

2601 Airport Drive, Suite 220
Torrance, CA 90505
t: 310-303-5086
www.providence.org

Community Health



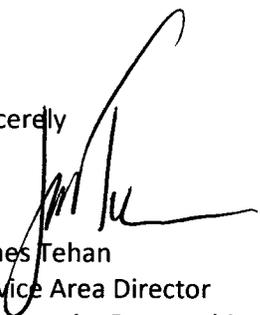
May 30, 2015

Mr. Mike Nelson
OSHPD
Healthcare Information Resource Center
400 "R" St, Room 250
Sacramento, CA 95811-6213

Dear Mr. Nelson

On behalf of our two Medical Centers, Providence Little Company of Mary, San Pedro and Providence Little Company of Mary, Torrance, I am pleased to provide you the 2014 Update to our Community Benefit Plan. Please let me know if I can be of any further assistance.

Sincerely



James Tehan
Service Area Director
Community Partnerships

2014 UPDATE TO COMMUNITY BENEFIT PLAN

Submitted to OSHPD by:

 **PROVIDENCE**
Little Company of Mary
Medical Center
San Pedro

 **PROVIDENCE**
Little Company of Mary
Medical Center
Torrance

May, 2015

A MEMBER OF:

 **PROVIDENCE**
Health & Services
Southern California

PROVIDENCE SOUTH BAY COMMUNITY

2014 ANNUAL UPDATE TO COMMUNITY BENEFIT PLAN

TABLE OF CONTENTS Page

I. Executive Summary.	1
A. Overview	
B. Organization of Community Outreach Resources	
C. The 2013 Needs Assessment	
D. Adoption of 2013 CHNA and 2014-16 Implementation Strategy	
II. Mission and Community Benefit	7
A. Incorporating Mission Philosophy Into Community Benefit	
B. Allocation of Community Outreach Resources Reflect the Mission	
C. Strengthening Communities through Prevention and Collaboration	
D. Benefits for the Broader Community & Health Professions Training	
III. Progress Towards Established Measurable Objectives during 2014	9
A. Establishing Benchmarks	
B. Progress Towards Three Year Benchmarks	
IV. Community Benefits and Economic Value.	16
B. Community Benefit Expenditures during 2014	
C. Number of Individuals Impacted by Community Benefit Programs	

Attachments:
Charity Care policy
Detail Listing and Description of Services/Programs Counted as Community Benefit, by Medical Center

I. EXECUTIVE SUMMARY

A. Overview

The Hospital Community Benefit Program (HCBP), commonly referred to as "SB 697," is a result of a 1994 State law that mandates private, not-for-profit hospitals, such as Providence Little Company of Mary Medical Centers in Torrance and San Pedro, to "assume a social obligation to provide community benefits in the public interest" in exchange for their tax-exempt status. Senate Bill 697 requires that non-profit hospitals throughout California conduct a triennial community needs assessment and develop a Community Benefits Plan based on the findings. This Annual Update for 2014 describes progress towards measureable objectives set forth in the 2013 Joint Community Health Needs Assessment adopted by the South Bay Community governing board.

The two Providence South Bay Community Medical Centers, Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance (hereafter South Bay Community), share a common geography because of their close proximity to each other. The South Bay Community Service Area is composed of 14 distinct municipalities, commonly referred to as the South Bay region of Los Angeles County. In accounting for charity care, the unpaid cost of Medi-Cal, and hospital-based programs, each Medical Center's Community Benefit expense is calculated separately, consistent with the Catholic Health Association's community benefit guidelines. Community outreach programs (to underserved communities) are generally allocated 50% to each Medical Center, unless a specific program operates in a community that is geographically linked to a specific Medical Center (i.e. Welcome Baby is specifically linked to the San Pedro Medical Center because program eligibility is based on a threshold of deliveries in the adjacent Wilmington community).

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

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

The Providence Mission statement directs special attention *for the poor and vulnerable*. This statement of organizational purpose reaffirms our commitment to underserved communities and simultaneously creates new challenges based in the reality that no single organization can meet all of the health care needs of high need communities. Accordingly, we work in collaboration with nonprofit organizations and public entities that share our purpose.

B. Organization of Community Outreach Resources

The Providence Little Company of Mary Community. The South Bay Community shares a common governing board, overlapping geography and complementary service lines. At its July, 2013 meeting, the governing board authorized the Community Health Department to conduct a joint community health needs assessment on behalf of Providence Little Company of Mary Medical Center, San Pedro and Providence Little Company of Mary Medical Center, Torrance. The two Medical Centers agreed to use a common definition of the community served and the governing board directed staff to conduct the needs assessment in the name of both Medical Centers on all forms, letters, and inquiries related to the conduct of the needs assessment. The South Bay Community Service Area includes 14 separate municipalities and encompasses 26 distinct zip codes in the South Bay/Harbor area of Los Angeles County.

The Community Health Department builds and sustains collaborative relationships with community safety net partners and is also designs, implements and evaluates programs/services that are responsive to community health needs, as prioritized by the triennial needs assessment adopted by the governing board. Community Health operates from the premise that:

- Diversity of language, culture, and perspective is an asset,
- Disparities can best be reduced through collaboration
- Targeted direct services facilitate health improvements in underserved communities.
- Limited resources should be targeted to communities with the greatest need.

Simply stated, the South Bay Community is committed to both collaboration with community partners and the delivery of services and programs that address the needs of the 14 communities that make up the South Bay, with particular attention to the six most economically disadvantaged communities

C. The 2013 Needs Assessment

Since the inception of SB697, the South Bay Community governing board (hereafter governing board) has delegated oversight of Community Benefit programs to a Standing Committee of the Board, the Mission Committee, while retaining oversight of the triennial needs assessment and annual update to the state regulatory agency, the Office of Statewide Health Planning and Development (OSHDP).

With the passage of the Patient Protection and Affordable Care Act, the IRS was granted expanded authority over the Community Health Needs Assessment (CHNA) process. As part of its oversight responsibility, the South Bay Community governing board requested a briefing on what changes, if any, should be considered in the conduct of the 2013 CHNA. Ultimately, the Board approved the formation of an ad hoc Board Committee on Community Benefits (hereafter BCCB) to assure that both Medical Centers continue to stay in the forefront of Community Benefit reporting, programs, and partnerships. The Board defined the composition of the Committee and the scope of its work as: 1) Review and revise the plan for the implementation of the needs assessment, 2) Consider the needs assessment findings, and 3) Make recommendations to the governing board on the adoption of priority health needs for 2014-2016.

The governing board also requested the BCCB consider the historical context of Community Benefit program in the South Bay Community as it formulated priorities for the CHNA. This was the first time the governing board had authorized a Committee to specifically address Community Benefits and the inclusion of 7 members (of the 14 appointed) in the prioritizations of community needs. Seven internal member represented the perspective of mission services, governing board, finance, nursing and the medical staff . Seven external members represented the perspective of public schools, faith based organizations, CBO's and the County Department of Public Health

On November 26, 2013, the Board adopted the priorities recommended by the BCCB, and after discussion, adopted the 2014-16 Implementation Strategy—which includes five strategies and 20 specific measurable objectives.

Methods & Process. On August 27, 2013, the Chair of the South Bay Community governing board convened the first of two meetings of the Board Committee on Community Benefits at Providence Little Company of Mary Medical Center, Torrance. The Committee was provided a detailed accounting of prior year Community Benefit Expenses, by Medical Center, related to 1) charity care, 2) Community Benefit Services, and 3) Unpaid Costs of Medi-Cal. They were briefed on the evolution of outreach to underserved communities and the ever increasing expectations that non-profit hospitals demonstrate evidence of community benefit impact in local communities. The Committee was also provided draft copies of the survey measures and was asked for input or suggestions prior to the onset of data collection. The Committee split into three groups and rotated through three separate discussion topics:

- 1) Should outreach continue to focus on economically disadvantaged communities?
- 2) How important is collaboration with external partners to successful outreach programs
- 3) Should more attention be paid to building communities?

In groups of four, the Committee members each had an opportunity to discuss the separate topics and the internal Providence facilitators reported out the consensus to the entire group towards the end of the session. This method was designed to emphasize external input and set the framework for the conduct of the needs assessment.

After those core issue were decided, primary and secondary data was collected by MPH students from UCLA School of Public Health over a two month period for BCCB review and to facilitate discussion that would result in prioritized needs that could be recommended to the governing board. After the BCCB identified the priorities going forward, a three year plan was established with five strategies, and 20 specific benchmarks to be accomplished by the end of 2016

On November 14, 2013, the South Bay Community governing board Chair convened the group at Providence Little Company of Mary Medical Center, San Pedro. The initial presentation summarized the four categories of data collected: 1) Secondary data from State and County sources, 2) Primary data including local nonprofits safety net organizations, a telephone survey of underserved clients and a parish survey in Hawthorne, 3) Community input from schools, clinics, CBOs, faith-based organizations, and representatives of elected officials, and 4) Input from three operating units within the Los Angeles County Department of Public Health. After a

presentation of the CHNA findings, including the BCCB recommended priorities, the governing board discussed the results and adopted the recommendation, set forth in full below.

Sources of Input. In an effort to further understand the top health needs in underserved communities, multiple primary data collection techniques were employed to seek input from community partners, residents of underserved communities and from community leaders with both a South Bay and Countywide perspective. This input, otherwise known as primary data, and the use of secondary data from County and public databases, provides strong evidence that the choices made help both Providence Little Company of Mary Medical Center in Torrance and Providence Little Company of Mary Medical Center in San Pedro be even more effective at addressing significant community health needs. Finally, extended conversations with key informants provided us specific and concrete things to do to improve the health care safety net in the South Bay. Further, their suggestions are expected to lead to new resources and collaborative partners to work together and positively impact the health of high need communities.

BCCB Recommendations to Community Ministry Board. The BCCB affirmed the need to continue with the five existing PLCM developed programs that have a track record of meeting established annual goals and objectives (Vasek Polak Clinic, Partners for Healthy Kids, Get Out And Live, Community Health Insurance Project and Creating Opportunities for Physical Activity). The Committee strongly supported continued emphasis and even expansion of preventive/educational services. It was the consensus of the group that educational programs that intervened either early in life or early in the development of a chronic condition were most likely to produce lasting results. Other points of view related to the value of programs for high risk populations with evidence based interventions were voiced but ultimately the group agreed that a higher priority should attach to education based interventions. Accordingly, the group ranked the following significant needs, in order of priority, for inclusion in the Implementation Strategy, even if the starting point is simply related to improved collaboration: 1) Services that allow seniors to live at home, 2) Mental Health Education/ Coping Skills, 3) Skills to Navigate the Health System and 4) Parenting Education. Understanding that resources are limited, the Committees decided that several significant needs were, in light of all the factors, were not deemed a sufficiently high priority to devote South Bay Community resources to building new programs: assistance with affordable housing, addressing cultural and language barriers, dental care, and acute mental health care and expanding the number of providers who accept Medi-Cal.

D. Adoption of 2013 CHNA & 2014-16 Implementation Strategy/Measurable Objectives

The BCCB recommendations were presented to the South Bay Community governing board at its November 26, 2013 meeting. After discussion of the process, and the findings and priorities recommended by the BCCB the CHNA report was accepted and adopted unanimously. After a further presentation of proposed strategies, objectives and benchmarks, the Board approved the following Implementation Strategy for 2014-2016:

Strategy 1: Increased access--Increase access to free, primary and subsidized health care, including insurance coverage through Medi-Cal and Covered California

Benchmarks

- By 2016, Enroll or renew 2000 children or adults annually.
- By 2016, Link 600 adults discharged from the ER to a medical home, as verified by kept appointments.
- By 2016, increase from 10 to 16 sites where mobile clinic regularly sees patients
- By 2016, increase the number of people receiving HPV immunizations over the 2013 baseline, by 20%
- By 2016, Improve identification and successful referral of Vasek Polak patients to GOAL diabetes project, by 20%, using 2013 as baseline
- By 2016, provide medical management for 150 uninsured adults at Vasek Polak, including subspecialty consults, advanced diagnostics and referral for those with ongoing chronic specialty conditions.

Strategy 2: Primary/secondary prevention-- Strengthen existing primary and secondary prevention programs (COPA, GOAL and Welcome Baby)

Benchmarks

- By 2016, Increase physical activity in children by 10% over (March 2014) baseline, as measured by pedometers, SOFIT or Fitnessgram.
- By 2016, provide COPA consultative services to 10 new locations, verified by trainings or MOU/contracts with school districts or community based organizations.
- By 2016, Increase to 50 the number of chronic disease self care cohorts (6-9 lessons) offered throughout the PLCMSA.
- By 2016, Sustain 1.5% average decrease in A1C levels for 80% of GOAL participants.
- By 2016, (PLCMMC-SP only) Increase Welcome Bay prenatal enrollments by 40%, using 2013 as baseline.
- By 2016, (PLCMMC-SP only) increase exclusive breastfeeding for Welcome Baby clients by 20%, using the first six months of home visits operations as baseline.

Strategy 3: External partnerships--Increase and strengthen partnerships with external stakeholders

Benchmarks

- By 2016, develop and sustain two collaborative task forces that address any of the top healthcare needs identified in the 2013 needs assessment AND that accomplish outcomes identified by the task force.
- By 2016, implement at least two capacity building projects that provide an infrastructure improvement for or in partnership with community partners (ie. Funding/ facilities/joint use agreement)

Strategy 4: Address BCCB Priorities--Explore feasibility of program development/ stakeholder collaboration in three areas prioritized by Board Committee on Community Benefits

Benchmarks

- By 2016, Design, pilot and implement a new program that addresses one of three new priority areas identified by the BCCB:
 - Services that allow Seniors to live at home
 - Mental Health Education/Coping Skills
 - Skills to Navigate Health Care System
- By 2016, convene an internal collaborative task force that addresses one of the BCCB priorities

Strategy 5—Monitor Community Benefit--Monitor Community Benefit programs and expenditure, consistent with Catholic Health Association guidelines

Benchmarks

- By 2016, increase charity care expense by 5%, using 2013 as baseline.
- By 2016, increase community outreach expense (non billed/negative margin) by 10%.
- By 2016, under the direction of the Mission Committee, conduct 6 site visits to explore client, stakeholder and employee satisfaction with specific programs provided by the Medical Centers' Community Health Department.
- By 2016, define, design and develop a data exchange project between PLCM and safety net and/or Public Health stakeholders

II Mission and Community Benefit.

A. Incorporating Mission Philosophy into Community Benefit

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

During the 1990's, the Sisters recognized that their diminishing numbers threatened to undo core mission commitments and they decided, in 1998, to become a Member of the Providence Health System. During the transition years, the Sisters retained their Mission statement and, when PHS merged with Providence Services in 2006, the Sisters finalized the transfer of assets and joined in the creation of Providence Health and Services; the governing board that oversees the two South Bay Community Medical Centers adopted the new Mission statement:

MISSION

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

B. Allocation of Community Outreach Resources Reflect the Mission

Central to community based outreach is the notion that diversity of language and culture is an asset and that disparities can be reduced through collaboration, advocacy among stakeholders and resources targeted to communities with the greatest need. The 2013 needs assessment describes the continuing process for determining which communities have the greatest need, bringing together primary and secondary data sources to identify specific disparities, and in collaboration with community partners, develop a three year plan that describes our priorities. While our Mission commands special attention to the poor and vulnerable, the Community Benefit Plan also includes programs that benefit the broader community. Using guidelines developed by the Catholic Hospital Association¹, our Community Benefit expenses fall into three broad areas: 1) Services for the Broader Community,) Programs for the Poor and Vulnerable, and 3) Health Professions Education. The South Bay Community tracks community benefit expenses throughout the year, as part of its operating commitments.

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

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

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

C. Strengthening Communities through Prevention & Collaboration

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

The South Bay Community seeks to balance the clear need for community outreach related to access to medical care services with the need for skills based prevention services that create health improvements in underserved communities. The challenge is to design a program with stakeholder input, implement a successful intervention, sustain it, achieve measurable results and, as new resources are found, expand to as many high need communities as resources will permit. Our ability to accomplish this result is directly linked to successful results.

Our Community Benefit Plan relies upon the South Bay Community to provide the initial funding to test out pilot projects that address identified or emerging community needs, develop them to a level of established effectiveness, and then extend them more broadly in partnership with other funding partners, typically private foundations and government entities. This cycle has repeated itself many times and has led to sustained growth in budget over the past 15 years, from \$1.5 Million in 2000 to \$4.5 Million in 2014. Currently, 50 Providence South Bay Community employees provide community outreach programs and services.

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

E. Benefits for the Broader Community & Health Professions Training

The South Bay Community sponsors four separate longstanding programs that benefit the broader community: Hospice Bereavement, free community health education lectures, a paramedic base station and the cost of employees who facilitate support groups for adults with chronic illnesses, on an ongoing basis. . Consistent with Catholic Health Association guidelines, we track the value of employee time spent preceptoring students who are enrolled in a broad range of health professions training programs, for the following disciplines: Registered Nurses/Nurse Practitioners, Pharmacy, Radiology, Radiation Oncology, Respiratory, Physical, Occupational and Speech Therapy, Social Work/Case Management, Laboratory, Pharmacy, Community Health, Dietetics, Ultrasound, Psychology and Hospice. In 2014, 719 students in health professions training programs were preceptored by South Bay Community employees.

III. PROGRESS TOWARDS MEASUREABLE OBJECTIVES DURING 2014

The purpose of establishing measurable benchmarks linked to the 2013 Community Health Needs Assessment (CHNA) strategies is to challenge the two Providence Little Company of Mary Medical Centers, San Pedro and Torrance (hereafter South Bay Community) to make a clear difference in underserved communities and reduce existing disparities related to:

- Increased Access to Health Care
- Primary and Secondary Prevention Services
- Capacity Building with External Community Partners
- Program Development in new priority areas of need identified by the CHNA

In addition, consistent with Providence core values, including stewardship, and mindful of our obligation to return the value of our tax exemption for the benefit of our South Bay Community, there are a set of benchmarks that monitor the program quality and expense of Community Benefit programs and services.

A. Establishing Benchmarks

The concept of committing to three year benchmarks was first approved by the South Bay Community governing board in 2007, as part of our triennial needs assessment and was repeated at the time of adoption of the Community Health Needs Assessment in 2010 and 2013. Benchmarks represent key performance indicators that provide the best evidence of the impact of the Community Benefit Plan on local communities related to access to health care, primary and secondary prevention, capacity building and program development in new priority areas.

In the first cycle, beginning in 2008, our success rate towards accomplishing our 21 benchmarks was 52% in the first year (ie. 11 of 21 benchmarks accomplished). This success rate increased significantly in the second year, to 71.5% (15 of 21 benchmarks accomplished); in the third year the success rate increased to 81% (17 of 21 benchmarks accomplished).

The Providence Little Company of Mary 2010 triennial needs assessment adopted by the governing board established four measurable objectives with 18 specific benchmarks to be addressed between 2011 and 2013. In the first year (2011), 13 of 18 benchmarks were accomplished, for a success rate of 72%. In 2012, this increased to 77% (14 of 18 benchmarks accomplished) and to 88% in 2013 (16 of 18 benchmarks accomplished).

In the absence of accepted State or national standards of community health improvement, these benchmarks also measure the strength of the three year benchmarks (ie. realistic but not too easy to accomplish and continuing year-to-year improvement in results). The expectation is NOT that all benchmarks will be achieved because many factors can thwart a three year plan. The implementation of the ACA has clearly impacted several benchmarks that previously were consistently met. In addition, the benchmarks for this 2014-16 cycle place greater emphasis on community capacity building and collaboration with partners, which is more difficult to measure.

By sticking with the same benchmarks for a three year period, stakeholders gain an appreciation for the importance of achieving specific outcomes and the importance of continuous improvement. In every Community Benefit program area, we are fully engaged with community partners in a collaborative process to improve working relationships built on trust and respect among Stakeholders. Ultimately, there is recognition among community stakeholders that no single organization can meet all of the identified community needs and when truly collaborative relationships exist, community partners working together can achieve far more than any single organization working on its own.

At the same time, multiple benchmarks within an objective allows for improvement in a measure when experience and the literature suggests that the benchmark may not be attainable

Section B below sets forth the original 2013 Community Benefit Goal, the objectives identified above and reports on the actual accomplishments during the 2014 calendar year. The comments section reports on those benchmarks that have been accomplished, those that are on track and those that have been modified . As with prior cycles, we have made adjustments to the three year objective where the 2013 result clearly demonstrates that the original objective is unlikely to be accomplished and/or where the evidence suggests a higher, lower or better performance standard should be set. In the last cycle, between 2011-13, four benchmarks were revised upwards (three in 2011 and one in 2012) based upon actual results that suggested that an unanticipated change would result in a higher performance level. Of the 20 benchmarks set forth in the 2013 CHNA three year Implementation Strategy, 4 have been met, 12 are on track to be met, 3 had a change in the baseline period (either 2014 or first six months of 2015) and 1 had a change in the benchmark to better reflect program quality changes. In addition, the opening of the new Providence Wellness Center in Wilmington will result in one additional benchmark in the 2015 Update, related to utilization of the facility by community partners and residents, as well as class offerings available to local residents.

B. Progress Towards Three Year Benchmarks

The South Bay Community governing board adopted the 2013 Community Benefit Plan and Implementation Strategy at its November 2013 meeting. The three year plan includes a single goal, with five programmatic strategies, each of which has multiple benchmarks, or indicators, which collectively provide evidence of the impact of the Community Benefit program in local underserved communities.

The goal of the Community Benefit Program for the two Providence Little Company of Mary Medical Centers is, simply stated, as follows.

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

The chart below documents progress towards the specific benchmarks established for each of the five strategies approved by the governing board:

MEASUREABLE OBJECTIVES				
Strategy 1. Increased access--Increase access to free primary and subsidized health care, including insurance coverage through Medi-Cal and Covered California				
3 Year Benchmarks established by 2013 Community Benefit Plan	Progress towards Three Year Objectives			
	2014 Actual	2015 ACTUAL	2016 Actual	Comment
By 2016, Enroll or renew 2,000 children or adults annually.	2,891			
By 2016, Link 600 adults discharged from the ER to a medical home, as verified by kept appointments	403			On track to reach benchmark
By 2016, increase from 10 to 16 sites where mobile clinic regularly sees patients	16			Benchmark met
By 2016, increase the number of people receiving HPV immunizations over the 2013 baseline, by 20%	37%			Baseline is 73; Unduplicated people receiving HPV does was 115. Benchmark met
By 2016, Improve identification and successful referral of Providence patients to GOAL diabetes project, by 20%, using 2014 as baseline [Change in baseline year].	NA			Benchmark changed to reflect a broader population of patients , namely adults diagnosed with out of control diabetes. Numerous requests from other practice sites for assistance has required the development of a new baseline. Baseline could not be established for 2014; new baseline period will be first six months of 2015 and will be tracked thereafter.
By 2016, provide medical management for 150 uninsured adults at Vasek Polak, including subspecialty consults, advanced diagnostics and referral for those with ongoing chronic specialty conditions.	0			Pilot project scheduled for implementation in 2015

Bold Statistics indicate 2013 benchmark accomplished				
MEASUREABLE OBJECTIVES				
Strategy 2: Primary/secondary prevention-- Strengthen existing primary and secondary prevention programs (COPA, GOAL and Welcome Baby)				
3 Year Benchmarks established by 2010 Community Benefit Plan		Progress towards Three Year Objective		
Benchmarks	2014 Actual	2015 ACTUAL	2016 Actual	Comment
By 2016, Increase physical activity in children by 10% over (March 2014) baseline, as measured by pedometers, SOFIT or Fitnessgram.	n/a			2014-15 data to be collected during June 2015 and analyzed by the end of 2015.
By 2016, provide COPA consultative services to 10 new locations, verified by trainings or MOU/contracts with school districts or community based organizations.	4			Lawndale Elementary School District Hawthorne School District St. Didacus Catholic School Boys & Girls Club of LA Harbor
By 2016, Increase to 50 the number of chronic disease self care cohorts (6-9 lessons) offered throughout the PLCMSA	16			On track to reach benchmark
By 2016, Sustain average decrease in A1C levels for all GOAL patient participants, using 2013 pre-post baseline data.	1.44%			2013 average A1C reduction = 1.3%, (9.81% pre to 8.50% post) . 2014 average A1C reduction = 1.44% (9.33 pre to 7.89 post). Objective met.
By 2016, Increase Welcome Bay prenatal enrollments by 40%, using 2013 as baseline. [Revised benchmark]	5.7%			2013 baseline annualized = 16 2014 prenatal enrollments = 17 After gaining experience with the Welcome Baby program, program staff proposed to change the benchmark from exclusive breastfeeding to prenatal enrollments because: 1) exclusive breastfeeding is at its peak at or around the birth of the child and the first home visit and then inevitably declines, even though program standards encourage exclusive breastfeeding for up to 1 year, and 2) prenatal enrollments functions as a better measure because all of the medical literature makes clear that

				mothers who receive home visits during pregnancy have better health outcomes for the child at all stages of development. With the start of the Torrance Memorial program the baseline will be re-set in 2015 to reflect the first six months of program operation. [Note: Providence community Health provides home visits services to patients of the TMMC
By 2016, increase program acceptance rated using the first six months of home visits operations as baseline through June 2015. [Revised baseline period]	6.2%			2013 Baseline annualized = 192 2014 Actual Acceptance = 203 Providence San Pedro Medical Center entered into a partnership with a neighboring Medical Center, Torrance Memorial (TMMC), to share responsibility for implementing Welcome Baby. TMMC employs a Hospital liaison who identifies and screens patients for participation in Welcome Baby. When the mother accepts the program in the hospital, a referral is made to Providence Community Health, which then initiates home visit services. The baseline acceptance rate will be re-set for 2015, using the first six months of operation at TMMC
Bold Statistics indicate 2013 benchmark accomplished				

MEASUREABLE OBJECTIVES				
Strategy 3. External partnerships--Increase and strengthen partnerships with external stakeholders				
3 Year Benchmarks established by 2013 Community Benefit Plan	Progress towards Three Year Objectives			
	2014 Actual	2015 Actual	2016 Actual	Comment
By 2016, develop and sustain two collaborative task forces that address any of the top healthcare needs identified in the 2013 needs assessment AND that accomplish	1			Wilmington Wide Wellness Task Force As the result of Task Force formation, new resources brought into the Wilmington community will be tracked and reported on in subsequent updates.

outcomes identified by the task force.				
By 2016, implement at least two capacity building projects that provide an infrastructure improvement for or in partnership with community partners (ie. Funding/ facilities/joint use agreement)	1			Providence Wellness and Activity Center in Wilmington (Center) With the opening of the Providence Center, tracking of utilization of the facility by the # of organizations, # of participants and # of classes, began in January 2015. Performance benchmarks will be added in 2015, based upon the first six months of Center operations and reported in subsequent Updates.

MEASUREABLE OBJECTIVES				
Strategy 4. Address BCCB Priorities--Explore feasibility of program development/ stakeholder collaboration in three areas prioritized by Board Committee on Community Benefits				
3 Year Benchmarks established by 2013 Community Benefit Plan	Progress towards Three Year Objectives			
	2014 Actual	2015 ACTUAL	2016 Actual	Comment
By 2016, Design, pilot and implement a new program that addresses one of three new priority areas identified by the BCCB: Services that allow Seniors to live at home Mental Health Education/Coping Skills Skills to Navigate Health Care System	0			CHAT Curriculum has been developed related to coping skills for adults. Implementation scheduled for 2015
By 2016, convene an internal collaborative task force that addresses one of the BCCB priorities	0			Nothing to report for this benchmark

MEASUREABLE OBJECTIVES

Strategy 5. Monitor Community Benefit--Monitor Community Benefit programs and expenditure, consistent with Catholic Health Association guidelines

3 Year Benchmarks established by 2013 Community Benefit Plan	Progress towards Three Year Objectives			
	2014 Actual	2015 ACTUAL	2016 Actual	Comment
By 2016, increase charity care expense by 5%, using 2014 baseline [Revised baseline year].	NA			Based on ACA impact and overall 21% reduction in charity care across the South Bay Community, objective will be reset to use 2014 as baseline (\$10.1 Million).
By 2016, increase community outreach expense (non billed/negative margin) by 10%, using 2013 baseline	-3%			Final IRS regulations on December 30, 2014, now require the offset of grants. This reduced this category of expense by \$1.5 million which had been counted previously under CHA guidelines and prior versions of IRS proposed regulations. Total expense in this category in 2013 was \$4,759,675 compared to \$4,624,765, a 3% reduction. While the IRS mandated accounting change will make it much more difficult to meet the benchmark, we have decided to keep it in place and evaluate during this calendar year whether it is realistic to meet this benchmark.
By 2016, under the direction of the Mission Committee, conduct 6 site visits to explore client, stakeholder and employee satisfaction with specific programs provided by the Medical Centers' Community Health Department.	0			Site visits expected to begin in 2015 and will include members of the governing board as part of the site visit.
By 2016, define, design and develop a data exchange project between PLCM and safety net and/or Public Health stakeholders	NA			Nothing to report on this benchmark
Bold Statistics indicate 2010 benchmark accomplished				

IV. COMMUNITY BENEFITS AND ECONOMIC VALUE

A. Community Benefit Expenditures during 2014

PLCM Community Benefit activities are classified into three broad expenditure categories consistent with standards established by the Catholic Health Association: 1) charity care, 2) Community Benefit Services and 3) Unpaid Costs of Medi-Cal². For OSHPD reporting purposes, we also identify the unpaid costs of Medicare but this statistic is not publicly reported. The chart below, summarizes all community benefit expense for 2014:

	2014	2015	2016
Charity Care	\$11,041,808		
Community Benefit Services	\$13,859,839		
Unpaid Costs of Medi-Cal	\$25,186,595		
TOTAL	\$50,088,242		
Unpaid Cost of Medicare	\$28,181,815		

Charity Care. Charity care saw a 31% drop from 2013, due to ACA implementation, and change in the methodology of calculating charity care by Providence Health and Services at the system level.

Unpaid Costs of Medi-Cal. Medi-Cal shortfall, the difference between the cost of providing care and the amount received from Medi-Cal fell 22% from 2013, due to a substantial increase in Medi-Cal net revenue and changes in the methods of calculating shortfall. In addition, at the San Pedro Medical Center provider tax revenues reduced the Medi-Cal shortfall from \$12 Million in 2013 to \$2.3 Million in 2014.

Community Benefit Services. Community Benefit Services combines all expenses of both Medical Centers. This category combines seven specific elements, broken out in the detailed report of all Community Benefit expense, by Medical Center, provided in Attachment A. Expenditures in the Community Benefit Services category decreased 14%, to \$13.8 Million, from \$16.1 Million in 2013 due primarily to two factors, 1) changes in IRS regulations requiring an offset of grant funds from external sources totaling \$1.3 Million and 2) changes at the State level that resulted in improved reimbursement from the State of California for hospice services for children. This resulted in a \$2.2 Million in additional Million revenue from the prior year

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

B. Number of Individuals Impacted by PLCM Community Benefit Programs

During 2014, there was a 18.3% reduction in the number of people who were impacted by Community Benefit programs, from 84,138 in 2013 to 68,668 in 2014. For different reasons, this downward trend showed up in the charity care, community benefit services and MediCal shortfall categories. For Community Benefit Services, the downward trend was primarily related to two internal hospital based programs: case management of Medi-Cal and uninsured patients, as well as transportation and taxi vouchers for medically indigent patients. In both cases improved methods of documentation have resulted in improvements that get to the actual number of patients impacted, compared to a duplicated visit count. The reduction in the number of people who receiving Medi-Cal is primarily related to changes at the System Office level that links charity care to the person and not to the individual visit or inpatient account.

NUMBER OF INDIVIDUALS IMPACTED, BY COMMUNITY BENEFIT CATEGORIES			
	2014	2015	2016
Charity Care	2,860		
Medi-Cal	25,250		
Community Benefit Services	42,141		
TOTAL	68,668		

Strategic Mission Priorities

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

Outreach to Poor/Underserved Populations	2014	2013
Community Health Insurance Program (CHIP)	2,891	1,883
COPA (School Day/After School Physical Activity)	8,982	5,287
Get Out and Live (GOAL Diabetes Education)	347	459
Partners for Healthy Kids (mobile clinic)	2,045	2,027
Linkage to Community Services & health fair outreach	1,925	2,435
SART(Sexual Assault Response Team)	176	184
Trinity Kids Care	325	228
Vasek Polak Health Clinic	2,913	3,562
Welcome Baby/Baby Friendly	248	149
TOTALS	19,852	16,214

In this area of community based outreach programs, the number of people impacted rose from 16,214 in 2013 to 19,852, a 22% increase. On an annual basis, there is typically shifts within programs based either on grant related funding or program expansion/reduction based on shifting

priorities in our implementation of programs. In 2013 there were major expansions of COPA (due to new grant funding in another community) and CHIP (increased funding for ACA enrollment in Medi-Cal and Covered California. Significant reduction (Vasek Polak Health Clinic and Linkage to Community Services) were primarily related to ACA expansion so that patients who were previously without insurance are now eligible for free or subsidized health care and the reduction in patients at the Clinic for uninsured adults also resulted in less patients needing linkage services. At the same time, the adults who are ineligible for ACA coverage are now getting more in depth case management services to help link them to health care needs beyond the scope of Clinic services.



Summary of Community Benefit Expense, by Ministry--2014

	2014	2014	2014	2014
	# Impacted	Expenses	Torrance	San Pedro
Charity Care (at cost)	2,860	\$ 11,041,808	\$ 8,692,101	\$ 2,349,707
COMMUNITY BENEFIT SERVICES				
Charity & Community Benefit	42,141	\$ 13,859,839	\$ 9,175,741	\$ 4,684,098
	45,001	\$ 24,901,647	\$ 17,867,842	\$ 7,033,805
UNPAID COST OF MEDI-CAL Reports to Community	23,667	\$ 25,186,595	\$ 22,190,619	\$ 2,995,975
	68,668	\$ 50,088,242	\$ 40,058,461	\$ 10,029,780
Only completed annually				
UNPAID COST OF MEDICARE Reports to OSHPD	-	\$ 28,181,815	\$ 15,213,968	\$ 12,968,067
	-	\$ 78,270,057	\$ 55,272,429	\$ 22,997,847

**PROVIDENCE LITTLE COMPANY OF MARY--2014
COMMUNITY BENEFIT SERVICES --Detailed Breakdown**

As of 12/31/2014

	2014		Torrance	San Pedro
	Persons	Benefit		
Community Health Education--Broader Community				
Hospice Bereavement/Gathering Place	1,423	\$ 561,315	\$ 280,657	\$ 280,657
Health Resource Center formerly Linkage to Community Servc	2,171	\$ 34,360	\$ 17,180	\$ 17,180
Support Groups	-	\$ 25,300	\$ 12,650	\$ 12,650
		\$ -	\$ -	\$ -
Subtotal	3,594	\$ 620,975	\$ 310,487	\$ 310,487
Community Health Education--Persons in Poverty				
Sexual Assault Response Team (SART)	176	\$ 46,514	\$ 23,257	\$ 23,257
COPA (school day and after school physical activity)	8,982	\$ 962,018	\$ 481,009	\$ 481,009
Community Outreach	1,008	\$ 540,827	\$ 270,414	\$ 270,414
Linkage to Community Services (Poor and Vulnerable)	917	\$ 303,298	\$ 151,649	\$ 151,649
Children's Health Insurance Program (CHIP)	2,891	\$ 174,059	\$ 87,029	\$ 87,029
Baby Friendly Journey	28	\$ 30,859	\$ 30,859	\$ 30,859
Get Out and Live (G.O.A.L.)(Diabetes)	347	\$ 137,246	\$ 68,623	\$ 68,623
Welcome Baby Program	220	\$ 642,569	\$ 68,623	\$ 642,569
		\$ -	\$ -	\$ -
Subtotal	14,569	\$ 2,837,390	\$ 1,081,981	\$ 1,755,409
Community Based Clinical Svcs-Persons in Poverty				
Partners for Healthy Kids (PFHK)	2,045	\$ 825,226	\$ 412,613	\$ 412,613
Mother Joseph Fund	-	\$ 204,961	\$ 102,481	\$ 102,481
		\$ -	\$ -	\$ -
Subtotal	2,045	\$ 1,030,187	\$ 515,094	\$ 515,094
Health Care Support Services--Persons in Poverty				
Case management of under/uninsured adults	1,662	\$ 2,793,840	\$ 2,793,840	\$ -
Post Discharge expense for medically indigent	195	\$ 524,352	\$ 524,352	\$ -
Post Discharge Pharmacy medications	1,907	\$ 136,624	\$ 136,624	\$ -
Transportation/Taxi Vouchers for medically indigent	3,317	\$ 96,026	\$ 48,013	\$ 48,013
		\$ -	\$ -	\$ -
Subtotal	7,081	\$ 3,550,842	\$ 3,502,829	\$ 48,013
SUBTOTAL--Community Based Outreach	27,289	\$ 8,039,394	\$ 5,410,391	\$ 2,629,003

**PROVIDENCE LITTLE COMPANY OF MARY--2014
COMMUNITY BENEFIT SERVICES --Detailed Breakdown**

HEALTH PROFESSIONS EDUCATION					
Pastoral Education	-	\$ 87,119	\$ 43,559	\$ -	\$ 43,559
Medical Library	-	\$ 17,468	\$ 8,734	\$ -	\$ 8,734
Preceptorships (including Urban Scholars)	703	\$ 2,624,350	\$ 1,742,558	\$ -	\$ 881,792
SUBTOTAL, Health Professions Education	703	\$ 2,728,937	\$ 1,794,851	\$ -	\$ 934,085
SUBSIDIZED HEALTH SERVICES					
Paramedic Base Station	9,945	\$ 849,489	\$ 849,489	\$ -	\$ -
Palliative Care Assessments	966	\$ 920,125	\$ 460,063	\$ -	\$ 460,063
Vasek Polak Health Clinic	2,913	\$ 755,691	\$ 377,845	\$ -	\$ 377,845
Trinity Kids Care (Hospice)	325	\$ 270,924	\$ 135,462	\$ -	\$ 135,462
Transitional Care Units	-	\$ -	\$ -	\$ -	\$ -
Psychiatric Unit	-	\$ -	\$ -	\$ -	\$ -
SUBTOTAL Subsidized Health Services	14,149	\$ 2,796,229	\$ 1,822,859	\$ -	\$ 973,370
FINANCIAL AND IN KIND CONTRIBUTIONS					
Cash Donations	-	\$ 104,120	\$ 52,060	\$ -	\$ 52,060
Cost of Fundraising for Community Benefit	-	\$ 134,659	\$ 67,330	\$ -	\$ 67,330
Free Space	-	\$ 56,500	\$ 28,250	\$ -	\$ 28,250
Adopt a Family (multiple Departments)	-	\$ -	\$ -	\$ -	\$ -
SUBTOTAL Financial/in kind contributions		\$ 295,279	\$ 147,640	\$ -	\$ 147,640
TOTALS	42,141	\$ 13,859,839	\$ 9,175,741	\$ -	\$ 4,684,098

	Original Effective Date: January 2013 Last Revision Date: January 2014 Revision Effective Date: January 2015	Page 1 of 6	Policy Number CA-FIN-501
	Subject: California Charity Care and Discount Payment Policy		Authorization: VP Revenue Cycle

Purpose:

The purpose of this policy is to outline the circumstances under which charity care discounts may be provided to qualifying low income patients for medically necessary healthcare services provided by Providence Health and Services (PH&S).

Policy:

PH&S is a Catholic healthcare organization guided by a commitment to its Mission and Core Values, designed to reveal God's love for all, especially the poor and vulnerable, through compassionate service. It is both the philosophy and practice of each PH&S ministry that medically necessary healthcare services are available to community members and those in emergent medical need, without delay, regardless of their ability to pay.

1. PH&S will comply with federal and state laws and regulations relating to emergency medical services and charity care.
2. PH&S will provide charity care to qualifying patients with no other primary payment sources to relieve them of all or some of their financial obligation for medically necessary PH&S healthcare services.
3. In alignment with its Core Values, PH&S will provide charity care to qualifying patients in a respectful, compassionate, fair, consistent, effective and efficient manner.
4. PH&S will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making charity care determinations.
5. In extenuating circumstances, PH&S may at its discretion approve charity care outside of the scope of this policy.
6. This policy is to be interpreted and implemented so as to be in full compliance with California Assembly Bill 774, codified at Health and Safety Code Section 127400 *et. seq.*, effective January 1, 2007, as revised by California State Senate Bill 350, effective January 1, 2008, Assembly Bill 1503 effective January 1, 2011 and SB 1276 effective 01/01/2015. All collection agencies working on behalf of Providence Health and Services Southern California (PHSSC) facilities shall comply with Health and Safety Code Section 127400 *et. seq.* as amended and applicable PHSS policies regarding collection agencies. See related Regional Business Office Policy, GOV-107, Debt Collection Standards and Practices Policy.

Definitions:

7. **"Charity Care"** refers to full financial assistance to qualifying patients, to relieve them of their financial obligation in whole for medically necessary or eligible elective health care services (full charity).
8. **"Discount Payment"** refers to partial financial assistance to qualifying patients, to relieve them of their financial obligation in part for medically necessary or eligible elective health care services (partial charity).
9. **Gross charges** are the total charges at the facility's full established rates for the provision of patient care services before deductions from revenue are applied. Gross charges are never billed to patients who qualify for partial charity or Private Pay Discounts.
10. **Private Pay Discount** is a discount provided to patients who do not qualify for financial assistance and who do not have a third party payor or whose insurance does not cover the service provided or who have exhausted their benefits. See Private Pay Discount Policy, CA-FIN-5003.
11. **Emergency Physician** means a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital

outside of the emergency department. Emergency room physicians who provide emergency medical services to patients at PHSSC hospitals are required by California law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level.

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

- a. Emergency services in the emergency department.
- b. Services for a condition that, if not promptly treated, would lead to an adverse change in the patient's health status.
- c. Non-elective services provided in response to life-threatening circumstances outside of the emergency department (direct admissions).
- d. Medically necessary services provided to Medicaid beneficiaries that are non-covered services.
- e. Any other medically necessary services determined on a case-by-case basis by PH&S.

13. **Eligible Elective Health Care includes:**

- a. Patients and their physicians may seek charitable services for elective, deferrable care. Elective care becomes eligible for charitable and discount services only when all of the following requirements are met:
 - i. A member of the medical staff of a PH&S facility must submit the charitable services request;
 - ii. The patient is **already** a patient of the requesting physician and the care is needed for good continuity of care; aesthetic procedures are not eligible for charitable services;
 - iii. The physician will provide services at the same discount rate as determined by the hospital per charity guidelines of this policy, up to and including free care;
 - iv. The patient lives within our services area (as determined by PH&S); and
 - v. The patient completes a Financial Assistance Application and receives approval in writing from PH&S prior to receiving the elective care.

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

- a. **Presumptive Charity** – Individual assessment determines that Financial Assistance Application is not required because:
 - i. Patient is without a residence address (e.g. homeless);
 - ii. Services deemed eligible under this policy but not covered by a third party payor were rendered to a patient who is enrolled in some form of Medicaid (Medi-Cal for California residents) or State Indigency Program (e.g. receiving services outside of Restricted Medi-Cal coverage) or services were denied Medi-Cal treatment authorization, as financial qualification for these programs includes having no more than marginal assets and a Medi-Cal defined share of cost as the maximum ability to pay; and/or
 - iii. Patient's inability to pay is identified via an outside collection agency income/asset search. Should the agency determine that a lawsuit will not be pursued, the account will be placed in an inactive status, where a monthly PH&S review will determine further action, including possible charity acceptance and cancellation from the agency and removal of credit reporting.
 - iv. Patient's inability to pay is identified by Regional Business Office staff through an income/asset search using a third party entity.
- b. **Charity** – Individual assessment of inability to pay requires:
 - i. Completion of a Financial Assistance Application for the Mary Potter Program for Human Dignity for all facilities in the PHSSC Region;
 - ii. Validation that a patient's gross income is less than two and one-half times (250%) the Federal Poverty Guidelines (FPG) applicable at the time the patient has applied for financial assistance. A patient with this income level will be deemed eligible for 100% charity care; and/or
 - iii. Validation that a patient's gross income exceeds 250% of the FPG applicable at the time the patient has applied for financial assistance and that their individual financial situation (medical debt load, etc) makes them eligible for possible discount payment (partial charity care) or 100% charity care. However, patients with gross income less than 350% of FPG will never owe more than 100% of the applicable Medicare allowable amount for the hospital where treatment was received. This amount shall be verified at least annually. A patient with a gross income exceeding 350% of FPG will owe no more than the applicable private pay inpatient or outpatient discounted reimbursement rate, or stated co-pay amount, whichever is

less. In addition, uninsured and insured patients with gross incomes less than 350% of FPG who incur total medical expenses in excess of ten percent (10%) of gross annual income during the prior 12 months will receive 100% charity benefit. Eligible costs for charity write off shall include only the patient liability amounts after insurance is billed and insurance liability amounts collected. Further, qualified retirement plan and deferred compensation, monetary assets may not be considered in determining an ability to pay and the first \$10,000 of other monetary assets and 50% of the remaining monetary assets must not be used in the evaluation for financial assistance.

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

15. Charity Care is not:

- a. **Bad Debt:** A bad debt results from a patient's unwillingness to pay or from a failure to qualify for financial assistance that would otherwise prove an inability to pay;
- b. **Contractual adjustment:** The difference between the retail charges for services and the amount allowed by a governmental or contracted managed care payor for covered services that is written off; or
- c. **Other Adjustments:**
 - i. **Service Recovery Adjustments** are completed when the patient identifies a less than optimal patient care experience;
 - ii. **Risk Management Adjustments:** where a potential risk liability situation is identified and Providence Risk Management has elected to absorb the cost of care and not have the patient billed;
 - iii. **Payor Denials:** where the facility was unable to obtain payment due to untimely billing per contractual terms; or retroactive denial of service by a managed care payor where appeal is not successful.

16. Reasonable Payment Plan: a default plan required by SB 1276 for patients qualifying for partial charity when a negotiated plan cannot be reached. SB 1276 defines the plan as monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.

- a. **"Essential Living Expenses"** means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs. Installment payments, laundry and cleaning, and other extraordinary expenses. Emergency Department physicians and their assignees may rely upon the hospital's determination of income and expenses in establishing a reasonable payment plan.

Evaluation Process:

PH&S will display signage and information about its charity care policy at appropriate access areas.

A person seeking charity care will be given a preliminary screening and if this screening does not disqualify him/her for charity care, an application will be provided with instructions on how to apply. As part of this screening process PH&S will review whether the guarantor has exhausted or is not eligible for any third-party payment sources. Where the guarantor's identification as an indigent person is obvious to PH&S a prima-facie determination of eligibility may be made and in these cases PH&S may not require an application or supporting documentation.

A guarantor who may be eligible to apply for charity care after the initial screening will be given fourteen (14) days to provide sufficient documentation to PH&S to support a charity determination. Based upon documentation provided with the charity application, PH&S will determine if additional information is required, or whether a charity determination can be made. The failure of a guarantor to reasonably complete appropriate application procedures shall be sufficient grounds for PH&S to initiate collection efforts.

An initial determination of sponsorship status and potential eligibility for charity care will be completed as closely as possible to the date of service.

PH&S will notify the guarantor of a final determination within ten (10) business days of receiving the necessary documentation.

The guarantor may appeal the determination of ineligibility for charity care by providing relevant additional documentation to PH&S within thirty (30) days of receipt of the notice of denial. All appeals will be reviewed and if the determination on appeal affirms the denial, written notification will be sent to the guarantor and the Department of Health in accordance with state law. The final appeal process will conclude within thirty (30) days of the receipt of a denial by the applicant.

PROCEDURE/GENERAL INSTRUCTIONS

- III. Communication and Notification of the availability of financial assistance within the community of each hospital shall be in accordance with AB 774, SB 350, SB 1276 and the federal PPACA (Patient Protection and Affordable Care Act)
- a. Signage about the availability of financial assistance will be posted in registration areas of hospitals including emergency rooms and in the Regional Business Office.
 - b. A Notice of Collection Practices shall be provided to all patients during registration and included in the final billing statement.
 - c. This policy will be posted on each facility's internet page and will otherwise be made available upon request.
 - d. Financial Assistance Applications will be available in the registration areas.
 - e. PHSSC employees including Admitting/Registration and Financial Counseling staffs as well as on site consultants such as Health Advocates will comprehensively screen patients for possible third party coverage including private health insurance (Covered California Health Exchange), Medicare, Medi-Cal, and other state programs and assist patients in applying for coverage when appropriate.
 - f. Self-Pay bills shall include the following:
 - i. Statement of Charges
 - ii. A request that the patient inform the hospital if the patient has insurance coverage and that if the patient does not have coverage that they may be eligible for Medicare, Healthy Families, Medi-Cal, insurance through the California Health Exchange, other state or county programs and charity.
 - iii. A statement indicating how the patient may obtain an application or apply for the aforementioned programs along with a referral to the local consumer assistance office at a local legal services office.
Note: If the patient or patient's representative indicates the patient has no third party coverage and requests a discounted rate or charity, the patient shall be provided with an application for the Medi-Cal program, Healthy Families program or other applicable state or county program.
 - iv. Information on the hospitals financial assistance and charity program applications including a statement that if the patient lacks or has inadequate insurance and meets certain low income requirements they may qualify for discounted payment or charity care. A telephone number for additional information on the hospitals discount payment and charity program should accompany this statement.
 - v. Verification that a patient does not qualify for third party coverage or is ineligible for a government program is required before finalizing a charity decision.
- IV. Patient eligibility with no application. Instances where a Financial Assistance Application is not required per charity definitions:
- a. Treatment Authorization Request (TAR) denials, Medi-Cal non-covered services, and untimely Medi-Cal billing write-offs will be recorded with their respective adjustment transaction codes. Medi-Medi accounts are written off to a unique transaction code to facilitate Medicare Bad Debt reimbursement.
 - i. Finance will identify the amounts posted to those codes and transfer those amounts from contractual to charity in the general ledger.
 - ii. For Medi-Medi adjustments, that portion not claimed as Medicare bad debt reimbursement will be reclassified as charity in the general ledger.
 - b. Services denied due to restricted Medi-Cal coverage will be written off to charity when the denial is received on a Medi-Cal remittance advice.
 - c. A patient may be verified as homeless at any time during the revenue cycle. The preferred method is at registration, where a lack of address documentation is indicated and coding to "Homeless" status is completed. This will generate the charity write-off at the time of billing.
 - d. PHSSC facilities will not engage in extraordinary collection efforts including referral to outside collection agencies before making a reasonable effort to determine whether the patient qualifies for financial assistance. Upon referral, outside collection agencies, in their collection activities, including when performing income and asset searches in preparation for lawsuit authorizations, can verify an inability to pay and can submit the account for charity approval under the following circumstances:
 - i. Self-pay patients with gross incomes at or below 250% of Federal Poverty Guidelines. The entire balance will be deemed charity.
 - ii. Self-pay patients with gross incomes in excess of 250% but less than 350% of FPG, and limited assets, may qualify for partial or full charity. The liability for this income group in all cases will never be more than the expected reimbursement from Medicare. For self-pay patients with gross incomes in excess of 350% of FPG, the patient's liability will be the self-pay discount rate in effect at time of service. Lastly, insured and self-pay patients with incomes less than 350% of FPG and healthcare expenses exceeding 10% of annual income during the past 12 months will be eligible for full charity.
 - iii. Equity in a principal residence can be considered in asset determination only when income is in excess of 350% of Federal Poverty Guidelines, and a lien against that equity can be approved, but in no instance will foreclosure proceedings be initiated. PHSSC and its collection agencies will wait until the principal residence is sold or refinanced to collect its debt. California law places restrictions on monetary assets that can be

considered in making an ability to pay determination. Consistent with California laws, monetary assets shall not include: (1) assets held under a qualified retirement plan; (2) the first ten thousand dollars (\$10,000) of a patient's monetary assets; or (3) fifty percent (50%) of a patient's monetary assets in excess of \$10,000.

V. Patient Eligibility as established by financial need per Financial Assistance Application.

- a. All PHSSC employees including registration staff, financial counselors, patient access representatives, patient account representatives, clinical social workers, nurses, case managers, chaplains as well as mission directors and medical staff physicians during their normal course of duties, can identify potential inability to pay situations and refer patients for financial assistance. Clinical social workers identifying potential charitable services cases should liaison with financial counselors/patient access representatives in evaluating charity potential and presenting financial assistance options to the patient/family. In these instances, a Financial Assistance Application can be offered to the patient/family and the account is accordingly documented to help guide future collection efforts.
- b. The Financial Assistance Application must be accompanied by proof of income, including copies of recent paychecks, W-2 statements, income tax returns, and/or bank statements showing payroll deposits. If none of these documents can be provided, one of the following is required:
 - i. If the patient/responsible party is paid in cash, a letter from the employer providing the rate of pay;
 - ii. If the patient/responsible party is provided services, such as room and board, etc., in lieu of pay for work performed, the person granting the services must provide a letter delineating the services provided and the value of those services; or
 - iii. If there is no employer/employee arrangement, other written documentation of in-kind income can be considered, on a case-by-case basis.
- c. Patients may request a Financial Assistance Application by calling the Regional Business Office (RBO), writing to the mailing address on their patient billing statement, or downloading the form from the PHSSC websites.
- d. Patients completing Financial Assistance Applications are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.

VI. Financial Assistance Application Review/Approval Process:

- a. For restricted services charity write-offs, or homeless patient charity write-offs, the write-off transaction can be initiated by any RBO employee. Standard transaction approval levels will apply.
- b. A Financial Assistance Application must be reviewed by a RBO financial counselor. If gross income is at or below 250% of FPG, the counselor may approve the charity application, based on the information submitted with the application (proof of income required). If the gross income is more than 250% but less than 350% of FPG, an assessment for qualification of partial or full charity based on income, assets, and medical debt load will be made by the financial counselor with write-offs subject to standard approval levels.
- c. Financial Assistance Applications shall be reviewed and approved, denied or returned to the patient with a request for additional information within ten (10) business days of receipt.
- d. Collection agency requests for charity or Financial Assistance Applications received from a collections agency shall be reviewed by a RBO Financial Counselor. The counselor shall follow the review process described in (b) above in determining ability to pay and approving partial, total or no charity. Standard transaction approval levels will apply.
- e. An approved charity determination is applicable to all services referenced in the application AND services provided up to six (6) months after the date of the approved application, provided there is no change in the applications financial status that would warrant a reevaluation.
- f. If charity is approved at 100%, any patient deposits paid toward accounts approved for charity must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and charity will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure.

VII. Notification of charity determination:

- a. In those instances where Medi-Cal restricted services are written off to charity, the notice of charity approval will be sent to the patient.
- b. For homeless charity write-offs, no notification is necessary.
- c. In all instances where a Financial Assistance Application was submitted, the person approving the application shall submit a written determination of no charity, partial charity or full charity to the person who submitted the applications on behalf of the patient within ten (10) days of final determination of the completed application.
- d. In the event partial or no charity is approved, the notification letter will advise that the patient may appeal the determination. Appeals should be in writing to:

**PH&S Regional Business Office
PO Box 3299**

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

- e. If partial charity is approved, the remaining patient balance may be paid in interest-free installments as mutually agreed between patient and facility. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, that agency agrees to abide by the requirements of this policy and of AB 774, SB 350 and SB 1276, including not garnishing wages or placing a lien on a principal residents.

VIII. Processing of charity write-off:

- a. If a self-pay discount has been issued, that discount must be reversed to restore full charges. This step permits Finance to apply a ratio of cost to charges against the amount of charity write-off to accurately determine the cost of charity care for external reporting purposes.
- b. The 100% charity discount percentages is then applied to the account, using existing adjustment mnemonic/transaction codes.
- c. A patient who paid a deposit at the time of service and is entitled to 100% charity, or a patient who paid a deposit and is entitled to partial charity and whose deposit exceeded the final liability per the charity policy, is entitled to both a refund of the excess or full deposit plus interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. Should a partial charity account need to be referred to an outside agency for collection, the account will be flagged as a partial charity recipient so that the agency can assure that:
 - i. It will not initiate a lawsuit for purposes of garnishing wages or attaching a lien on a principal residence; and
 - ii. It will not report the delinquency to a credit-reporting agency until 150 days after the date of service, or 150 days after the patient received partial charity approval.

AUDIT/CONTROL/RECORDS/RETENTION:

All Financial Assistance Applications will be retained for a period of seven (7) years from date of completion.

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

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

Approval Limits	Approval Authority
Total Providence Facility Charges: \$0 - \$2,500	Financial Assistance Team member
Total Providence Facility Charges: \$0 - \$5,000.	Financial Assistance Lead
Total Providence Facility Charges: \$2,501 - \$25,000	FC Supervisor
Total Providence Facility Charges: \$2,501 – 100,000	Providence Representative, Manager or Director (or designee)
Total Providence Facility Charges: \$15,000.01 and over	RCM Service Area or Regional Director (or designee)

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

COLLABORATION

This policy was developed in collaboration with the following departments:

PHSSC Finance Division
Providence Health & Services Department of Legal Affairs

<p><u>AUTHORIZATION:</u></p> <p><u>Teresa Spalding</u> VP Revenue Cycle <i>Signature on file</i></p> <p>Date:</p>
--

PH&S CA Charity Care Percentage Sliding Fee Scale

For guarantors with income and assets above 250% of the FPL household income and assets are considered in determining the applicability of the sliding fee scale.

Assets considered for evaluation; IRA's, 403b, 401k are exempt under this policy, unless the patient is actively drawing from them. For all other assets, the first \$10,000 is exempt.

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	Poverty guideline
For families/households with more than 8 persons, add \$4,160 for each additional person.	
1	\$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,750
7	36,730
8	40,890

ATTACHMENT B

NOTICE OF COLLECTION PRACTICES

NOTICE

PATIENT RIGHTS WITH RESPECT TO COLLECTION OF DEBTS FOR HOSPITAL SERVICES

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

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

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

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

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



Request for Financial Assistance

I. Patient Information					
PATIENT'S NAME	LAST	FIRST	MI	SOCIAL SECURITY NUMBER	
ADDRESS STREET		CITY	STATE	ZIP	TELEPHONE HOME WORK
DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)			U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	

II. Guarantor Information					
NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL				RELATIONSHIP	
ADDRESS STREET		CITY	STATE	ZIP	SOCIAL SECURITY NUMBER
TELEPHONE NUMBER HOME WORK		U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF BIRTH	

Please check this box if you have not received services and are applying to pre-qualify.

Have you been approved for Financial Assistance by another Health Care organization? YES NO

If yes, please provide name of organization _____

Are you being referred by a physician or surgeon? YES NO

If yes, please provide name and phone of number of physician _____

III. Household Information – Please indicate ALL people living in your household, including applicant use additional paper if needed
--

Please list anyone living in your household (including yourself). Income includes (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, rent or living expenses exchanged for services provided, etc.

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER NAME	MONTHLY GROSS INCOME PRIOR TO DATE OF SERVICE	INSURED? (circle yes or no) If yes, list insurance (i.e. Blue Cross, PHP, etc.)
1.					Yes or No
2.					Yes or No
3.					Yes or No
4.					Yes or No
5.					Yes or No
6.					Yes or No
7.					Yes or No
8.					Yes or No
9.					Yes or No

Continued on the other side.

IV. Expenses and Assets

Rent _____ Recreational vehicles _____
 Mortgage payment _____ Send proof Health insurance premiums _____
 Mortgage balance _____ Send proof Stocks, bonds, retirement accounts, etc. _____
 Cost of utilities _____ Monthly child care _____
 Checking account balance _____ Real estate other than primary home _____
 Savings account balance _____ Other assets _____
 Car payment _____
 Year and make of vehicle _____
 Are you a full time student? _____ Please send student loan report.
 Do you receive any form of public assistance (food stamps, HUD housing, etc.) _____ If yes, please send proof.
 What were your total medical expenses during the prior 12 months? (Please provide proof of payment)

Are you being supported by a parent or other person? Yes No
 If yes, please provide income and tax information of the person supporting you.
 If you need to write a letter explaining your individual situation please attach it to this form.

V. Required Information – Must be included with this application

Please check that you have included the following:

Copy of previous year's tax returns Copy of last 3 months bank statements Income verification showing earnings or pay stubs for all income year to date

If you are self-employed, please include a copy of the last 12 month's P & L statements and last year's tax return.
 Additional information may be required in order to process your application. If so, we will contact you.

VI. Authorization

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Providence Health & Services to verify any or all information given and understand that a credit report may be run as part of this verification process.

X _____

RESPONSIBLE PERSON'S SIGNATURE

DATE