funding for outreach programs to underserved communities, even in the face of other funding cutbacks. The *Broader Community* subcategory increased 35.7%, from to $734,293 in 2011 to $996,679., and primarily represents new financial support for hospice bereavement related programs which is a non reimbursed expense under Medicare regulations.
The *Community Based Clinical Services for Persons in Poverty* dropped 40%, $1,597,238 in 2011 to 4956,370 in 2012, due primarily to the end of two grants. The core non billed clinical services program for people in poverty, Partners for Healthy Kids, had a 7% increase in community benefit expense.

For many years, both PLCM Medical Centers have invested substantial resources in post discharge expense for patients who are medically indigent and continue to need a level of care that allows them to return to good health. Over the past three years, both Medical Centers have invested substantial financial resources that compensate hospitalists to manage medically indigent patients both in the Emergency Department and when they are admitted to the Medical Center. In addition, there have been significant expense in the cost of transportation, pharmacy medication and other expense incurred for medically indigent patients with no resources at the time of discharge. This expense increased 112%, from $1,331,315 in 2011 to $2,827,216. The chart below summarizes community benefit expense for all components of Community Based Services:

Breakout of Community Benefit Services	**2012 Total Expense, by sub category**
Broader Community	$ 966,679
Community Health Education-Persons in Poverty	$2,505,158
Community Based Clinical Services-Persons in Poverty	$ 956,370
Health Care Support Services-People in Poverty	$2,827,216
Subsidized Health Services	$6,554,061
Health Professions Education	$1,869,789
Financial and In Kind Contributions	$ 566,689
Total Community Benefit Services	**$16,275,962**

Overall, PLCM's ability to sustain outreach to poor and underserved populations in light of the recession and dramatic increases in charity care is a departure from prior years that saw double digit increases in support for community outreach to underserved communities in the South Bay. With considerable turbulence in the healthcare industry as the result of expected healthcare

reform, our current plans are to sustain existing funding levels and priorities in the face of future uncertainties.

A. Number of Individuals Impacted by PLCM Community Benefit Programs

Across each of the three Community Benefit categories, there has been a slight decline in the number of individuals impacted in the past year, from 94,628 in 2011, to 93,323 in 2012. Much of the change that has occurred in the last several years has been due to changes in procedures that resulted in many more people being included in the charity care program and dramatic prior year increases in the number of Medi-Cal patients. Both of these numbers have stabilized and the growth of programs and services in the Community Benefit Services category has remained essentially flat over the past three years. We continue to make improvements in the monitoring and tracking of patients through the implementation of a case management software (Carescope) for community benefit programs which furthers improves our ability to arrive at an unduplicated count of individuals served in a specific time period.

NUMBER OF INDIVIDUALS IMPACTED, BY COMMUNITY BENEFIT CATEGORIES			
	2012	**2011**	**% Change PY**
Charity Care	15,971	16,994	-6%
Medi-Cal	23,462	25,615	-8%
Community Benefit Services	53,890	52,019	+3.6%
TOTAL	93,323	94,628	1.3%

Strategic Mission Priorities

Consistent with the PLCM Mission Statement and the Ethical and Religious Directives for Catholic Healthcare Services, our Community Benefit Plan places a priority on community based outreach to the poor and vulnerable. We carefully track the number of individuals impacted by programs and services provide in underserved communities and seek to leverage PLCM resources with private and governmental support.

Individual Served by Outreach Programs Located in High Need Communities		
Outreach to Poor/Underserved Populations		**2012**
COPA (School Day/After School Physical Activity)		5,434
Children's Health Insurance Program		1,098
Community Outreach at Health fairs & school MAA events		4,032
Diabetes Education		208
Partners for Healthy Kids (mobile clinic)		2,429
Low Cost X-Ray Interpretation for FQHC patients		923
Promotora Outreach & Referral to Community Resources		3,139
SART(Sexual Assault Response Team)		197
Trinity Kids Care		179
Vasek Polak Health Clinic		4,637
Women (CPSP) and Children's Clinic		1,246
TOTALS		**23,522**

In addition to tracking the number of individuals impacted, the focus on measurable objectives for these programs demands close and continuing monitoring of programs effectiveness. **(See Section III of this report.)** The lack of national standards and benchmarks in the community

outreach arena and the obligation that comes with accepting funds from external sources results in close attention to the qualitative and quantitative impact of these programs.

PROVIDENCE
Health & Services
Southern California

Policies & Procedures
Southern California Region

Subject:	**Charity Care and Discount Payment Policy**		
Effective Date: **Supersedes:**	01/01/13 01/01/12	**Category:** **Number:**	Finance CA-FIN-5001
Southern California Leadership Council **Approval** **Date:**		**Responsibility for review and maintenance of this policy is assigned to:**	
Head of Regional Division **Submission Date:** **Approval Signature:** **Title:** *Chief Financial Officer*		**Author and/or Designee:** *Regional Director, Regulatory and Quality Assurance*	
		Policy Applies to: Patients	

POLICY

In keeping with the mission and values of Providence Health & Services, it is the policy of Providence Health & Services, California Region (PHSSC), to provide services to all persons, regardless of age, sex, race, religion, origin, or ability to pay. Upon verifying an inability to pay, PHSSC entities and hospitals (Providence Tarzana Medical Center, Providence Holy Cross Medical Center, Providence Saint Joseph Medical Center, Providence Little Company of Mary Medical Center, Torrance and Providence Little Company of Mary Medical Center, San Pedro) will provide financial assistance to qualifying patients to relieve them of their financial obligation in whole or in part for qualifying medically necessary healthcare services provided by PHSSC. An inability to pay may be identified at any time. Further, financial assistance for qualifying patients is also available from emergency room physicians treating patients at PHSSC acute care hospitals.

PURPOSE

To describe the process PHSSC hospitals will follow in providing financial assistance to qualifying patients. Accordingly, this written policy:

- Describes eligibility criteria for financial assistance – free and discounted (partial charity) care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how PHSSC hospitals will widely publicize the policy within the community served
- Limits the amount each PHSSC hospital will charge for emergency or other medically necessary care provided to individuals eligible for partial charity to an amount generally received by the applicable hospital for Medicare patients

This Policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 *et. seq.*, effective January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008 and revised by Assembly Bill 1503 effective January 1, 2011. All collection agencies working on behalf of PHSSC shall also comply with the provisions of AB 774 and SB 350 and applicable PHSSC policies regarding collection agencies. See related Regional Business Office Policy, GOV-107, Debt Collection Standards and Practices Policy.

DEFINITIONS

1) **"Charity care"** refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary or eligible elective health care services (full charity).

2) **"Discount payment"** refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary or eligible elective health care services (partial charity).

3) **Gross charges** are the total charges at the facility's full established rates for the provision of patient care services before deductions from revenue are applied. Gross charges are never billed to patients who qualify for partial charity or Private Pay Discounts.

4) **Private Pay Discount** is a discount provided to patients who do not qualify for financial assistance and who do not have a third party payer or whose insurance does not cover the service provided or who have exhausted their benefits. See Private Pay Discounting Policy, CA-FIN-5003

5) **Emergency physician** means a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at PHSSC hospitals are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level.

6) **Services Eligible Under the Policy**: The charity care and discount payment policy applies to all services provided to eligible patients receiving medically necessary care or eligible elective care, including self pay patients and co-payment liabilities required by third party payers, including Medicare and Medi-Cal cost-sharing amounts, in which it is determined that the patient is financially unable to pay. Medically necessary health care includes:

   a) Emergency services in the emergency department.

   b) Services for a condition that, if not promptly treated, would lead to an adverse change in the patient's health status.

   c) Non-elective services provided in response to life-threatening circumstances outside of the emergency department (direct admissions).

d) Medically necessary services provided to Medicaid beneficiaries that are non-covered services.

e) Any other medically necessary services determined on a case-by-case basis by PHSSC.

7) **Eligible Elective Health Care** includes:

a) Patients and their physicians may seek charitable services for elective, deferrable care. Elective care becomes eligible for charitable and discount services only when all of the following requirements are met:

i) A member of the medical staff of a PHSSC facility must submit the charitable services request;

ii) The patient is ALREADY a patient of the requesting physician and the care is needed for good continuity of care; aesthetic procedures are not eligible for charitable services;

iii) The physician will provide services at the same discount rate as determined by the hospital per charity guidelines of this policy, up to and including free care;

iv) The patient lives within our service area (as determined by PHSSC); and

v) The patient completes a Financial Assistance Application and receives approval in writing from PHSSC prior to receiving the elective care.

b) Certain elective care, such as aesthetic (cosmetic) procedures, acute rehabilitation unit, sub-acute (vent/trach) unit, skilled nursing facility, chemical dependency unit, and bariatric procedures are generally not eligible for charity care and discount services.

8) **Eligibility for Charity** shall be determined by an inability to pay defined in this policy based on one or more of the following criteria:

a) Presumptive Charity- Individual assessment determines that Financial Assistance Application is not required because:

i) Patient is without a residence address (e.g., homeless);

ii) Services deemed eligible under this policy but not covered by a third party payor were rendered to a patient who is enrolled in some form of Medicaid (Medi-Cal for California residents) or State Indigency Program (e.g., receiving services outside of Restricted Medi-Cal coverage) or services were denied Medi-Cal treatment authorization, as financial qualification for these programs includes having no more than marginal assets and a Medi-Cal defined share of cost as the maximum ability to pay; and/or

iii) Patient's inability to pay is identified via an outside collection agency income/asset search. Should the agency determine that a lawsuit will not be pursued, the account will be placed in an inactive status, where a monthly PHSSC review will determine further action, including possible charity acceptance and cancellation from the agency and removal of credit reporting.

iv) Patient's inability to pay is identified by Regional Business Office staff through an income/asset search using a third party entity.

b) Charity- Individual Assessment of inability to pay requires:

i) Completion of a Financial Assistance Application for the Mary Potter Program for Human Dignity for all facilities in the Providence Health & Services, Southern California Region;

ii) Validation that a patient's gross income is less than two and one-half times (250%) the Federal Poverty Guidelines (FPG) applicable at the time the patient has applied for financial assistance. A patient with this income level will be deemed eligible for 100% charity care; and/or

iii) Validation that a patient's gross income exceeds 250% of the FPG applicable at the time the patient has applied for financial assistance and that their individual financial situation (medical debt load, etc.) makes them eligible for possible discount payment (partial charity care) or 100% charity care. However, patients with gross income less than 350% of FPG will owe no more than 100% of the applicable Medicare allowable amount. This amount shall be recalculated at least annually to remain current with Medicare reimbursement rates and will be based on Medicare rates that specifically apply to the applicable hospital. A patient with a gross income exceeding 350% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is the lesser. In addition, as required by applicable California law, a patient with a gross income less than 350% of FPG who incurs total medical expenses in excess of ten percent (10%) of gross annual income will receive 100% charity benefit. Further, certain assets (retirement plan vested benefits, IRA's, 401k or 403b assets) may not be considered in determining an ability to pay and the first $10,000 of other monetary assets and 50% of the remaining monetary assets must not be used in the evaluation for financial assistance.

iv) Gross charges never apply to patients who qualify for partial charity or private pay discounts. Once gross charges are adjusted to the appropriate Medicare or private pay rate, the patient liability will not change even if eventually referred to a collection agency.

9) **Charity Care is not**:

a) Bad debt: A bad debt results from a patient's unwillingness to pay or from a failure to qualify for financial assistance that would otherwise prove an inability to pay;

b) Contractual adjustment: The difference between the retail charges for services and the amount allowed by a governmental or contracted managed care payer for covered services that is written off; or

c) Other adjustments:

i) Service recovery adjustments when the patient identified a less than optimal patient care experience;

ii) Risk management adjustments, where a potential risk liability situation is identified and Providence Risk Management has elected to absorb the cost of care and not have the patient billed;

iii) Payer denials where the facility was unable to obtain payment due to untimely billing per contractual terms; or retroactive denial of service by a managed care payer where appeal is not successful.

PROCEDURE/GENERAL INSTRUCTIONS

1) Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with AB 774 and SB 350 and the federal PPACA (Patient Protection and Affordable Care Act).

   a) Signage about the availability of financial assistance will be posted in registration areas of hospitals including emergency rooms and in the Regional Business Office.

   b) A Notice of Collection Practices shall be provided to all patients during registration and included in the final billing statement.

   c) This policy will be posted on each facility's internet page and will otherwise be made available upon request.

   d) Financial Assistance Applications will be available in the registration areas.

   e) PHSSC employees including admitting/registration and financial counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third party coverage and assist patients in applying for coverage when appropriate. Verification that a patient does not qualify for third party coverage or is ineligible for a government program is required before finalizing a charity decision.

2) PATIENT ELIGIBILITY WITH NO APPLICATION. Instances where a Financial Assistance Application is not required per charity definitions:

   a) Treatment Authorization Request (TAR) denials, Medi-Cal non-covered services, and untimely Medi-Cal billing write-offs will be recorded with their respective adjustment transaction codes. Medi-Medi accounts are written off to a unique transaction code to facilitate Medicare Bad Debt reimbursement.

   i) Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.

   ii) For Medi-Medi adjustments, that portion not claimed as Medicare bad debt reimbursement will be reclassified as charity in the general ledger.

   b) Services denied due to restricted Medi-Cal coverage will be written off to charity when the denial is received on a Medi-Cal remittance advice.

   c) A patient may be verified as homeless at any time during the revenue cycle. The preferred method is at registration, where a lack of address documentation is indicated and coding to "Homeless" status is completed. This will generate the charity write-off at the time of billing.

   d) PHSSC facilities will not engage in extraordinary collection efforts including referral to outside collection agencies before making a reasonable effort to determine whether the patient qualifies for financial assistance. Upon referral, outside collection agencies, in their collection activities, including when performing income and asset searches in preparation for lawsuit authorizations, can verify an inability to pay and can submit the account for charity approval under the following circumstances:

i) Self pay patients with gross incomes at or below 250% of Federal Poverty Guidelines. The entire balance will be deemed charity.

ii) Self pay patients with gross incomes in excess of 250% of FPG, and limited assets, can still qualify for partial or full charity, if medical debt load is significant enough to create an inability to pay. The liability, if gross income is between 250% and 350% of FPG will be no more than Medicare allowable. For gross income in excess of 350% of FPG, the patient's liability will be no more than the self-pay discount rate.

iii) Equity in a principal residence can be considered in asset determination only when income is in excess of 350% of Federal Poverty Guidelines, and a lien against that equity can be approved, but in no instance will foreclosure proceedings be initiated. PHSSC and its collection agencies will wait until the principal residence is sold or re-financed to collect its debt. California law places restrictions on monetary assets that can be considered in making an ability to pay determination. Consistent with California laws, monetary assets shall not include: (1) assets held under a qualified retirement plan; (2) the first ten thousand dollars ($10,000) of a patient's monetary assets; or (3) fifty percent (50%) of a patient's monetary assets in excess of $10,000.

3) PATIENT ELIGIBILITY AS ESTABLISHED BY FINANCIAL NEED PER FINANCIAL ASSISTANCE APPLICATION.

a) All PHSSC employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and refer patients for financial assistance. Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family. In these instances, a Financial Assistance Application can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.

b) The Financial Assistance Application must be accompanied by proof of income, including copies of recent paychecks, W-2 statements, income tax returns, and/or bank statements showing payroll deposits. If none of these documents can be provided, one of the following is required:

i) If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay;

ii) If the patient/responsible party is provided services, such as room and board, etc., in lieu of pay for work performed, the person granting the services must provide a letter delineating the services provided and the value of those services; or

iii) If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.

c) Patients may request a Financial Assistance Application by calling the Regional Business Office (RBO), writing to the mailing address on their patient billing statement, or downloading the form from the PHSSC websites:

d) Patients completing Financial Assistance Applications are responsible for making

reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.

4) FINANCIAL ASSISTANCE APPLICATION REVIEW/APPROVAL PROCESS:

a) For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any RBO employee. Standard transaction approval levels will apply.

b) A Financial Assistance Application must be reviewed by a RBO financial counselor. If gross income is at or below 250% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income required). If the gross income exceeds 250% FPG, an assessment for qualification of partial or full charity based on income, assets, and medical debt load will be made by the financial counselor with write-offs subject to standard approval levels.

c) Financial Assistance applications shall be reviewed and approved, denied or returned to the patient with a request for additional information within three business days of receipt.

d) Collection agency requests for charity or Financial Assistance Applications received from a collection agency shall be reviewed by a RBO financial counselor. The counselor shall follow the review process described in b) above in determining inability to pay and approving partial, total or no charity. Standard transaction approval levels will apply.

e) An approved charity determination is applicable to all services referenced in the application AND services provided up to six months after the date of the approved application, provided there is no change in the applicant's financial status that would warrant a reevaluation.

f) If charity is approved at 100%, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure.

5) Notification of charity determination:

a) In those instances where Medi-Cal restricted services are written off to charity, the notice of charity approval will be sent to the patient.

b) For homeless charity write-offs, no notification is necessary.

c) In all instances where a Financial Assistance Application was submitted, the person approving the Application shall submit a written determination of no charity, partial charity or full charity to the person who submitted the Application on behalf of the patient within ten days of final determination of the completed Application.

d) In the event partial or no charity is approved, the notification letter will advise that the patient may appeal the determination. Appeals should be in writing to:

Regional Director, Regulatory and Quality Assurance

Providence Health & Services, Southern California
4180 190th Street
Torrance CA 90504

The Regional Director, or designee, shall respond to charity denial appeals. Should the patient's appeal be denied, and the original denial upheld, collection activities will be re-started to afford the patient ample opportunity to make payment, per the provisions of applicable California law.

e) If partial charity is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of AB 774 and SB 350, including not garnishing wages or placing a lien on a principal residents.

6) Processing of charity write-off:

a) If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.

b) The 100% charity discount percentage is then applied to the account, using existing adjustment mnemonic/transaction codes.

c) A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to partial charity and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Should a partial charity account need to be referred to an outside agency for collection, the account will be flagged as a partial charity recipient so that the agency can assure that:

i) It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and

ii) It will not report the delinquency to a credit-reporting agency until 150 days after the date of service, or 150 days after the patient received partial charity approval.

AUDIT/CONTROL/RECORDS RETENTION:

All Financial Assistance Applications will be retained for a period of seven years from date of completion.

The charity determinations shall be subject to outside review to determine consistency in judgment and to provide further education/training; however, a charity determination shall not be reversed at any time.

Write-off approvals are subject to internal and external audit. Standard transaction approval levels are:

Less than	$ 5,000	Manager Level
Greater than	$5,000 to $10,000	Regional Director,
Greater than	$10,000	Regional Director, Revenue Cycle Management

REFERENCE(S)/RELATED POLICIES

American Hospital Association Charity Guidelines
California Hospital Association Charity Guidelines
California Alliance of Catholic Healthcare Charitable Services Guidelines
Providence Health & Services Commitment to the Uninsured Guidelines
Patient Protection and Affordable Care Act of 2010 (Federal Exemption Standards)
Private Pay Discounting Policy CA-FIN-5003
Regional Business Office Debt Collection Standards and Practices Policy, RBO-GOV-107

COLLABORATION

This policy was developed in collaboration with the following Departments:

PHSSC Finance Division
Providence Health & Services Department of Legal Affairs

ATTACHMENT A

2013 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
For families/households with more than 8 persons, add $4,020 for each additional person.	
1	$11,490
2	15,510
3	19,530
4	23,550
5	27,570
6	31,590
7	35,610
8	39,630

ATTACHMENT B

NOTICE OF COLLECTION PRACTICES

NOTICE

PATIENT RIGHTS WITH RESPECT TO COLLECTION OF DEBTS FOR HOSPITAL SERVICES

State and Federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or on-line at www.ftc.gov.

If you have coverage through group or private insurance, or other third party payer program, and you wish us to bill that organization, you must supply us with your enrollment information. This requirement is met by presenting your insurance card or other suitable document that provides policy information, (and dependent coverage, if applicable). If you require assistance in paying this debt, you may be eligible for the Medicare, Medi-Cal, Healthy Families, California Children's' Services, liability California Victims of Violent Crimes, automobile medical insurance, or other third-party programs, including charity care. Ask a hospital admissions or business office representative if you would like to pursue these options. Hospital charity and self-pay discount policies may be obtained by either asking an admissions or business office representative for assistance, or by visiting the hospital's web site for a downloadable form.

Non-profit credit counseling services may also be of assistance. Please consult a telephone directory for a listing of these programs.

The patient or responsible person will be required to sign the Conditions of Hospital Admission or Outpatient Treatment. That document will include an acknowledgment of financial responsibility for payment for services provided by the hospital. The hospital will bill any third party payer for which you provide enrollment information. You will be asked to pay co-payments, as prescribed by those payers. You may be responsible for services those programs do not cover. You will be billed following the conclusion of your service, although deposits may be requested prior to services being rendered. Should the debt remain unpaid, the account may be referred to an outside collection agency under contract with the hospital. The collection agency will abide by the above debt collection principles. Should the debt remain unpaid, the collection agency, on behalf of the hospital, will list the unpaid debt with credit-reporting agencies and may initiate legal proceedings, which may result in wage garnishment or a lien placed against an asset of the patient or responsible party. The Providence Health and Services charity policy provides that persons with household gross income below 250% of Federal Poverty Guidelines (FPG) are eligible for full assistance upon submission of a Financial Assistance Application. Persons with gross income above 250% may also be eligible for partial or full assistance, depending upon the information provided on the application.

If you have any questions about this notice, please ask any admissions or business office representative or by calling 800 (insert phone number for appropriate hospital).

ATTACHMENT C

FINANCIAL ASSISTANCE APPLICATION

(Available in English and Spanish)

Date: _____

Dear, _____

The Mary Potter Program is designed to provide financial assistance for those who have medical care needs, but have limited means to pay. Our policy has specific guidelines for qualification. I have enclosed an application for this program to assist you with your hospital bill.

Please complete the enclosed application and return the form to the address below. All information will be kept confidential.

Please attach the following items:

1. Paycheck stubs for 3 months (i.e. disability, unemployment, state aid, or employment)
2. Most recent tax return or W-2
3. Last 3 months of Checking and Savings Account Statements
4. Proof of income for all household members.

If you have any questions, please do not hesitate to contact our customer service office at 800-750-7703.

Return application to:

Regional Business Office

PROVIDENCE HEALTH & SERVICES
SOUTHERN CALIFORNIA REGION
PATIENT FINANCIAL ASSISTANCE APPLICATION

Date of Request: _____

Patient Name: _____ *Account No.* _____

Address: _____ *Date of Service:* _____

City/State: _____ *Zip Code:* _____

SS #: _____ *Telephone #:* _____

Date of Birth: _____

SECTION 1: RESPONSIBLE PARTY (Complete if different from above)

Name: _____

Address: _____

City/State: _____ *Zip Code:* _____

SS #: _____ _ *Telephone #:* _____

Occupation:

_____

Employer:

_____

Employer Address:

_____

Employer Telephone #: _____

SECTION 2: EVALUATION REQUIRED BY STATE OF CALIFORNIA

Ethnic Origin: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other*Specify)*_____

City/State of Birth: _____*Country of Origin:* _____

Are you a U.S. Citizen or Legal Resident? ☐ Yes ☐ No

Do you have documentation of your status? ☐ Yes ☐ No

Mother's Maiden Name: _____

_____

SECTION 3: FINANCIAL EVALUATION

Family Members Living in Household: *Include all persons living in household.*
Include all INCOME (i.e. wages, public assistance, social security, unemployment, alimony, and child support)

Name	Age	Relationship	Annual Income

Monthly Expenses:

Mortgage or Rent Payments: _____

Car Payments: _____

Utilities: _____

Other: (briefly describe)

_____ _____

List all Debts (greater than $500.00):

Description	Amount

List all Assets:

Do you own your home? ☐ Yes ☐ No Market Value _____

Do you own any cars/trucks? ☐ Yes ☐ No

Other assets: _____

SECTION 4: ADDITIONAL INFORMATION

Please make additional comments about your household's financial circumstances that affect your ability to pay the hospital bill:

SECTION 5: CERTIFICATION

I, _____, (person responsible for paying hospital bill) hereby certify that the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I further understand that intentional misrepresentation or falsification of any information contained in the questionnaire is punishable by law. According to the Fair Debt and Practice Act, the hospital has the right as a creditor to check your credit status with credit agencies. Your signature below will signify that you have been notified of such:

Signature:

_____ *Date:*

Patient or Responsible Party

FOR BUSINESS OFFICE USE ONLY

Approved Assistance: ☐ Full ☐ Partial ☐ Not Approved

Payment Arrangement: ☐ Yes ☐ No Amount per Month: _____

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Summary of Community Benefit Expense--2012

	# Impacted	2012 Expenses	2011 Expenses
Charity Care (at cost)	**15,971**	**$ 15,954,711**	$ 12,395,824
COMMUNITY BENEFIT SERVICES	**60,810**	**$ 16,275,964**	$ 14,062,499
Charity & Community Benefit (PH&S Scorekeeping)	**76,781**	**$ 32,230,675**	$ 26,458,323
Net Patient Revenue		**$ 574,655,000**	$ 510,921,000
% NPR		**5.6%**	5.2%
UNPAID COST OF MEDI-CAL	**23,462**	**$ 35,003,446**	**$ 17,199,914**
Reports to Community	**100,243**	**$ 67,234,121**	**$ 43,658,237**
Only completed annually			
UNPAID COST OF MEDICARE	**28,035**	**$ -**	**$ 8,561,904**
Reports to OSHPD	**128,278**	**$ 67,234,121**	**$ 52,220,141**

PROVIDENCE
Little Company of Mary

Summary of Community Benefit Expense--2012

PROVIDENCE LITTLE COMPANY OF MARY--2012 As of 12/31/12

COMMUNITY BENEFIT SERVICES --Detailed Breakdown

	Persons	Expenses	Offset	2012 Benefit	PY 2011 Comparison
Community Health Education--Broader Community					
Hospice Bereavement/Gathering Place	369	$ 915,179	$ -	$ 915,179	
Health Resource Center formerly Linkage to Community Servic	4,969	$ 70,670	$ -	$ 70,670	
Support Groups	972	$ 10,830	$ -	$ 10,830	
Subtotal				$ 996,679	$ 734,293
Community Health Education--Persons in Poverty		*Expenses*	*Revenue/Offset*	*Benefit*	
Sexual Assault Response Team (SART)	197	$ 227,890	$ 134,190	$ 93,700	
COPA (school day and after school physical activity)	5,434	$ 767,963	$ -	$ 767,963	
Community Outreach	4,032	$ 598,460	$ -	$ 598,460	
Linkage to Community Services (Poor & Vulnerable)	3,139	$ 344,056	$ -	$ 344,056	
Children's Health Insurance Program (CHIP)	1,098	$ 268,802	$ -	$ 268,802	
Baby Friendly Journey	41	$ 143,763	$ -	$ 143,763	
Get Out and Live (G.O.A.L.)(Diabetes)	208	$ 288,414	$ -	$ 288,414	
Subtotal				$ 2,505,158	$ 2,503,359
Community Based Clinical Svcs-Persons in Poverty		*Expenses*	*Revenue/Offset*	*Benefit*	
Partners for Healthy Kids (PFHK)	2,429	$ 914,404	$ -	$ 914,404	
Lively Lung Program	43	$ 41,966	$ -	$ 41,966	
Subtotal				$ 956,370	$ 1,597,238
Health Care Support Services--Persons in Poverty	*Persons*	*Expenses*	*Revenue/Offset*	*Benefit*	
Case management of under/uninsured adults	6,933	$ 1,951,874	$ -	$ 1,951,874	
Post Discharge expense for medically indigent	219	$ 552,139	$ -	$ 552,139	
Post Discharge Pharmacy medications	416	$ 185,295	$ -	$ 185,295	
Transportation/Taxi Vouchers for medically indigent	5,239	$ 132,868	$ -	$ 132,868	
Mexico Immersion Trip	5	$ 5,040	$ -	$ 5,040	
Subtotal				**$ 2,827,216**	$ 1,331,315
			$ 6,288,744		
SUBTOTAL--Community Based Outreach				**$ 7,285,423**	$ 6,166,205

PROVIDENCE
Little Company of Mary

Summary of Community Benefit Expense--2012

HEALTH PROFESSIONS EDUCATION		Expenses	Revenue/Offset	2012 Benefit	PY 2011 Comparison
Pastoral Education	5	$ 93,630	$ -	$ 93,630	
Medical Library	675	$ 31,092	$ -	$ 31,092	
Preceptorships(including Urban Scholars)	402	$ 1,745,067	$ -	$ 1,745,067	
SUBTOTAL, Health Professions Education				**$ 1,869,789**	$ 1,814,576

SUBSIDIZED HEALTH SERVICES		Expenses	Revenue/Offset	Benefit	
Paramedic Base Station	9,006	$ 780,209	$ -	$ 780,209	
Palliative Care Assessments	858	$ 1,805,899	$ -	$ 1,805,899	
Pediatric and Prenatal Clinic	1,246	$ 1,495,879	$ 608,430	$ 887,448	
Vasek Polak Health Clinic	4,637	$ 1,333,648	$ 346,102	$ 987,546	
Trinity Kids Care (Hospice)	179	$ 3,437,794	$ 1,344,835	$ 2,092,959	
	6,920				
SUBTOTAL Subsidized Health Services				**$ 6,554,061**	$ 5,272,005

FINANCIAL AND IN KIND CONTRIBUTIONS	Persons	Expenses	Revenue/Offset	Benefit	
Cash Donations	-	$ 39,575	$ -	$ 39,575	
Donation - Usable Equipment/Supplies/Shoes		$ 9,000	$ -	$ 9,000	
Cost of Fundraising for Community Benefit	-	$ 227,153	$ -	$ 227,153	
Free Space	972	$ 83,600	$ -	$ 83,600	
Mother Joseph Fund	-	$ 204,961	$ -	$ 204,961	
Adopt a Family (multiple Departments)	167	$ 2,400	$ -	$ 2,400	
SUBTOTAL Financial/in kind contributions				**$ 566,689**	$ 809,175

		Expenses	Revenue/Offset	[Net] Benefit	
TOTALS	**60,810**	**$ 18,709,520**	**$ 8,722,302**	**$ 16,275,962**	$ 14,061,961