

ORANGE COAST MEMORIAL

MEMORIALCARE® HEALTH SYSTEM

Orange Coast Memorial Medical Center

Annual Report and Plan for
COMMUNITY BENEFIT

Fiscal Year 2012
July 1, 2011 through June 30, 2012

Submitted to:
Office of Statewide Health Planning & Development
Healthcare Information Division
Accounting and Reporting Systems Section
Sacramento, California

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Letter from CEO

November 19, 2012

Orange Coast Memorial Medical Center strives to accomplish its mission to improve the health and well-being of individuals and families through continued implementation of Community Benefit programs and activities.

As a member of the MemorialCare Health System, Orange Coast Memorial demonstrates the organization's steadfast focus on delivering high quality, cost-effective health care that meets the changing needs of the communities we serve.

Orange Coast Memorial works in partnership with dedicated individuals and local organizations to remain consistent with our values and to continue investing our resources to best serve those with identified needs. As such, we are committed to strategically focusing our investment of charitable resources to address the identified, unmet health needs of the diverse communities within our market area. For fiscal year 2012, Orange Coast Memorial's community benefit contributions totaled \$33,828,000.

We are proud to continue the quest established by MemorialCare Health System which has enabled us to provide leading, essential health care for our community.

Sincerely,

A handwritten signature in black ink, appearing to read "m manker".

Marcia Manker
Chief Executive Officer

Orange Coast Memorial
MemorialCare Health System
18111 Brookhurst St.
Fountain Valley CA 92708
714-378-7000

Mission

To improve the health and well-being of individuals, families and our communities through innovation and the pursuit of excellence.

Vision

Exceptional People. Extraordinary Care. Every Time.

Values

The ABCS of MemorialCare

With a focus on solid fundamentals – Accountability, Best Practices, Compassion and Synergy – MemorialCare Health System is delivering the highest standard of patient care and exceptional clinical outcomes. What sets us apart is our ability to leverage the strengths of our health system, from operational efficiencies and the application of new technologies, to the exchange of ideas, expertise and best practices. It's what we mean when we say: MemorialCare. Excellence in Health Care.

MemorialCare Health System

Orange Coast Memorial is a member of the not-for profit, integrated delivery system that includes six top hospitals – Long Beach Memorial, Miller Children's Hospital Long Beach, Community Hospital Long Beach, Orange Coast Memorial, and Saddleback Memorial in Laguna Hills and San Clemente; medical groups – MemorialCare Medical Group, Memorial Prompt Care; an Independent Practice Association (IPA) – Greater Newport Physicians; MemorialCare HealthExpress retail clinics; and numerous outpatient health centers throughout the Southland. For more information, go to memorialcare.org.

Orange Coast Memorial

Orange Coast Memorial became a member of the MemorialCare Health System in January 1996. In May 1997, the hospital was granted not-for-profit status retroactive to December 26, 1995, the date of incorporation. Formerly, Orange Coast Memorial was known as FHP Hospital and operated as a for-profit facility.

Orange Coast Memorial is the only not-for-profit hospital in the Fountain Valley/Huntington Beach area. We are home to the MemorialCare Cancer Institute, MemorialCare Breast Center, MemorialCare Imaging Center, MemorialCare Heart & Vascular Institute, MemorialCare Center for Obesity, MemorialCare Center for Childbirth, the Parkinson's and Movement Disorders Institute, and the Miller Children's Specialty Center.

Orange Coast Memorial fulfills its community's health care needs with innovation and a commitment to excellence. We strive to provide compassionate care and personalized service to our community. We have been recognized by *US News and World Report* as one of the region's top hospitals for 2012-2013.

Orange Coast Memorial's (OCM) Board of Directors guided the direction of community benefit.

Voting Members

Hugh Moran, Chairman Businessman	Larry Lambert, Vice-Chair Businessman	Julio Ibarra, M.D. Secretary, Physician	Barry Arbuckle, Ph.D. President and CEO, MemorialCare Health System
Bob Schack Businessman	Bill Barnes Community Member	Gale Schluter Community Member	Art Aviles Community Member
Tim Helgeson Businessman	John Stroh Community Member		

Invited Guests (non-voting)

Marcia Manker CEO Orange Coast Memorial	Rob Realmuto, M.D. Chief-of- Staff Orange Coast Memorial	Frank Marino, M.D. Medical Director Orange Coast Memorial	Dale Vital CNO/VP, Pt. Services Orange Coast Memorial
Steve McNamara CFO Orange Coast Memorial	Lorraine Booth VP, People and Culture MemorialCare Health System	Emily Randle VP of Operations Orange Coast Memorial	Tammie Brailsford VP, COO MemorialCare Health System
Helen Cicino Fabian General Council, Sr. VP of HR MemorialCare Health System	Rick Graniere CFO MemorialCare Health System	Karen Testman Sr. VP, Financial Operations MemorialCare Health System	Paul Stimson Director, Orange Coast Memorial Foundation

About the Community

Orange Coast Memorial is located in Orange County, California, in the City of Fountain Valley. The primary service area served by Orange Coast Memorial includes: Costa Mesa, Cypress, Fountain Valley, Garden Grove, Huntington Beach, Los Alamitos, Newport Beach, Seal Beach, Surfside, Tustin, Westminster, and parts of Anaheim (92804) and Santa Ana (92703, 92704, and 92707).

Within the hospital service area there are a number of communities with disproportionate unmet health needs. Two population groups have been identified as vulnerable populations: Vietnamese families and senior adults. Nearly 75% of the entire Orange County Vietnamese community resides in the hospital's service area. This population represents nearly 10% of those served by the hospital. Senior adults, ages 65 and older, represent 12% of the population in the hospital's service area.

Community Health Needs Assessment

In 2010, Orange Coast Memorial conducted a community health needs assessment as part of the Orange County Health Needs Assessment (OCHNA) collaborative. OCHNA is a community-based, not-for-profit collaborative that was created and designed to meet the requirements of SB697 for all not-for-profit hospitals in Orange County. The collaborative is jointly funded by the Health Care Agency of Orange County, the Children and Families Commission, CalOptima, and the nine Orange County not-for-profit HASC member hospitals.

The 2010 needs assessment plan included a trend analysis of four previous OCHNA health needs surveys (1998, 2001, 2004, and 2007), as well as examination of primary data from the Census Bureau's American Community Survey, and the California Health Information Survey. Population estimates for OCHNA 1998 and 2001 were updated with the latest estimates from the State of California Department of Finance. In addition, OCHNA incorporated objective/secondary data sources, demographics/census data, and a key informant survey that OCHNA administered online, to be used as the source of qualitative data.

Objective/secondary data came from numerous sources, including Department of Finance, 2009 and 2010 Census estimates by Nielsen Claritas, Orange County Health Care Agency, and Healthy People 2010 objectives (used as benchmarks). The following health topics were examined for the Orange Coast Memorial service area:

- Health care access and coverage
- Health care utilization
- Health status
- Preventive care or risk factors
- Chronic diseases
- Maternal and infant health
- Nutrition, obesity, and exercise
- Child health
- Senior health

The Community Benefits Key Informant Survey, targeted local health care leaders selected by the OCHNA Steering Committee to determine community opinions on the health needs in Orange County, as well as the barriers faced by patients in accessing health care. 144 out of 474 invited individuals completed the online survey, for a 31% response rate. Key informants also answered questions about challenges in the county's health care system, as well as about the forms and quality of collaborative relationships between their organizations, service area hospitals, and other groups. There was broad representation of the health care sector, with particular representation from Community Based Organizations (CBOs).

The key organization groups used for analysis were Health Provider CBOs (21 key informants), County or City Governments (14), Hospitals (13), Community Clinics or FQHCs (11), and Health Advocacy or Education Organizations (8). The majority of key

informants (68% or 105) were Executives (such as CEOs, Directors, VPs), or Managers (such as Program Coordinators, Supervisors). The sample also included health care providers, educators, and researchers. Over 80% of key informants were affiliated with organizations that provided direct services, either to the entire county or to specific populations (e.g. seniors, Asian and Pacific Islanders, low-income). Of the 144 key informants, 24 key informants viewed Orange Coast Memorial as a current collaborative partner, in addition to other hospitals, clinics or organizations.

Community Health Needs Assessment Findings

This overview summarizes some of the significant findings drawn from the Community Health Needs Assessment.

Obesity and Chronic Disease Status

- 53% of adults in the Orange Coast Memorial service area were estimated to be overweight or obese
- Just over 9% of overweight/obese adults reported having heart disease, compared to 5% of healthy weight adults
- Heart disease was the leading cause of death in the service area in 2008, accounting for 26% of the deaths
- Nearly 15% of overweight/obese adults reported having diabetes, compared to less than 2% of healthy weight adults
- 30% of overweight/obese adults reported high blood pressure, and 27% of overweight/obese adults reported high cholesterol compared to only 15% and 14% of healthy weight adults
- 27% of overweight/obese adults had arthritis, compared to 16% of healthy weight adults
- 15% (54,022) of adults (18+) in the Orange Coast Memorial service area that were at normal or healthy weight reported having at least one poor mental health day in the past month. In contrast, 33% (41,173) of adults in the Orange Coast Memorial service area who were obese reported having at least one poor mental health day in the past month

Diabetes and Other Chronic Diseases

Adults who have been diagnosed with one chronic disease, such as diabetes, are at greater risk for additional chronic diseases than those who do not have diabetes.

Moreover, of adults in the service area who had diabetes in 2004, 9% (6,342) were normal weight, 51% (36,750) were overweight, and 40% (28,419) were obese.

- Of adults 18+ years who reported that they had diabetes, 36% also reported that they had arthritis. Among adults who did not have diabetes, 19% reported that they had arthritis
- Of adults with diabetes, 55% also had high blood pressure. In comparison, only 20% of adults without diabetes had high blood pressure
- Of adults with diabetes, 22% also reported that they had had heart disease. Only 6% of adults who did not have diabetes reported suffering from heart disease
- Of adults with diabetes, 16% were also diagnosed with cancer. Only 8% of adults who did not have diabetes reported that they had cancer

- Of adults with diabetes, 40% were also diagnosed with high cholesterol. Only 21% of adults who did not have diabetes reported that they had high cholesterol

Health Disparities in the Vietnamese Population

- Vietnamese adults were much more likely to rate their own health as *fair* or *poor* than any other ethnicity in the service area
- Of the 5% of individuals in the county who spoke Vietnamese at home, 63.7% (93,350) spoke English less than "very well" in 2009
- Over one in three (35%) Vietnamese women (40+) never had a mammogram or breast ultrasound, compared to 19% of white women
- Only 56% of Vietnamese women received a pap smear, compared to 97% of white and 92% of Hispanic/Latino women
- Vietnamese men were less likely to have received a digital rectal exam compared to white men (28% vs. 68%)
- Whites were also more likely than Vietnamese to have received a prostate exam (53% vs. 24%)
- Vietnamese had the highest percentage of current smokers, with nearly 11% (13,340) of adults indicating that they were smokers

Well-Being of Older Adults

- Nearly 12% (140,297) of the population in the service area is made up of adults who are 65 or older. The senior population in this services area has grown by 19% between 2000 and 2009, and is expected to grow by another 14% by 2014
- 15% of adults in the Orange Coast Memorial service area had at least some difficulty performing their daily activities, such as, eating, bathing, or dressing; in the county, the percentage of adults that had difficulty with activities of daily living was slightly lower (11%)
- 16% of older adults in the Orange Coast Memorial service area reported they had experienced a fall in the past 12 months; the countywide estimate of adults who experienced a fall was similar
- 9% of adults ages 65 to 74 and 4 % of adults ages 75 or older were caregivers to someone else
- Seniors living at or below the federal poverty level (FPL) in some of the cities located within the Orange Coast Memorial service area range from 16% in Garden Grove, 13% in Westminster, 12% in Costa Mesa and 10% and 9% for Anaheim and Costa Mesa

Results from Key Informant Survey

Top Health Priorities or Needs

- 55% indicated a need for adequate funding for health services from public programs
- 52% indicated a need to increase funding to community clinics
- 39% indicated a need for dental care for low-income/uninsured individuals
- 37% indicated a need for housing support for low to moderate-income

- 35% indicated a need for comprehensive efforts to improve healthy eating and exercise

Top Health Care Delivery System Challenges

Many of the challenges related to funding issues or insufficient primary care for underserved groups:

- 76% indicated government funding cuts and 54% indicated cuts from other sources or within organizations as challenges
- 37% of respondents believed that there are insufficient federally qualified health centers (FQHC) to care for underserved populations or that the referral system for health services is fragmented
- 35% of respondents indicated that there are insufficient physicians available to care for low-income populations; Community Clinics were the most likely to pick this option

Top Service Gaps for Underserved Populations

- 58% identified gaps in behavioral health services (e.g. outpatient services, services for children and families) and 55% identified gaps in primary care services for underserved populations
- 46% identified gaps in adult dental care services for underserved groups; adult dental care is a notable priority for both Community Clinics and Hospitals
- 45.3% or 63 would like to see more affordable prescription programs, and 42% (59) would like to see more case managers for health care for underserved populations

Top Patient Barriers to Health Care

- 63% thought that health coverage may be inadequate to cover all needs, and 55% thought that government eligibility levels are restrictive
- 64% of key informants selected the cost of medical services and 49% selected the cost of prescriptions as other key patient barriers
- Lack of adequate transportation was also high priority barrier (45%)
- 40% of key informants identified patient unfamiliarity with the health care system as another barrier

Priority Needs

Orange Coast Memorial engages members of the community to provide oversight for community benefit activities on its Community Benefit Oversight Committee (CBOC). The CBOC reports to the Orange Coast Memorial Board of Directors (Appendix 1 lists the CBOC members and their affiliations).

The CBOC assisted Orange Coast Memorial in the implementation of community benefit programs and activities through the proper implementation of the Advancing the State-of-the-Art in Community Benefit framework. The CBOC received regular reports of on-going activities and provided feedback for recommended outcomes measurement as well as recommended course of action for complete program development. The CBOC also conducted a review of the community needs assessment (CHNA) and set the focus

on sustainable community benefit programming based on the most recent CHNA report. The CBOC recommended that the Orange Coast Memorial Board of Directors approve community benefit resources to support programs that will address the needs of Vietnamese families and seniors, as well as for overweight and obesity prevention and complications of obesity.

While there are other needs identified in the community, the CBOC recognized the work of a number of engaged community partners that are addressing: behavioral and mental health needs, access to primary care services, at-risk youth, cancer prevention, as well as other identified needs.

Community Benefit Services Summary

Community Health Improvement Services

Community Health Education

The community was served by the provision of a variety of health education classes and events made available to the public at no cost. Health education targeted the general community, pregnant and lactating mothers, seniors, and the Vietnamese community.

- General health and wellness education reached more than 1,400 individuals on topics that included: Cardiovascular health, cancer, digestive disorders, women's and men's health, back health, skin health, eye health, nutrition and more
- Childbirth, baby care and lactation support classes were provided to 22 low-income mothers from the community
- Senior health and wellness education reached 2,255 individuals on topics that included: Nutrition, diabetes management, cancer prevention and treatment, fall prevention, cardiovascular disease, digestive disorders, fibromyalgia, back and spinal conditions, allergies, osteoporosis, and caregiving
- Vietnamese health and wellness education reached 903 individuals on topics that included: Women's health, cancer, hepatitis, cardiovascular disease, and lung disease

Health Fairs, Screenings, Flu Clinics and Exams

- Six health and wellness fairs for seniors
- Three flu shot clinics for older adults and seniors
- One flu shot clinic for the broader community
- Six carotid artery stroke risk screenings for seniors
- Three Vietnamese health and wellness fairs
- Two Vietnamese flu shot clinics
- Screenings targeting the Vietnamese community were provided for 597 individuals and included hepatitis, bone density, stroke risk, heart health, body fat, prostate cancer, and breast cancer
- An additional 1,075 individuals in the broader community received screenings for prostate cancer, heart disease, lung function, body fat, and skin cancer at three community-wide screenings

Health Promotion Activities

- Orange Coast Memorial offered a targeted health outreach program on local radio and cable TV to the Vietnamese community. Information on a variety of topics, including preventive practices was presented weekly on local access channels. Radio listeners were able to call in with questions. It is estimated that 250,000 people listened to and watched these presentations
- Senior Plus newsletter was mailed to senior residents to notify them of free health classes, events, and important information for seniors. This information was also posted at memorialcare.org
- Care Connection newsletter was mailed to residents to notify the community of free classes, screenings, and support groups held at Orange Coast Memorial and in the community. The information was also posted at memorialcare.org

Community Based Clinic Services

- Flu vaccines were provided for 338 seniors at flu clinics in senior centers and a local senior living facility

Health Care Support Services

- Cancer support groups and survivor events provided support assistance for more than 516 people
- Counseling was provided to 24 individuals

Enrollment Assistance and Referral Services

- Patient Financial Services help individuals enroll in MSI, regardless of where they receive care
- Vietnamese Community Outreach Coordinator
 - Coordinates free community education and outreach, free health screenings
 - Assists with securing medical transportation for the Vietnamese community
- Senior Advocate
 - Collaborates with local agencies and organizations to assist older adults in securing needed services
 - Coordinates free medical transportation program for seniors
 - Coordinates free health screenings, flu clinics, health education and disease prevention classes for seniors
 - Coordinates socialization and enrichment events for seniors

Health Professions Education

Orange Coast Memorial recognized the need, many years ago, to help build a strong health care workforce. We continued that commitment in FY2012.

Continuing Medical Education

CME lectures were offered throughout the year for educational purposes available to all physicians and health care professionals in the community; 753 professionals attended these lectures.

Nursing Education

One hundred nursing student precept and direct supervised encounters were performed by Orange Coast Memorial registered nurses during the 2011/2012 academic year. Nursing students attended: Golden West College; Saddleback College; California State University Fullerton; California State University Long Beach; Arizona State University; University of California Irvine; Walden University; Sonoma State University; Indiana State University; and Vanguard University.

Other Health Professions

Ninety two imaging student encounters, 21 respiratory therapy student encounters and 18 cardiac student encounters were comprised of training and direct supervision by Orange Coast Memorial clinical staff. Students attended Golden West College and Orange Coast College. In addition, three surgical tech students from Concord Career College were trained and directly supervised by Orange Coast Memorial registered nurses.

Cash and In-Kind Donations

Contributions to nonprofit community organizations and charity events were made to (partial listing):

- Boys & Girls Club of Huntington Valley – donations to support physical activity, healthy food choices and enrichment opportunities for at-risk children
- Kiwanis Club of Fountain Valley – donations to support activities for at-risk children
- Fountain Valley Senior Center – donations to maintain exercise equipment, provide enrichment activities and nutritional support for seniors
- Fountain Valley Senior Center – flu shots for vulnerable seniors
- Huntington Beach Council on Aging – donations to support senior nutrition, transportation, social services and enrichment activities
- Huntington Beach Senior Center – flu shots for vulnerable seniors
- Fountain Valley Senior Expo – donation for senior classes and activities
- City of Fountain Valley – donations for community activities
- Costa Mesa Senior Center – donations to support senior nutrition and enrichment activities
- Elwyn California – donation to support programs for developmentally disabled adults
- AltaMed Huntington Beach Community Clinic– donation to support health care services for underserved individuals
- Children of Promise Foster Youth Initiative – donation to support at-risk youth
- Community SeniorServ – donations to support senior nutrition programs

Community Building Activities

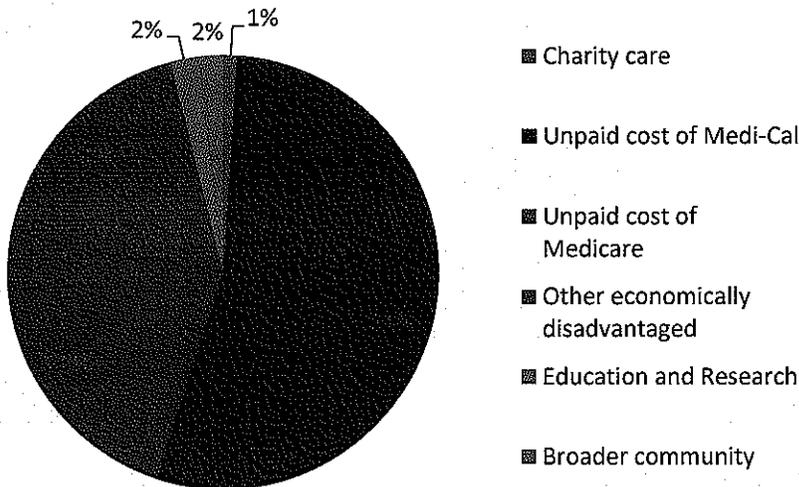
The Hospital supported the following organizations (partial listing):

- Service on the Huntington Beach Council on Aging Board of Directors
- Service on the BGCHV Health Committee, which guides health and wellness assemblies, activities, screenings and nutrition awareness for children
- Fundraising support for the Susan G. Komen Race for the Cure
- Service on the Kiwanis Club of Fountain Valley FAVORS Committee, which supports low-income seniors in their homes
- Service on the Fountain Valley Chamber of Commerce Board of Directors
- Service on the Fountain Valley Chamber of Commerce Government Affairs Committee
- Service on the Huntington Beach Chamber of Commerce Legislative Action Committee

Financial Summary of Community Benefit

Orange Coast Memorial's community benefit funding for FY2012 is summarized in the table below.

Community Benefit Categories	Dollar Amount
CHARITY CARE ¹	\$ 302,000
UNPAID COSTS OF MEDI-CAL ²	\$ 18,254,000
OTHERS FOR THE ECONOMICALLY DISADVANTAGED ³	\$ 5,970,000
EDUCATION AND RESEARCH ⁴	\$ 740,000
OTHER FOR THE BROADER COMMUNITY ⁵	\$ 732,000
TOTAL COMMUNITY BENEFIT PROVIDED Excluding Unpaid Costs of Medicare	\$ 25,998,000
UNPAID COSTS OF MEDICARE ²	\$ 7,830,000
TOTAL COMMUNITY BENEFIT PROVIDED Including Unpaid Costs of Medicare	\$ 33,828,000



¹ Charity Care includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation.

² Unpaid costs of public programs include the difference between costs to provide a service and the rate at which the hospital is reimbursed. Estimated costs are based on the overall hospital cost to charge ratio. *This total includes the Hospital Provider Fees (HPF) paid by Orange Coast Memorial to the State of California. Orange Coast Memorial was a contributing hospital and did not benefit from the HPF program.

³ Includes other payors for which the hospital receives little or no reimbursement (County indigent).

⁴ Costs related to the medical education programs and medical research that the hospital sponsors.

⁵ Includes non-billed programs such as community health education, screenings, support groups, clinics and other self-help groups.

Community Benefit Plan for FY 2013

The Community Benefit Oversight Committee (CBOC) assists Orange Coast Memorial in the implementation of community benefit programs and activities through the proper implementation of the Advancing the State-of-the-Art in Community Benefit framework. Orange Coast Memorial has continued the implementation of ASACB guidelines and Core Principles in FY 2012. All programs, classified as community benefit, have been assessed for their focus, impact and expenditures on vulnerable populations and presented to the CBOC.

In FY2013, Orange Coast Memorial will focus on measurement outcomes for community benefit programs with oversight from CBOC members who are active in community outreach activities and local governance. Orange Coast Memorial has solicited feedback and evaluation from grassroots community organizations. The planned outcome-evaluation process will help to ensure that programs meet identified needs and make an impact on those that they serve. This outcome accountability will provide a better picture of how programs are performing.

The CBOC conducted a review of Orange Coast Memorial's 2010 Community Health Needs Assessment (CHNA) and set the focus for sustainable community benefit programming based on this most recent report, which can be viewed at memorialcare.org.

Overweight and Obesity Prevention

In FY2013, Orange Coast Memorial, with oversight of the CBOC, will continue further involvement with the Boys & Girls Club of Huntington Valley to help prevent obesity through:

- Service on the Health Committee
- Provide expert speakers, upon request, for health assemblies focusing on nutrition, physical activity and health risk behaviors
- Provide exercise equipment and expert training to staff
- Donate nutritious snacks to children of parents in the Twilight Education Project, which is a program for low-income families designed to:
 - Help English language learners succeed in school
 - Help parents get the English language skills they need to support their children financially, academically and socially

Orange Coast Memorial will continue its involvement with the Orange County Nutritional and Physical Activity Collaborative (OC NuPAC) to help educate our communities about ways to improve health and prevent obesity through promotion of healthy eating and drinking habits, as well as fun physical activities.

Resources will also be focused on management of conditions that are complications of obesity such as heart disease, diabetes and cancer.

Vietnamese Community Outreach

At the recommendation of the CBOC and the approval of the Orange Coast Memorial Board of Directors, Orange Coast Memorial will focus resources for the Vietnamese community in the areas of:

- Cancer prevention and detection
- Disease prevention
- Access to care

Senior Outreach

At the recommendation of the CBOC and the approval of the Orange Coast Memorial Board of Directors, Orange Coast Memorial will focus resources for the senior community in the areas of:

- Heart disease prevention and detection
- Over weight and obesity prevention
- Cancer prevention and detection
- Access to care
- Medical transportation

Community Health Needs Assessment

Orange Coast Memorial is conducting a CHNA in FY 2013, to align new federal requirements with current state CHNA timeline requirements.

- Review CHNA for priority health needs
- Develop and approve Implementation Strategy
- Make the completed Orange Coast Memorial FY 2013 CHNA widely available

Appendix 1: Community Benefit Oversight Committee

The Community Benefit Oversight Committee for FY 2012 included the following members:

Gary Vatcher, local resident and retired businessman
Frank Marino, M.D., family medicine physician in private practice
Stanley Arnold, M.D., internal medicine physician in private practice
Marc Ecker, Ph.D., Superintendent, Fountain Valley School District
Tanya Hoxsie, CEO, Boys & Girls Club of Huntington Valley
Haydee Tillotson, local resident and business owner
Norma Brandel-Gibbs, local resident
David Truong, local resident and business owner
Art Aviles, local resident
Marcia Manker, CEO, Orange Coast Memorial
Jan Murphy, LCSW, Social Worker, Orange Coast Memorial
Debra Culver, Director of Public Relations and Marketing, Orange Coast Memorial
Chris Shinar, Pharm.D., Executive Director, Quality Improvement, Orange Coast Memorial
Beth Hambelton, non-voting staff

Invited guest:

Cathy Capaldi, VP Strategy and Business Development, Orange Coast Memorial

Appendix 2: Community Partners

In order to help meet the rapidly growing needs of vulnerable individuals in the service area, Orange Coast Memorial collaborated with the following organizations:

Abrazar Inc.
Alamitos IPA
AltaMed Community Clinic, Huntington Beach
American Cancer Society, Orange County Chapter
Arizona State University
Asian Community Clinic
Boys & Girls Club of Huntington Valley
California State University, Fullerton
California State University, Long Beach
Sonoma State University
City of Costa Mesa
City of Fountain Valley
City of Huntington Beach
Community Action Partnership
Community SeniorServ
Concord College
County of Orange
Edinger Medical Group
Fountain Valley Chamber of Commerce
Fountain Valley Regional Hospital
Fountain Valley School District
Golden West College Nursing Program
Hoag Hospital
Huntington Beach Chamber of Commerce
Huntington Beach Council on Aging (HBCOA)
Huntington Beach Senior Outreach Center
Illumination Foundation
Kiwanis Club of Fountain Valley
Memorial HealthCare IPA
MemorialCare Medical Group
Monarch HealthCare IPA
Nhan Hoa and Asian Community Clinics
Nutrition and Physical Activity Cooperative of Orange County (NuPAC OC)
Office of Assemblyman Allan Mansoor
Office of State Senator Tom Harman
Office of Congressman Dana Rohrabacher
Office of Congresswoman Loretta Sanchez
Office of Orange County Supervisor Janet Nguyen
Office of Orange County Supervisor John Moorlach
Orange Coast College
Orange County Health Needs Assessment (OCHNA)
Pacific College

Rotary Club of Huntington Beach
Saddleback College
Social Security Administration, Santa Ana office
St. Anselm Cross Cultural Community Center
Sonoma State University
Surf City Rotary Club
Susan G. Komen Foundation
Talbert Medical Group, a division of HealthCare Partners
University of California, Irvine
Vanguard University
Vietnamese American Cancer Foundation
Walden University

Appendix 3: Financial Assistance Policy

 Memorial Health Services Policies and Procedures	Effective Date: January 12, 2012 Note: For origination date see History at end of Policy.
Subject: Financial Assistance	Approval Signature: [Barry Arbuckle] Barry Arbuckle President & CEO
Manual: Finance/Purchasing Policy/Procedure # 236	Sponsor Signature: [Patricia Tondorf] Patricia Tondorf Executive Director Revenue Cycle Management

PURPOSE: Memorial Health Services (MHS) is a non-profit organization that provides hospital services in five distinct Southern California communities. Memorial Health Services and its member hospitals are committed to meeting the health care needs of patients, including those who may be uninsured or underinsured. Consistent with this commitment, MHS has developed this Financial Assistance Policy to assist qualified patients with the cost of medically necessary services.

The Financial Assistance Policy establishes the guidelines, policies and procedures for use by hospital personnel in determining patient qualification for financial assistance. This policy also specifies the appropriate methods for the accounting and reporting of Financial Assistance provided to patients at hospitals within Memorial Health Services.

Emergency physicians providing emergency medical services at any MHS hospital are also required by law to provide discounts to uninsured patients or patients with medical costs who are at or below 350 percent of the federal poverty level as defined in this policy.

POLICY

Definitions:

Financial Assistance- includes both Charity Care and Low Income Financial Assistance, and is defined as any necessary¹ inpatient or outpatient hospital service that must be provided at an MHS facility to a patient who is unable to pay for care. Patients unable to pay for their care may apply to Memorial Health Services for financial assistance.

¹ Necessary services are defined as health care services or supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that is not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Eligibility for patient financial assistance will be evaluated in accordance with the requirements contained in the Financial Assistance Policy.

Charity Care- Memorial Health Services has a Charity Care program for patients whose household income is less than or equal to two hundred percent (200%) of the current Federal Poverty Level (FPL) Guidelines. Qualifying patients who also meet all other Financial Assistance Program qualification requirements may be entitled to a discount of one hundred percent (100%) of the patient liability portion of the bill for services, for both insured and uninsured patients.

Low Income Financial Assistance (LIFA) - Memorial Health Services also provides Low Income Financial Assistance to patients whose household income is less than or equal to 350% of the current FPL Guidelines, and excluded from Charity Care due to monetary assets. Qualifying patients who also meet all other Financial Assistance Program qualification requirements may be entitled to a discount of the patient liability portion of the bill for services.

Cash Discount- Available to all patients not utilizing insurance regardless of income or assets. Under the cash discount program, the patient's payment obligation will be one hundred percent (150%) of the total expected payment, including co-payment and deductible amounts that the Medicare program would have paid for the service if the patient was a Medicare beneficiary

Federal Poverty Level- means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Depending upon individual patient eligibility, financial assistance may be granted on a full or partial aid basis. Financial assistance may be denied when the patient or other responsible guarantor does not meet the MHS Financial Assistance Policy requirements.

Financial Assistance Reporting

All MHS system hospitals will report the amounts of Charity Care financial assistance provided to patients to the California Office of Statewide Health Planning and Development (OSHPD) in accordance with OSHPD regulatory requirements, as described in the OSHPD Accounting and Reporting Manual for Hospitals, Second Edition and any subsequent OSHPD clarification or advisement. To comply with these regulations, each hospital will maintain this policy as written documentation regarding its Charity Care criteria, and for individual patients, each hospital will maintain written documentation regarding all financial assistance determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

Charity Care will be reported as an element of each hospital's annual Community Benefit Report submitted to OSHPD and any other appropriate state agencies.

General Process and Responsibilities

Access to emergency medical care shall in no way be affected by whether financial assistance eligibility under this policy exists; emergency medical care will always be provided to the extent the facility can reasonably do so.

All patients who do not indicate coverage by a third party payer will be provided a Medi-Cal application prior to discharge.

The Memorial Health Services Financial Assistance Policy relies upon the cooperation of individual applicants for accurate and timely submission of financial screening information. To facilitate receipt of such information, MHS hospitals will use a Financial Assistance application to collect information from patients who:

- Are unable to demonstrate financial coverage by a third party insurer and request financial assistance;
- Insured patients who indicate that they are unable to pay patient liabilities; and
- Any other patient who requests financial assistance.

The financial assistance application should be offered as soon as there is an indication the patient may be in need of financial assistance. The form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. Accordingly, eligibility for the MHS Financial Assistance Program may be determined at any time the hospital has sufficient information to determine qualification.

A complete financial assistance application includes:

1. Submission of all requested information necessary for the hospital to determine if the patient has income and/or assets sufficient to pay for services;
2. Authorization for the hospital to obtain a credit report for the patient or responsible party;
3. Documentation useful in determining eligibility for financial assistance; and
4. An audit trail documenting the hospital's commitment to providing financial assistance.

Eligibility- refer to grid on appendix A

Eligibility for financial assistance shall be determined solely by the patient's and/or patient guarantor's ability to pay. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

The patient/guarantor bears the burden of establishing eligibility for qualification under any financial assistance program. Patients/guarantors are required to provide timely, honest and complete disclosure in order to obtain financial assistance. The hospital

reserves the right to require a certified copy of the patient's income tax return. Each hospital will provide guidance and/or direct assistance to patients or their guarantors as necessary to facilitate completion of government low-income program applications when the patient may be eligible. Assistance should also be provided for completion of an application for the MHS Financial Assistance Program.

Completion of the Financial Assistance application and submission of any or all required supplemental information may be required for establishing eligibility with the Financial Assistance Program. Generally, the 2 most recent pay stubs or last year's tax return including W-2 may be required to establish income. Patients applying for Financial Assistance will be mailed a written notice within 10 business days from the date the Patient Financial Services Department receives a completed application with all necessary documentation to approve or deny Financial Assistance.

Financial Assistance Program qualification is determined after the patient and/or patient guarantor establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance. In the event of a dispute regarding eligibility for financial assistance, a patient may seek review from management in Patient Financial Services.

Once determined, Financial Assistance Program eligibility will remain in effect for a period of six (6) months and then may be renewed by the hospital upon submission of required information by the patient. Patient Financial Services will develop methods for accurate tracking and verification of financial assistance program eligibility.

Any eligible patient account balance created by a visit that resulted in the request for Financial Assistance Program coverage and those occurring for a period of six (6) months following eligibility determination will be considered for full or partial write-off. Generally, other pre-existing patient account balances outstanding at the time of eligibility determination by the hospital will be included as eligible for write-off at the sole discretion of management, whether tracked as an Accounts Receivable or Bad Debt

Patient obligations for Medi-Cal Share of Cost (SOC) payments will not be waived under any circumstance. However, after collection of the patient SOC portion, any other unpaid balance relating to a Medi-Cal SOC patient may be considered for Charity Care.

Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include, but shall not be limited to the following:

- No insurance coverage under any government or other third party program
- Household² income
- Household net worth including all assets, both liquid and non-liquid

² "Household" includes the patient, the patient's spouse, any individual to whom the patient is a dependent and any other individual legally responsible to provide for the patient's health care needs. At age 18, a patient's income will be considered separately, regardless of living arrangements, unless the hospital is informed that the patient is still a dependent.

- Employment status
- Unusual expenses
- Family size as defined by Federal Poverty Level (FPL) Guidelines
- Credit history

Eligibility criteria are used in making each individual case determination for coverage under the MHS Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need. To assure appropriate allocation of assistance, financial need may be determined based upon consideration of both income and available patient family assets.

Covered services include necessary inpatient and outpatient hospital care, provided that the services are not covered or reimbursed by any state or federal government program (including Medicare, Medi-Cal, or county indigent programs) or any other third party payer. All patients not covered by third-party insurance and those insured patients who indicate that they are unable to pay patient obligations such as co-payments and deductibles, may be considered for eligibility under the Financial Assistance Program.

For the purpose of determining eligibility for LIFA discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns, and assets will not be considered. Any patient not wishing to disclose their assets will automatically be ineligible for a Charity Care write-off but may still qualify for LIFA.

INCOME QUALIFICATION LEVELS

Full Charity

If the patient's household income is two hundred percent (200%) or less of the established poverty income level, based upon current FPL Guidelines and the patient meets all other Financial Assistance Program qualification requirements, one hundred percent (100%) of the patient liability portion of the bill for services will be written off.

Low Income Financial Assistance (LIFA)

If the patient's household income is less than three hundred fifty percent (350%) of the established poverty income level, based upon current FPL Guidelines, excluded from Charity Care due to monetary assets, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply:

a. Patient's care is not covered by a payer. If the services are not covered by any third party payer so that the LIFA-qualified patient ordinarily would be responsible for the full billed charges, the LIFA-qualified patient's payment obligation will be one hundred percent (100%) of the total expected payment, including co-payment and deductible amounts, that the Medicare program would have paid for the service if the patient was a Medicare beneficiary. If the service provided is not covered under the Medicare program then the LIFA-qualified patient will be responsible for forty (40%) of billed charges.

b. Patient's care is covered by a payer. If the services are covered by a third party payer so that the LIFA-qualified patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the LIFA-qualified patient's payment obligation will be one-hundred percent (100%) of the patient liability portion of total payment up to the point where total payments (patient + insurance) equal one-hundred percent (100%) of the total expected payment, including co-payment and deductible amounts, that the Medicare program would have paid for the service if the LIFA-qualified patient was a Medicare beneficiary.

ASSET QUALIFICATION

Patient owned assets may be evaluated to determine if sufficient patient household resources exist to satisfy the hospital's bill for services rendered. Evaluation of patient assets will consider both the asset value and amounts owed against the asset to determine if potential net worth is available to satisfy the patient payment obligation.

Recognizing the need to protect basic household assets, each patient family unit evaluated will be allowed the following asset exemptions:

- Primary residence
- One vehicle per patient or two vehicles per family unit
- Tax-exempt retirement program funds
- Ten Thousand Dollars (\$10,000) and fifty percent (50%) greater than Ten Thousand Dollars (\$10,000) in other total assets
- Deferred Compensation Plans

Patients who have assets beyond those specifically exempted will be expected to leverage the assets through independent financing in order to satisfy the patient account. Patients with sufficient assets will be denied eligibility for Charity Care even when they meet basic income qualification requirements.

For the purpose of determining eligibility for discounted payment, either LIFA or Cash Discount, documentation of income shall be limited to recent pay stubs or income tax returns and assets will not be considered

SPECIAL CIRCUMSTANCES:

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, net worth, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by the MHS hospital.

- If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

- If the patient/guarantor has recently been declared bankrupt by a Federal Bankruptcy Court he/she will be deemed eligible for the Financial Assistance Program.

Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off as Charity Care. All such circumstances shall be identified in the account notes or on the patient's Financial Assistance Application as an essential part of the documentation process.

OTHER ELIGIBLE CIRCUMSTANCES:

Memorial Health Services deems those patients that are eligible for any or all government sponsored low-income assistance programs to be indigent. Therefore, such patients are automatically eligible for Charity Care or LIFA under the MHS Financial Assistance Policy and account balances classified as Charity Care if the government program does not make payment for all services provided, or days during a hospital stay.

For example, patients who qualify for Medi-Cal, CCS, CHDP, Healthy Families, MSI, CMSP, Trauma or other similar low-income government programs are included as eligible for the MHS Financial Assistance Program.

Any or all non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any other failure to pay for covered or non-covered services provided to Medi-Cal and/or other government low-income qualified patients are covered.

Patients with restricted coverage, and/or other forms of limitation shall have non-covered amounts classified as Charity Care when payment is not made by the low-income government program.

Pending Medi-Cal patients not approved for Medi-Cal are also eligible for Charity Care.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as Charity Care if:

1. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients; or
2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance. The determination of a catastrophic medical event shall be based upon the amount of the patient liability according to the billed charges, and considering the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic

medical event. As a general guideline, any account with a patient liability for services rendered that exceeds \$100,000 may be considered for eligibility as a catastrophic medical event.

Any account returned to the hospital from a collection agency that has determined the patient or guarantor does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or guarantor's inability to pay for services will be maintained in the Charity Care documentation file or in the account notes.

Criteria for Re-Assignment from Bad Debt to Charity Care

All outside collection agencies contracted with MHS to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to Charity Care:

1. Patient accounts must have no applicable insurance coverage including governmental or other third party payers); and
2. The patient or guarantor must have an Experian credit score rating of less than or equal to 500. If the collection agency is using a credit scoring tool other than Experian, the patient and or guarantor must fall into bottom 20th percentile of credit scores for the method used; and
3. The patient or guarantor has not made a payment within one hundred eighty (180) days of assignment to the collection agency; and
4. The collection agency has determined that the patient/guarantor is unable to pay; and/or
5. The patient does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score.

Public Notice

Each MHS hospital shall post notices informing the public of the Financial Assistance Program. Such notices shall be posting in high volume inpatient, outpatient and emergency service areas of the hospital. Notices shall also be posted in the patient financial services and collection departments. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. These notices shall be posted in English and Spanish and any other languages that are representative of five percent (5%), or more, of the patients in the hospital's service area according to the Federal Title VI guidelines.

Data mailers and statements sent to patients as part of the routine billing process will contain information about the MHS Financial Assistance Program. These notices shall be available in English and Spanish and any other languages that are representative of five percent (5%), or more, of the patients in the hospital's service area according to the Federal Title VI guidelines.

A patient information brochure that describes the features of the MHS Financial Assistance Program will be made available to patients and members of the general

public. These notices shall be posted in English and Spanish and any other languages that are representative of five percent (5%), or more, of the patients in the hospital's service area according to the Federal Title VI guidelines.

Billing and Collection Practices

Patients in the process of qualifying for government or hospital low-income financial assistance programs will not be assigned to collections prior to 120 days from the date of initial billing.

If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with guidelines outlined in California Health and Safety Code 127400 et seq. Low-income patients, who at the sole discretion of the hospital are reasonably cooperating to settle an outstanding hospital bill by making regular and reasonable payments towards their outstanding hospital bill, will not be sent to an outside collection agency if doing so would negatively impact the patient's credit. The hospital extended payment plan may be declared no longer operative after the patient's failure to make all consecutive payments due during a 90-day period. Before declaring the hospital extended payment plan no longer operative the hospital shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. Prior to the hospital extended payment plan being declared inoperative, the hospital shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The hospital shall not report adverse information to a consumer credit reporting agency or commence a civil action against the patient or responsible party for nonpayment prior to the time the extended payment plan is declared to be no longer operative. For purposes of this section, the notice and phone call to the patient may be made to the last known phone number and address of the patient.

Patients who communicate that they have an appeal for coverage of services pending will not be forwarded to collections until the final determination of that appeal is made. Examples of appeals are; Health Plan Appeals, Independent Medical Review, Medi-Cal and Medicare coverage appeals.

The hospital shall reimburse the patient or patients any amount actually paid in excess of the amount due under this article, including interest. Interest owed by the hospital to the patient shall accrue at the rate of ten-(10%) percent per annum; beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars (\$5.00). The hospital shall give the patient a credit for the amount due for at least 60 days from the date the amount is due.

All extended payment plans will be interest free.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy shall be guided by these standards.

Good Faith Requirements

Every MHS hospital makes arrangements for financial assistance with medical care for qualified patients in good faith and relies on the fact that information presented by the patient is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, inaccurate or incomplete information has been given. In addition, the MHS hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order qualify for the MHS Financial Assistance Program.

In the event that a patient qualifies for partial financial assistance under the LIFA component of this Policy and then fails to make payment in full on their remaining patient liability balance, the hospital, at its sole and exclusive discretion, may use any or all appropriate means to collect the outstanding balance while in compliance with California Health and Safety Code 127400 et seq.

History:

Origination: May 22, 2006 (Replaces Policies #230 Low Income Financial Assistance (LIFA), Qualifications For: and #231 Charity Care, Qualification and Process for Assignment)

Reviewed/Revised: January 1, 2007

Reviewed/Revised: December 20, 2007

Three Year Review: February 18, 2010

Reviewed/Revised: December 27, 2011

Revised: January 12, 2012

Appendix A.

	CHARITY CARE		CASH DISCOUNT
FPL INCOME LEVEL	0-200%	<= 350% and disqualified from 100% Charity Care	OVER 350%
DISCOUNT	Charity Care 100% Write-off	Charity Care- Low Income Financial Assistance Discounted Payment 100% of Medicare	Cash Discount 150% of Medicare
Income*	For purposes of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans.	For purposes of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.	Not to be Considered
Assets	For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars (\$10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars (\$10,000) be counted in determining eligibility.	Not to be considered	Not to be Considered
Qualifications	Available to Uninsured patients or Patients with high medical costs as defined by: (1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months. (2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.	Available to Uninsured patients or Patients with high medical costs as defined by: (1) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months. (2) Annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.	Patients not utilizing insurance.