



Saddleback Memorial Medical Center

Annual Report and Plan for
COMMUNITY BENEFIT

Fiscal Year 2012

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Letter from the CEO

Stephen B. Geidt

It is my pleasure to present Saddleback Memorial Medical Center's Community Benefit Report for fiscal year 2011. Saddleback Memorial has proudly served the communities in and around the Saddleback Valley for the last 38 years. With the addition of our San Clemente campus in 2005, we have been able to better serve all of the southern Orange County communities.

Saddleback has been in the epicenter of an exploding and aging population. We have always served a community of active seniors, and as this population advances in age, it is no surprise that we face the challenges that are coincidental; a growing incidence of a population with multiple chronic conditions. Saddleback is a bellwether of what the population at large will see in the years to come, with a significant penetration of the population dealing with heart failure, pulmonary disease, cerebrovascular disorders and diabetes. Finding new and innovative ways to provide care and health promotion to this population will continue to be a focus of ours going forward.

A serious and growing concern is the advancing diabetes crisis that is connected to obesity, most especially childhood obesity. Left unchecked, this poses one of this country's greatest public health threats, and we must coordinate with all community resources available to improve nutrition and exercise among the entire population in order to address this ticking time bomb.

These, and other local community health needs, are described in this report, along with what SADDLEBACK MEMORIAL is investing in to address them. Saddleback is not alone in this effort; we work in concert with numerous community organizations, churches and government agencies to connect with, and make a difference in the lives of, vulnerable populations.

Sincerely,



Stephen B. Geidt
Chief Executive Officer

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 strives to deliver the highest standard of patient care and exceptional clinical outcomes. Leveraging the strengths of the health system, from operational efficiencies and the application of new technologies, to expertise and best practices, MemorialCare is committed to providing the highest quality of health care to the benefit of the communities we serve.

MemorialCare Health System

MemorialCare Health System is a leading Southern California not-for-profit integrated delivery system with nearly 11,000 employees and 2,300 affiliated physicians. The MemorialCare hospitals include Long Beach Memorial Medical Center, Miller Children’s Hospital Long Beach, Community Hospital Long Beach, Orange Coast Memorial Medical Center-Fountain Valley Saddleback Memorial Medical Center Laguna Hills and Saddleback Memorial Medical Center San Clemente.

Four leading physician groups joined the health system as the founding members of the MemorialCare Medical Foundation, launched in early 2011. With this addition, our health system now includes five urgent care locations, 21 primary care locations and two specialty care locations, in addition to the MemorialCare HealthExpress retail clinics in Albertsons stores in Huntington Beach, Irvine and Mission Viejo.

The health system has gained widespread recognition for our unique approach to health care. The organization has been identified as one of the Top 100 Integrated Health Networks in the Nation, as well as Top 10 in the West (from SDI). Our hospitals are ranked as high performers in 18 specialties by US News and World Report. We are particularly proud to be one of only 29 companies worldwide selected as a 2011 Gallup Great Workplace winner!

Saddleback Memorial Medical Center

A 325-bed acute care, not-for-profit hospital with two locations, Laguna Hills and San Clemente, Saddleback Memorial Medical Center has been meeting the healthcare needs of South Orange County residents since 1974. Saddleback Memorial treats more than half a million people each year, including inpatients, outpatients, new babies and patients in the emergency department. In addition to 24-hour emergency care, Saddleback Memorial offers complete critical, surgical

and obstetrical services, as well as a variety of educational classes and programs in keeping with its mission of enhancing the health and well-being of individuals, families and the community. Its centers of excellence include:

- Saddleback Women's Hospital, with LDRP suites, a fetal diagnostics center for high-risk pregnancies, a neonatal intensive care unit and MemorialCare® Breast Center;
- Saddleback Heart and Wellness Center, including two cardiac catheterization laboratories, an open-heart surgery program, a cardiac rehabilitation program, educational classes, screenings and support groups;
- Saddleback Rehabilitation and Orthopedic Services and Talega Outpatient Rehabilitation Center, offering inpatient and outpatient rehabilitation programs and comprehensive orthopedic services, including hip and knee replacements;
- Saddleback Cancer Services, with a full line of oncology treatments and state-of-the-art radiology services;
- Saddleback Home Care Services, providing skilled home care and hospice services.

Saddleback Memorial Medical Center's Governing Board is comprised of community members, civic leaders and physicians, and hospital and corporate administrative leaders. The Governing Board reviews both the community benefit plan and report and receives periodic updates from community outreach staff.

Saddleback Memorial Medical Center opened in 1974 as a result of the efforts of local residents to build a community hospital. Saddleback Memorial's beginnings were humble and have provided a framework of community values that drive policy formulation, strategic planning and collaboration with other organizations. Saddleback Memorial Medical Center's mission, as established by our Governing Board, includes an imperative to enhance the health of our community. We provide accessible, high quality health care services that meet the needs of our community. The strategic planning and budgeting process incorporates community benefit planning.

About the Community

Saddleback Memorial Medical Center is located in Orange County, California, with two locations, one in the City of Laguna Hills and the second in the City of San Clemente. The communities we serve at Saddleback Memorial Medical Center - Laguna Hills (Saddleback Memorial - Laguna Hills) encompasses the following 12 communities: Aliso Viejo, Foothill Ranch, Irvine, Ladera Ranch, Laguna Beach, Laguna Hills, Laguna Niguel, Laguna Woods, Lake Forest, Mission Viejo, Rancho Santa Margarita, and Trabuco Canyon.

The communities we serve at Saddleback Memorial Medical Center - San Clemente (Saddleback Memorial - San Clemente) include Capistrano Beach, Dana Point, San Clemente, and San Juan Capistrano.

Within Saddleback Memorial's service area are a number of communities with disproportionate unmet health needs. Two groups have been identified as vulnerable populations: older adults ages 65 and above and families living in poverty, in neighborhoods in San Juan Capistrano, San Clemente, and Dana Point.

Nearly 12% (83,931) of Saddleback Memorial - Laguna Hills and 14% (20,551) of Saddleback Memorial - San Clemente service areas are made up of adults who are 65 or older. Compared to Orange County, the older adult population growth in both service areas has been pronounced over the years. Between 2000 and 2010, the Saddleback Memorial - Laguna Hills senior population grew by 46% and the Saddleback Memorial - San Clemente senior population grew by 36%; the overall countywide senior population grew by 29% over the same time period. The five year projected growth from 2010 to 2015 is estimated to be 18% for Saddleback Memorial - San Clemente and 23% for Saddleback Memorial - Laguna Hills. The 65-74 years population is expected to increase by at least 27%. The "oldest old" population, or adults 85+ years, is expected to grow by 12% in both service areas. As the senior population increases in size and individuals are beginning to live longer, there will be a greater need for care giving services, health services, and social support.

Census estimates for 2010 show that the following service areas have varying degrees of racial/ethnic diversity: the cities of San Juan Capistrano, Lake Forest, and Irvine exhibiting notable diversity. Over one in four of the San Juan Capistrano population five years and above spoke Spanish at home, higher than the countywide average. While South Orange County is noted for its affluence relative to the rest of Orange County, this masks the places within the service area that display genuine health and social needs. There are communities with low annual household income and high poverty levels: almost one in three households in Dana Point and San Juan Capistrano had annual incomes below \$50,000. The proportion of all people in San Juan Capistrano living in poverty was higher than the overall countywide rate.

Community Health Needs Assessment

SB697 Requirements

In 1994 Senate Bill 697 (SB697) was signed into law which created a mandate for not-for-profit, private hospitals. The intent of SB697 is to provide hospitals with a formal mechanism for fulfilling their obligations as tax exempt organizations, by assessing community health needs every three years and by reporting to the community about charitable services and benefits in response to identified needs.

Summary of Methodology and Assessment Process

The Orange County Health Needs Assessment (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 Hospital Association of Southern California (HASC) member hospitals.

Due to the economic downturn county hospitals and governmental partners were unable to provide sufficient funding to conduct the random digit dial telephone survey of 5,000 households for the Orange County 2010 health needs assessment. An alternative needs assessment plan was developed that incorporated a mix mode approach to data collection that included a trend analysis of four previous OCHNA health needs surveys (1998, 2001, 2004, and 2007), as well as additional 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, so the estimates provided for the county will differ from county estimates provided in previous reports released by OCHNA. 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 (all cited within the report), including Dept. of Finance, 2009 Census estimates by Nielsen Claritas, Orange County Health Care Agency, and Healthy People 2010 (used as benchmarks). Qualitative data was obtained through a key informant survey of community based organizations, foundations, health advocates, community clinics, local political/policy leaders, public health organizations, and other hospitals.

In prior assessment years, hospitals have had to analyze their own raw data, and results have been mixed, depending on staff resources. New for the 2010 assessment year, OCHNA provided an objective analysis—including all tables, graphs, and text—of all data for each individual hospital, highlighting health priorities. The goal was to provide statistically reliable data analyses, which would be broad in scope, but allow for a more in-depth evaluation of specific health indicators at the hospital service area, to better meet the policy and program planning needs of each individual hospital.

The following priority health topics are highlighted for the discrete service areas of Saddleback Memorial Medical Center Laguna Hills and Saddleback Memorial Medical Center San Clemente.

- Health care access and coverage
- Health care utilization
- Health status
- Preventive behaviors
- Chronic diseases
- Mental/behavioral health
- Maternal and infant health

- Nutrition, obesity, and exercise
- Child health
- Senior health

The 2010 Community Benefits Key Informant Survey, which was conducted in September 2010, 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 that have limited the scope of health care services, 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 belonged to organizations that provided direct services, either to the entire county or to specific populations (e.g. seniors, Asian and Pacific Islanders, the low-income). Of the 144 key informants, 39 key informants viewed Saddleback Memorial Medical Center as a current collaborative partner, in addition to other hospitals, clinics or organizations. Please note that percents have been rounded to the nearest whole number and that the number of key informant responses (n) may vary for each question.

Key Informant Collaborative Partners

39 key informants selected Saddleback Memorial Medical Center as a current collaborative partner. The 39 Saddleback Memorial partners also collaborated with other organizations; the top 10 groups are presented below:

- Mission Hospital (79% or 31)
- UCI Medical Center (77% or 30)
- County of Orange, Health Care Agency (74% or 29)
- Hoag Memorial Medical Center (74% or 29)
- St. Joseph Hospital (74% or 29)
- CalOptima (69% or 27)
- Kaiser Permanente Orange County (69% or 27)
- St. Jude Medical Center (69% or 27)
- Laguna Beach Community Clinic (69% or 27)
- Camino Health Center (62% or 24)

Community Health Needs Assessment Findings

Older Adult (65+ Issues)

Chronic Diseases in Older Adults

In 2007, OCHNA survey data highlighted that 63.2% (244,405) of older adults in Orange County had a chronic or serious health problem, such as heart disease, arthritis, or a mental health condition, that required frequent medical care (e.g., regular doctor visits or daily medications). In the Saddleback Memorial - Laguna Hills service area, older adult with chronic conditions was slightly higher (66.6% or an estimated 45,048). In 2008, the top five causes of death for all Orange County older adults (65+) were the following:

- Heart disease accounted for 30% of deaths among older adults, with 405 deaths from Heart Failure.
- Cancer accounted for 23% (2,999) of deaths among older adults.
- Cerebrovascular disease accounted for 7% (951) of deaths among older adults.
- Chronic Lung Respiratory Disease accounted for 7% (926) of deaths among older adults, with 79 deaths from Chronic Bronchitis or Emphysema and with 760 deaths from other Chronic Obstructive Pulmonary Diseases.
- Alzheimer's disease accounted for 7% of deaths among older adults.

Health Access and Utilization for Older Adults

- While it is assumed that adults 65+ universally have health care coverage, mostly because of the Medicare program, almost 7% of seniors in Lake Forest and 6% of seniors in Irvine went without coverage in 2009; data was not available for all other Saddleback Memorial service area cities (American Community Survey 2009).
- In the Saddleback Memorial - Laguna Hills service area, close to half of older adults (65+) lacked dental health coverage and one in three older adults lacked vision coverage (OCHNA 2007).
- An aggregation of ACS data for Irvine, Lake Forest, and Mission Viejo (available cities) showed that almost 91% of older adults (65+) had public health care coverage, most likely Medicare (American Community Survey 2009).
- Moreover, one in four CalOptima Medi-Cal members in the Saddleback Memorial Medical Center service area was at least 65 years as of August 2010. Countywide this proportion was 17.4% (CalOptima).
- The total number of Emergency Department (ED) visits at both Saddleback Memorial campuses increased by over 12% from 2005 to 2009 for a total of 39,586 ER encounters; in 2009 29% (11,505) of ED encounters were adults age 60 years and older; almost 50% (48.7% or 5,606) of ED encounters among the senior population were adults age 80 years and older (OSHDP).

Transportation Needs for Older Adults

Because of debilitating health conditions many older adults stop driving and instead rely on family members, friends, caregivers, or programs to take them to important medical appointments or social engagements. The lack of transportation serves as a barrier to crucial medical care, complicating health condition, and also hastens social isolation. (Note: there were insufficient respondents in the Saddleback Memorial service area, thus the following pertains to Orange County as a whole.)

- A greater proportion of older adults found it difficult to obtain needed transportation in 2007 (19%) vs. 2001 (5%).
- Older adults in the age category 65-74 years were more than twice (24% vs. 10%) as likely as adults in the age category 85 and older to report they had difficulty obtaining transportation.
- 21% of females have difficulty obtaining transportation, compared to only 11% of males.
- Females were almost twice as likely to have difficulty obtaining transportation than males.

Adult Health Issues (18+)

Obesity, Heart Disease, Diabetes and Other Chronic Conditions

The impact of obesity on health overall is dramatic, especially when comparing to individuals who have a healthy body weight. 54% of all adults in Orange County were estimated to be overweight or obese, which was similar to proportion of adults (53%) in the Saddleback Memo service area. The following applies to the Saddleback Memorial - Laguna Hills service area:

- 8% of overweight/obese adults reported having heart disease.
- 10% of overweight/obese adults reported having diabetes.
- 35% of overweight/obese adults reported high blood pressure.
- 40% of overweight/obese adults reported high cholesterol.
- 16% of overweight/obese adults had arthritis.

Maternal / Infant Health

Breastfeeding

Breast Feeding and Child Weight

There are various studies cited by the CDC that demonstrate a relationship between breast feeding and a reduced risk of pediatric overweight or obesity. The duration of breast feeding may also play a role in lowering the risk, where the longer the duration, the lower the chance of a child being overweight. Exclusive breast feeding also appears to provide more protection against overweight when comparing to breast feeding and formula feeding in combination, although more research is needed. Furthermore, the benefits of breast feeding with respect to healthy weight may last into the teenage years, and even into adulthood.

Saddleback Memorial Medical Center has experienced a steady increase in the

proportion of new mothers initiating any breastfeeding at the hospital from 2004 to 2007. In contrast, the countywide breastfeeding rate has remained mostly constant over the past five years.

- The exclusive breastfeeding rate decreased slightly at the hospital from 2004 to 2007: from 57.6% (1,808) to 43.2% (1,140). For Orange County, the exclusive breastfeeding rate was 26.7% (12,425) in 2004 and increased to 30.2% (13,406) in 2007.
- In 2008, there were 2,575 births at Saddleback Memorial; 90.3% (2,324) of mothers initiated any breastfeeding, and 49.4% (1,272) of mothers initiated exclusive breastfeeding.
- Countywide, 84.8% (32,604) of new mothers indicated they would initiate any breastfeeding, and 25.5% (14,955) of new mothers indicated they would initiate exclusive breastfeeding in 2008.
- Saddleback Memorial Medical Center surpassed the countywide breastfeeding initiation rates for white, Hispanic, and Asian mothers in 2008.
- White mothers were far more likely to initiate exclusive breastfeeding at the hospital compared to Hispanic or Asian mothers, although the white exclusive breastfeeding rate was lower than the countywide rate.
- The Hispanic and Asian exclusive breastfeeding initiation rate at the hospital was higher than countywide rates.
- Healthy People 2010 Objective: Increase the proportion of mothers who breastfeed their babies: 81.9% Ever; 60.5% At 6 Months; 34.1% At 1 Year.

Results from Key Informant Survey

Top Health Priorities or Needs

- 55% (78 out of 144) indicated a need for adequate funding for health services from public programs.
- 52% (75) indicated a need to increase funding to community clinics.
- 39% (56) indicated a need for dental care for low-income/uninsured individuals.
- 37% (54) indicated a need for housing support for low to moderate-income.
- 35% (51) 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% (108 out of 142) indicated government funding cuts and 54% (76) indicated cuts from other sources or within organizations as challenges.

- 37% (53) of respondents believed that there are insufficient FQHC's to care for underserved populations or that the referral system for health services is fragmented.
- 35% (50) 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 (55%).

Top Service Gaps for Underserved Populations

- 58% (80 out of 139) viewed gaps in behavioral health services (e.g. outpatient services, services for children and families).
- 54.7% (76) viewed gaps in primary care services for underserved populations.
- 46% (64) viewed gaps in adult dental care services for underserved groups; adult dental care is a notable priority for both Community Clinics (73% or 8) and Hospitals (62% or 8).
- 45.3% or 63 would like to see more affordable prescription programs.
- 42% (59) would like to see more case managers for health care for underserved populations.

Top Patient Barriers to Health Care

The chief patient barriers related to health coverage or costs of medical services or prescriptions:

- 63% (88 out of 139) thought that health coverage may be inadequate to cover all needs
- 55.4% (77) thought that government eligibility levels are restrictive
- 64% (88) of key informants selected the cost of medical services
- 49% (68) selected the cost of prescriptions as other key patient barriers.

PRIORITY NEEDS

Chronic Disease

Chronic disease is currently the biggest threat to population health, with over 130 million Americans currently living with a chronic disease (Bryce, J. The Disturbing Facts on Chronic Disease. Ezine Articles. Sept. 7, 2010 EzineArticles.com) and these numbers are expected to rise dramatically with the Baby Boomers beginning to turn 65 years old in 2011. In 2007, older adults (65 years and older) made up 14% of the total adult population in California compared to 3.7% (but expected to grow by more than 40% between 2010 and 2020) in Orange County (Chronic Conditions of Californians, 2007 California Health Interview Survey). With these staggering numbers and percentages, and the findings from the OCHNA Saddleback Memorial Medical Center 2010 Needs Assessment Report, the prevention and management of chronic disease was the main priority for the FY12 Community Benefit Plan.

Chronic Lower Respiratory Diseases

Chronic Lower Respiratory Diseases (CLRD) refers to chronic diseases that affect the lower respiratory tract (including the lungs). The most prevalent diseases are

Chronic Obstructive Pulmonary Diseases (COPD), which includes emphysema, chronic bronchitis, and other smoking-related disorders.

- In 2008, the Orange County rate of adults 45+ dying from COPD was 82.3 deaths per 100,000 adults;
- In 2008, chronic lung respiratory disease which includes chronic bronchitis, emphysema, and other chronic obstructive pulmonary disease was the 4th leading cause of death in adults 65 years and older, but the 3rd leading cause of death in those 65-74 years in Orange County.

Healthy People 2020 Objective: Reduce to 98.5 deaths per 100,000 adults aged 45 years and older from chronic obstructive pulmonary disease.

Diabetes

Diabetes was the seventh leading cause of 2007 deaths in the US, according to the CDC. Type 1 diabetes accounts for 5% to 10% of all diagnosed cases and Type 2 diabetes accounts for 90% to 95% of cases.

- 8.1% of adults 20+ statewide were diagnosed with diabetes in 2008. (CDC)
- Orange County surpassed the HP 2020 Objective in 2008.
- There were 425 Orange County deaths from Diabetes in 2008. (CDPH 2008)
- Age-Adjusted Diabetes Death Rate per 100,000 population:
 - 13.8 (222 Deaths) Females
 - 16.9 (203 Deaths) Males
 - 15.1 Overall rate

Healthy People 2020 Objective: Reduce to 65.8 diabetes-related deaths per 100,000 population by 2020.

Heart Failure

Heart disease was the leading cause of hospitalizations for older adults in Orange County, (17.3% hospitalization rate) with the City of Laguna Woods accounting for some of the highest rates of hospitalizations and emergency department visits.(Objective Data 2008, Health Care Agency Research Center). At Saddleback Memorial Medical Center 54% of those admitted with a diagnosis of heart failure, myocardial infarction (heart attack), chronic obstructive pulmonary disease (COPD), and stroke were residents from Laguna Woods Village (zip code 92637), a city with a population of almost 20,000 residents.

Because hospital and other Orange County Health Needs Assessment (OCHNA) data have demonstrated that chronic disease disproportionately affects Saddleback Memorial's older adult population, often leading to a poor quality of life and reduced physical functionality that can cause disability, chronic disease played a significant role in Saddleback Memorial Medical Center's FY12 Community Benefit Program.

With goals to improve the quality of life and functional status, delay and reduce co-morbidities, and (acute) complications, the FY12 Community Benefit Plan focused on older adults already living with one or more chronic diseases. Research has shown that chronic disease and the resultant complications leading

to a poor quality of life are not part of the normal aging process; therefore prevention programs targeted at this population also played a role in community benefit programming. Programs included screening programs, educational classes and support groups.

Collaborating with community agencies that also address the health and social needs of the older adult population has been key to building program sustainability and capacity.

Obesity, Nutrition, and Exercise

Scope of the Obesity Crisis

Obesity has become a priority public health issue because an alarming proportion of children and adults are heavy. The following figures examine the changes in overweight or obesity rates over the last four OCHNA survey years among children (2-17) and adults (18+) in the Saddleback Memorial service areas as well as the entire county. It appears that the rate of *at risk of overweight/overweight* children has in fact been declining from 2001 to 2007; this may reflect the success of various efforts initiated by the hospital and its partners to address the growing childhood obesity problem.

- The Saddleback Memorial - Laguna Hills service area consistently had lower percentages of overweight/risk of overweight children than the county. Saddleback Memorial - San Clemente, on the other hand, had larger fluctuations.

Area	1998	2001*	2004	2007	% Change from 1998-2007
Saddleback Memorial - Laguna Hills	43.4% 79,548	-	48.0% 145,160	51.3% 182,695	7.9% Increase
Saddleback Memorial - San Clemente	33.0% 26,956	-	45.8% 38,433	44.3% 28,307	34.2% Increase
Orange County	44.5% 886,571	-	51.8% 1,079,511	53.5% 1,069,198	20.2% increase

*Adult weight status was not reported for 2001 because height and weight data was not collected.

- In 2004, 48.0% (145,160) were overweight or obese in the Saddleback Memorial - Laguna Hills service area. In 2007, the percent of overweight/obese adults in the service area grew to 51.3%, an increase of 6.9%. The Saddleback Memorial - San Clemente service area consistently had lower percentages of overweight/obese adults than Saddleback Memorial - Laguna Hills and the entire county.

The various negative impacts resulting from obesity can lead to considerable financial burdens on individuals, employers, and hospitals. With the growing number of children who are overweight, and adults who are obese, the financial costs continue to rise as the quality of life declines.

Within the Saddleback Memorial - Laguna Hills service area, the OCHNA 2004 survey estimated that overweight or obese adults had higher rates of diabetes (Chi-square=8.707, p=0.003), high blood pressure, (Chi-square=21.777, p<0.001), and high cholesterol (Chi-square =5.526, p=0.019), compared to healthy weight adults.

As health problems related to obesity have become more widespread, there has been an upswing in the economic costs associated with overweight and obesity. In 2006 the economic costs of obesity in California were estimated to be \$41.2 billion, with \$3.3 billion attributed to Orange County. By 2011 the projected costs of obesity in the state of California are estimated to reach \$52.7 billion, according to a study by the California Center for Public Health Advocacy.

Overweight or obese people may incur higher medical costs due to diagnostic and treatment services for health problems usually related to unhealthy weight, such as diabetes and heart disease. The Medical Expenditure Panel Surveys (MEPS) show that treatment and care for these chronic diseases can be staggering to the health care system, the individual, and the larger economy. Of the 10 most costly health conditions in 2007 in the United States, four are conditions often linked to obesity, poor nutrition, or lack of exercise.

Community Benefit FY12

Through the key informant surveys and other OCHNA assessment methodologies, numerous and varied socio, economic and health issues have been identified in the communities in which Saddleback Memorial Medical Center serves. It's through the collaboration with other organizations that Saddleback Memorial is able to address many of these identified needs. For issues that Saddleback Memorial is unable to address, for reasons such as the specialization required or the enormity of the need, other organizations are identified as being more appropriate to address these needs.

External Stakeholders

In collaboration with a variety of not-for-profit organizations who work with underserved populations, Saddleback Memorial has been able to further its community benefit work in identifying unmet social and health needs and providing support in addressing these needs. The following is a partial list of community partners with whom Saddleback Memorial has collaborated and/or provided funding during FY12.

- American Association of Diabetes Educators
- American Cancer Society
- American Diabetes Association

- American Heart Association
- American Stroke Association
- Association of Community Cancer Centers
- Boys and Girls Club of San Clemente
- City of San Clemente
- Families Forward
- Laguna Beach Community Clinic
- iHope
- Orange County Cancer Coalition
- Roxanna Todd Stroke Foundation
- San Clemente Collaborative Leadership Council
- Susan G. Komen Foundation
- Vital Link Inc.

Disease Management Program (Heart Failure)

Heart failure is one of the most common diagnoses for patients discharged from Saddleback Memorial, with more than 420 cases per year. Frequent readmissions are accompanied by decreasing quality of life and reduced functional status for the frail elderly population. During FY12, the Disease Management (DM) program grew from 100 to 118 participants (60 patients were managed for heart failure and 58 participants were managed for chronic obstructive pulmonary disease or COPD). The program goals included: improvement in the participant’s health, quality of life and functional status through intensive education and coaching toward disease self-management. Outcomes for the Heart Failure Program are listed below.

Heart Failure Disease Management Program Outcomes

GOALS	ACTIVITIES	OBJECTIVES	OUTCOMES
Heart failure program participants will experience improvement in their self-reported quality of life and functional status	Empower participants with self-management skills through intensive coaching and education	Quality of Life will improve from baseline through self-report survey by 25 %	Participants reported a 47% improvement in their Quality of Life, from baseline, per the Dartmouth Survey.
Improvement in participant health status	DM Program participants complete baseline Quality of Life and Functional Status Surveys	Functional status will improve from baseline measured by self-report surveys by 20%. Health status improvement will be evidenced by a 30% decrease in preventable readmissions	Program participants reported a 37% improvement in their functional status, from baseline, per the Duke Survey. 33 %decrease in hospital readmissions from FY11

Community Benefit Services and Programs Summary

Community Health Improvement Services

Activities carried out to improve community health.

Community Health Education

The community was provided with various health education classes made available to the public at no cost. Health education targeted the general community, seniors, and classes for those with diabetes, heart failure and pulmonary conditions.

- Over 875 community residents attend free general health and wellness education classes.
- Free lactation consultation was provided by registered nurses to 5,654 new mothers using the Lactation Help Line at a benefit of over \$277,000.
- Classes targeting older adults were attended by 237 people.
- Smoking Cessation programs were offered free and in partnership with the Tobacco Use Prevention Program at Saddleback Memorial – Laguna Hills and San Clemente.
- Over 875 individuals attended general health education classes during FY12 and over 235 older adults attended classes designed to educate them on a variety of topics.
- As a CPR training center of the American Heart Association, Saddleback Memorial provided free CPR training to 64 people during 2012.

Health Fairs and Screenings

- 425 older adults participated in free screenings and education at senior health fairs
- An additional 2,150 individuals at various businesses were provided with a variety of health education and screenings
- 1, 716 community residents attended health fairs sponsored by Saddleback Memorial.

Health Promotion Activities

- Senior Care Connections newsletters were mailed to senior residents to notify them of free health classes and events for seniors and provide education on a variety of health topics.
- Care Connections newsletters were mailed to area residents to notify the community of free classes, screenings, support groups held at Saddleback Memorial and education on a variety of topics.

Health Care Support Services

- Look Good Feel Better – partnership program with the American Cancer Society for women undergoing treatment for cancer – 30 women participated
- Cancer Support Group - 21 attendees

Senior Advocacy

- Assistance with medical bills –440 seniors
- Seniors applying for assistance – 25 seniors
- Assistance with dual eligibility – 20 seniors

Health Professions Education

Educational programs nursing students, and other health care professionals and students.

Nursing Students

456 nursing student clinical rotations

Phlebotomy Training

6 students were trained in phlebotomy by the Clinical Laboratory Services

Imaging Students

3 students interned in Imaging Services

Pharmacy/Pharmacy Technician Training

1 student interned in the in-patient pharmacy

Silverado High School Health Academy Program and Dana Hills Health and Medical Occupations Academy

174 high school students job shadowed in a variety of hospital departments

Medical Careers in Action

Partnership with Vital Link Inc. - program that provides high school students with a look into healthcare careers through a performance where physicians, nurses and other health care providers enact what they do on a daily basis to interest students in a healthcare career - 300 high school students and instructors attend each year

Cash and In-Kind Donations

Funds and in-kind services donated to community groups and other nonprofit organizations.

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

- Age Well Senior Services (provides transportation and Meals on Wheels program to South Orange County seniors)
- Saddleback Memorial Courtesy Bus Transportation - served 3,114 people
- Laguna Beach Community Clinic
- San Clemente Rotary Foundation
- Boys and Girls Club of South Coast Area
- San Clemente Educational Foundation

Non-Quantifiable Benefits

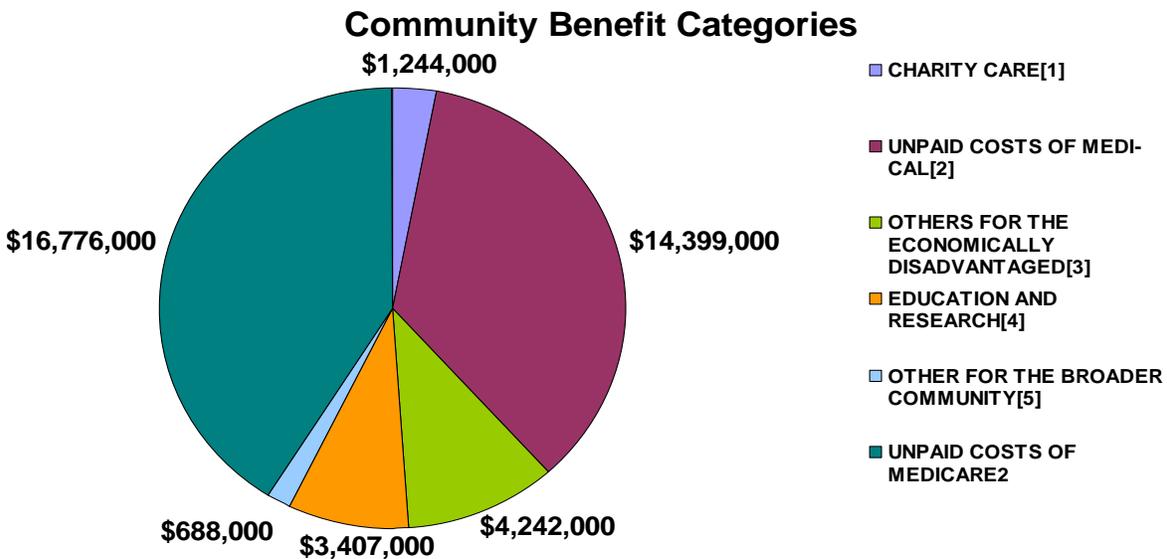
In addition to the quantifiable community benefits provided by Saddleback Memorial, various non-quantifiable programs and services were offered. Some of these non-quantifiable benefits include:

- 24-hour emergency room services, obstetrics, neonatal and newborn care, social services, rehabilitation services, breast center and other inpatient and outpatient medical/surgical services.
- Saddleback Memorial is one of the City of Laguna Hill's largest employers and as such strives to create a healthy work environment through the Good Life program, which focuses on the health and wellness of employees and their families. As part of MemorialCare, Saddleback Memorial provides a supportive work environment where employees are encouraged and empowered to eat well, get more exercise and quit smoking.
- Saddleback Memorial offers an extensive volunteer program, helping to meet the social and educational needs of youth and senior community members.
- Saddleback Memorial provides Pastoral Care Services that respond to the community's spiritual needs. One of Saddleback Memorial's Chaplains serves on Orange County's Interfaith Partnership Committee, which strives to promote understanding among Orange County's diverse faiths. A yearly breakfast and program is hosted by Saddleback Memorial.
- Saddleback Memorial's executives and staff work in collaboration with community service organizations. Saddleback Memorial provides leadership and actively works with both public and private organizations and agencies in our service area to address health care and social issues.
- Saddleback Memorial's employees and medical staff annually adopt families and seniors who are in need during the holiday season, providing gifts and food to help them during the holidays.

Financial Summary of Community Benefit

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

Community Benefit Categories		
CHARITY CARE ¹		\$ 1,244,000.00
UNPAID COSTS OF MEDI-CAL ²		\$ 14,399,000.00
OTHERS FOR THE ECONOMICALLY DISADVANTAGED ³		\$ 4,242,000.00
EDUCATION AND RESEARCH ⁴		\$ 3,407,000.00
OTHER FOR THE BROADER COMMUNITY ⁵		\$ 688,000.00
TOTAL COMMUNITY BENEFIT PROVIDED Excluding Unpaid Costs of Medicare		\$ 23,980,000.00
UNPAID COSTS OF MEDICARE ²		\$ 16,776,000.00
TOTAL COMMUNITY BENEFIT PROVIDED Including Unpaid Costs of Medicare		\$ 40,756,000.00



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 Saddleback Memorial to the State of California. Saddleback Memorial was a contributing hospital and did not benefit from the HPF program.

³ Includes other payers 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 FY13

Saddleback Memorial Medical Center has demonstrated its commitment to the surrounding communities of both facilities, through the many activities, programs and services that have been provided to address health needs identified through the 2010 Community Health Needs Assessment. The objectives of the FY13 Community Benefit Plan include the following:

- Expand the community benefit program to include greater emphasis on population health management strategies and partnership development with community agencies, to expand our reach into the community and provide services that compliment rather than duplicate each other.
- Expand programs and partnerships that focus on the prevention, early detection, and management of the following chronic diseases and conditions:
 - chronic obstructive pulmonary disease
 - heart failure
 - diabetes
 - frail elderly

Forming partnerships and collaborating with community agencies that address the health and social needs of the adult and older adult population is key to Saddleback Memorial's FY13 Community Benefit program, with the emphasis on population health strategies and programs. These agencies may include local senior centers, skilled nursing facilities, faith-based groups, and other organizations that are already providing services as part of the continuum of care for our shared population.

Appendix 1: Fair Pricing 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 to 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	Charity Care- Low Income Financial Assistance Discounted Payment	Cash Discount
	100% Write-off	100% of Medicare	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.