November 6, 2007

Agenda: November 20, 2007

Board of Supervisors
Santa Cruz County
701 Ocean Street
Santa Cruz, CA. 95060

Subject: Annual Report on Hospital Issues and Access To Care Services

Dear Members of the Board:

The Health Services Agency (HSA) annually reports to your Board on the status of local hospital services and compliance with the County Access to Care agreements with local hospitals. Santa Cruz County has three excellent hospitals serving the community: Dominican Hospital, Watsonville Hospital, and Sutter Maternity and Surgery Center. Like other hospitals across the state, local hospitals face challenges to maintain their financial stability in these difficult times. This report updates your Board on some of the most significant issues facing hospital providers and reports on activities delivered in the three hospitals in 2006. Primary sources of data are the Office of Statewide Health Planning & Development data (oshpd.ca.gov) and special reports from each hospital documenting access to care activities.

Hospital Challenges:

- **Health Reform and Universal Coverage**: It is well known that the current structure of health insurance and health care is broken. This is prominently seen in hospitals where uninsured and underinsured patients present for emergency care and hospitalization. As costs for health insurance continue to increase at a rate of 10% or more per year, employees and employers are reducing, eliminating, or deferring coverage for themselves or their dependents. Hospital emergency room volumes continue to be high because of this gap and local hospitals had no difficulty meeting county goals for access to care. It is noteworthy that the hospitals did support the Governor's Plan, including the 4% tax on their institutions, because universal coverage will help rationalize the healthcare system and provide better support for acute care. The outcome of efforts on healthcare reform will be provided to your Board in depth in another report. However, the linkage between health insurance and hospital financing is significant. Of particular concern in the health insurance debate are threats to the Healthy Kids program which has been very positive for families whose children need hospital care.
Labor Shortages and Associated Costs: Hospitals in Santa Cruz County continue to have the highest labor costs in the nation according to the annual Medicare Wage Index study for hospitals. This study focuses primarily on nursing staff costs. Clearly the nursing shortage combined with mandatory nursing ratios has severely impacted costs for hospital care and thus insurance rates. The partnership with Cabrillo has been helpful but approved candidates for the nursing program are still waiting over three years to be admitted to the nursing program. More nursing slots and capacity are needed to address this crisis.

In addition, Locality 99 rates are still a major issue with physicians and impact recruitment and retention particularly in the private sector. Hospitals are very dependent on specialists and sub-specialists to do the clinical work we need from an acute care institution. All of the local hospitals are subsidizing recruitment of physicians to the area to try to retain critical specialties. Hospital cost burdens for recruitment and for on-call physicians linked to emergency department services are a new budget challenge, which emerged in this last decade.

Facility Infrastructure and Technology: Each facility has unique needs in this area. The State has new seismic requirements which were imposed on the hospitals. Changes in technology, both medical and information technology, have contributed to financial challenges this year. Dominican is planning major facility upgrades, as it has the oldest buildings and many demands on its wide array of services. Dominican has also been adding to its clinical technology in radiology, cancer and the cardiac arenas. Sutter is focusing on physician office additions to free up space in the current facility and offer more care. Sutter has purchased the “drive-in” property next to their facility, but has no specific plans for expansion on that site at this time. Watsonville is working to add both technology in terms of radiological capacity and new physician space adjoining their hospital. Some of these changes will require applications to your Board through the Planning Department. Internal renovations are governed by the State Department of Health Services Licensing and the Office of Statewide Health Planning and Development (OSHPD). These changes are extremely expensive, but necessary to offer a full range of care options in an up-to-date clinical environment.

Quality of Care and Electronic Health Records (EHR): The advent of Electronic Health Records holds great promise in terms of improvements of quality and seamless care between inpatient and outpatient systems. Dominican is the first hospital to have an electronic medical record. They are using the Cerner system and are the “beta” site for the entire Catholic Healthcare West Corporation. This takes extra commitment, as there are many “bugs” in new software that must be worked out. Dominican and Watsonville have also supported the Elysium clinical messaging product, which already does share some medical information between inpatient and outpatient providers, including admissions and discharge summaries, lab reports, and consultation. All of the safety net clinics are using Elysium to communicate between providers and to connect to specialists. This has been a very valuable, easy-to-use system for clinical messaging between providers. Sutter anticipates implementing Epic hospital software in 2010 and has rolled out the outpatient module to its physician providers this year. This is the system used by the County clinics and is expanding to safety net clinics. Watsonville Hospital is studying options for electronic health records.
The most significant impacts from electronic health records relate to quality. The EHR prompts the physician to review many issues associated with best practices in quality of care: drug interactions, allergies, needed tests, abnormal lab values, etc. In addition, there are no longer problems with reading handwriting and prescriptions, and information can be available in real time to other doctors, hospitals, and the patients. Most of the EHR programs do have portals for patient direct access to records, labs, and appointments.

Charity Care and Bad Debt Foraiveness Policies

Healthcare costs are the number one reason for personal bankruptcy. All three of the local hospitals have charity care and bad debt forgiveness policies that are attached to this report. Patients can apply for charity care before or after treatment. Usually, if patients apply after treatment, it is handled as forgiveness for debt. The hospitals also assist uninsured patients in applying for coverage in government programs, specifically Medi-Cal, Healthy Kids, MediCruz, and Medicare.

Different hospitals have different income limits for these programs. Watsonville’s charity care covers individuals up to 200% of the federal poverty level. The Sutter Maternity and Surgery Center charity care policy covers individuals with incomes up to 300% of federal poverty levels with no share of cost and up to 400% with a sliding scale. Dominican Hospital also provides charity care assistance for patients up to 300% of the federal poverty level. There are also significant discounts for paying within 30 days and other special programs. The hospitals have updated policies and procedures for charity care which are attached. Individuals who are low income are encouraged to work with hospital billing offices to apply for these programs in an effort to reduce hospital debt.

In 2006 the federal government implemented a plan through the States to reimburse hospitals for undocumented individuals using emergency services including emergency admissions. Watsonville Hospital reported 4.9 million dollars in revenue from the new federal source in 2006. This is significant and has a positive effect on the financial picture for the hospital. Watsonville Hospital also qualifies for disproportionate share Medi-Cal funding which allows additional reimbursement when there is a high number of Medi-Cal hospital days.

Attachment B is a trend chart from OSHPD data on just charity care for each institution as a function of gross charges. It shows growing trends in this area particularly for Sutter.

Access To Care 2006 Activities:

All three hospitals met their Access To Care goals for 2006. Allowable activities include charity care, bad debt forgiveness, cash contributions to health organizations and activities in health that benefit the community. The definitions for these activities were developed by the Office of Statewide Health Planning & Development (OSHPD) and all hospitals report annually. Each hospital meets the goal of 7 percent to these activities on hospital costs after deducting government programs. The government programs deducted include Medicare, Medi-Cal, MediCruz, and the new reimbursement for undocumented individuals. Because the institutions vary greatly by size and gross budgets, the goals vary as well. The most significant shift this year was that the new
public revenue for undocumented persons lowered Watsonville’s obligation under access to care.

It is important to note that the reports are required to be audited. Dominican’s audit is in process, Sutter’s report is audited, and Watsonville is not audited. It is recommended that HSA work with the Auditor’s office to audit the Watsonville reports in the future if they choose to not have an independent auditor.

Special Contributions of the Hospitals:

In this report, it is important to acknowledge the leadership and contributions of each of our hospitals. Dominican, Watsonville and Sutter Hospitals participate and contribute time to the Health Improvement Partnership Council of Santa Cruz County and were founding members of the Council. This body takes on complex community health challenges and opportunities as a group. The Council also includes leaders from community clinics, Physicians Medical Group, Santa Cruz Medical Foundation, the Medical Society, Public Health, the Pajaro Valley Health Trust, the Community Foundation of Santa Cruz County, the leaders of the Emergency Department medical groups, the Central Coast Alliance for Health, executive physician leaders from the hospitals and others. Critical work this year which the hospitals have supported include advocacy on healthcare reform, Healthy Kids insurance program, improving stability in the Emergency Departments, Locality 99 Medicare rates, best practices for childhood obesity, end of life care planning, quality improvement and other major issues impacting our community. This level of collaboration and partnership on health issues is unique and has served our community well.

In addition Dominican Hospital has continued its leadership in many areas. Dominican is a 379-bed facility with a broad range of high quality clinical care options and community initiatives. Besides the hospital’s leadership in improving quality through its quality improvement programs and new electronic health records, the leaders of
quality improvement programs and new electronic health records, the leaders of Dominican have worked to develop a new nationally approved special treatment program for stroke victims, a palliative care unit for the terminally ill, expanded cardiac capacity, a special resource center for cancer victims (Katz Cancer Resource Center), a neo-natal intensive care nursery, and hospitalist services for community clinics and other practices. The hospitalist program partnership between Dominican and the safety net clinics has been a wonderful enhancement to care. Santa Cruz Medical Clinic and the Dominican Foundation provide the highly skilled physician team to support inpatient care.

This year Dominican appointed a new Chief Executive, Dr. Nan Mickiewicz. As a physician she brings a fresh view to many of the programs in the hospital and is a wonderful partner and supporter of community programs. She is a true asset to our community. Martina O'Sullivan, Dominican Community Liaison, has chaired the Healthy Kids Steering Committee and been a strong advocate for community collaboration. Vice President Kelly Duffin serves on the Executive Board of the Health Improvement Partnership Council and the Board of Directors of the Central Coast Alliance for Health. Dominican also contributes significant staff time to planning and activities of the Emergency Medical Commission.

Dominican also began its physician foundation this year. This is extremely important in terms of recruitment and retention of physicians and providing support for billing, computer systems, and general infrastructure. Many of the doctors in private practice are joining this Foundation as it will assist physicians with operating a successful practice and getting assistance on the business end. This Foundation is similar in its goals to Santa Cruz Medical Foundation and was a very important step forward.

Sutter Maternity and Surgery Center has also worked as a strong partner with the County and community on many important health initiatives. Besides contributing significant funding towards premiums for Healthy Kids and other support for non-profit health organizations, Sutter has worked to increase access to needed specialist care and inpatient procedures for community clinic uninsured patients and MediCruz patients. Sutter continues to provide more and more inpatient procedures and surgical access for safety net clinic patients, high-risk pregnancy services, HIV home care assistance, and large prevention activities focused on seniors and prostate cancer. Dr. DeGhetaldi, the CEO, has also worked extensively on Medicare Locality 99 advocacy with the Medical Society and other community partners. He also serves on the Executive Committee of the Health Improvement Partnership Council and is a Board member for the Central Coast Alliance for Health. Sutter also provided a special $200,000 grant this year to Salud Para La Gente to assist them with their roll out of electronic health records.

Santa Cruz Medical Clinic physicians group is also working on a merger of their medical staff with Palo Alto and Camino Medical groups. This will help with access to subspecialists who practice at Stanford and other highly complex care. Attachment C from Sutter summarizes some of these issues.

Watsonville Hospital has a new partnership with Salud Para La Gente to provide primary care services on the hospital campus that will in time reduce unnecessary emergency department use. The Watsonville staff has also done significant work to maintain a top quality emergency medical system through the Emergency Medical Commission and its committees. The hospital is adding digital radiology, MRI and Ultrasound technology to
enhance treatment and diagnostics. Watsonville is also working to add a hospitalist program in the next year and is working on physician recruitment.

These are but a few highlights of the contributions made by our local hospitals that are to be acknowledged. We appreciate their leadership and dedication to our community.

It is, therefore, RECOMMENDED that your Board:

1. Accept and file this report; and
2. Direct the Health Services Agency to report back in November 2008 on hospital services and data collected for Access to Care contracts in the year 2007.

Sincerely,

Rama Khalsa, Ph.D.
Health Services Agency Director

RK:pb

Attachments:  A-1) Charity Care Policy – Dominican Hospital
              A-2) Charity Care Policy – Sutter Maternity & Surgery Center
              A-3) Charity Care Policy – Watsonville Community Hospital
              B) Charity Care Trends from OSHPD
              C) Sutter Santa Cruz/PAMF Report

RECOMMENDED:

Susan A. Mauriello
County Administrative Officer

Cc: County Administrative Office
    County Counsel
    Auditor-Controller
    HSA Administration
    Dominican Hospital
    Sutter Maternity and Surgery Center
    Watsonville Hospital
    Emergency Medical Commission
    Health Improvement Partnership Council
    Public Health Commission
POLICY:

Charity care, the caring for persons with special needs and an inability to pay for needed services, holds a high priority for the Adrian Dominican Sisters. Service to the poor and vulnerable is integral to the Sisters’ mission and is clearly evident in Dominican Hospital’s Mission and Philosophy:

A further commitment is to serve the health care needs of the poor.

We at Dominican Value:

“Human life, the dignity of all persons, the right to health care...”

Leadership in society that is positive and active on issues affecting the well-being of people.”

The granting of charity care/financial assistance will be based solely on the person’s ability to pay, regardless of age, gender, race, socio-economic or immigrant status, sexual orientation or religious affiliation. Inpatients and outpatients will be screened for their financial ability to pay for treatment and to determine the need for charity care/financial assistance, a payment plan and/or assistance with other resources. Based on the individual circumstances of patients, every reasonable effort will be made to explore appropriate alternative sources of payment and coverage from third parties, and other public and private programs, to allow Dominican to provide the maximum level of charity care/financial assistance to the greatest number of persons in need. Information about Dominican’s Financial Assistance program will be posted in the Emergency and main Admitting Departments and will be written in the primary languages spoken by the residents of the community served by Dominican. Refer to Attachment CC-A.

Dominican Hospital is committed to providing charity care/financial assistance to persons who have health care needs and are uninsured, under-insured, ineligible for a government program and are otherwise unable to pay for medically necessary care based on their individual financial situations. Dominican will assess patients prior to services being rendered, if feasible, and after services are rendered, if not already done so, to determine charity care/financial assistance. The manner of screening shall reflect the Dominican Spirit of compassionate caring, human dignity and faithful stewardship. It is an expectation that the patient/guarantor will cooperate and supply all necessary information required to make a determination for charity care/financial assistance eligibility. Applicants are required to fully cooperate and apply for any program for which th
may be eligible prior to their evaluation for charity care/financial assistance. The PFS Director or CFO may waive such conditions in situations where the patient/guarantor is not capable of meeting these requirements.

Dominican will report charity care as required by law, in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate. Charity care statistics shall not include amounts that are properly considered to be bad debt or contractual discounts.

PROCEDURE:

A. **DEFINITION OF CHARITY CARE/FINANCIAL ASSISTANCE:**

For purposes of this policy, “charity/financial assistance” refers to health care services provided without charge or at a discount to qualifying patients. The following health care services are eligible for financial assistance:

- Emergency medical services provided in an emergency room setting;
- Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting;
- Medically necessary services provided to Medicaid beneficiaries that are not covered by their respective Medicaid programs;
- Any other medically necessary services, evaluated on a case-by-case basis at Dominican Hospital’s discretion.

Those goods and services that are not Hospital Services and therefore not eligible for the Payment Assistance discount include the following:

- Goods or services provided principally for cosmetic purposes;
- Elective goods or services not necessarily to treat an illness or injury;
- Experimental goods or services (including, but not limited to, those provided to a patient as part of a clinical trial or research program);
- Physician services, treatments and procedures; and
- Goods or services covered by any Third-party Payer.
B. **CHARITY CARE/FINANCIAL ASSISTANCE FINANCIAL SCREENING:**

All patient’s who present themselves as not able to fulfill/satisfy their fbll responsibility for care will be financially screened. Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government program, and are unable to pay for their care. Requests for a charity care/financial assistance forms should be made to the Patient Accounting Department. The completed information is to be returned to the PFS Director for review and follow up.

Requests for charity care/financial assistance should be submitted prior to rendering of services. For all persons presenting to the hospital for emergency services however, financial assistance will be considered after the rendering of service if there is a documented need. Future consideration will also be given if, after billing, patients are unable to pay.

If appropriate, and when possible, the benefits of Medicaid and other public and private programs will be explained to the patient/guarantor at the time of registration and potentially eligible patients will be asked to apply.

Information about Dominican Hospital’s Financial Assistance program will be posted in the Emergency and Main Registration/Admitting Departments, the Registration Department at the Rehab Campus and at the main information desk in both English and Spanish. (See Attachment CC-A)

Charity care/financial assistance is provided on an individual occurrence basis. At the time a patient applies for charity care/financial assistance all outstanding receivables from prior services, including those in bad debt status, are to be reviewed. When applicable, the need for charity care/financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than a year before.

The information supplied on the completed application will be used by authorized representatives of Patient Accounting in the evaluation of the patient’s financial situation and in making a decision regarding the patient’s ability to pay for services provided, or for fbll or partial waiver of payment (sliding fee schedule). See Attachment CC-C for “Charity Care/Financial Assistance Application Process.”

Attachment CC-D is used to assist in analyzing potential charity care based on gross income. It is based on 200% of the Federal Poverty Guideline, which is one of the criteria that Santa Cruz County uses for determining Medi-Cruz eligibility. The table allows for a decreasing level of charity/financial assistance. Anyone falling within this criterion would receive, as a minimum, the charity/financial assistance indicated. In addition, if there are extenuating circumstances not apparent by reviewing a person’s income, additional charity/financial assistance may be allowed. Services eligible under
this policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination, as follows:

- Patients whose gross income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose gross income is above 200% but not more than 350% of the FPL are eligible to receive services at the highest average rate the hospital would receive for providing services from Medicare, Medicaid or any other government-sponsored health program of health benefits in which the hospital participates, whichever is greater.
- Patients whose gross income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the highest average rate the hospital would receive for providing services from Medicare, Medicaid or any other government-sponsored health program benefits in which the hospital participates.
- Patients whose gross income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Dominican Hospital.

Additional discounts may be available for patients meeting Hardship Criteria and patients with high medical costs:

- **Hardship Criteria:** In addition to the Charity Care Discount based upon the sliding scale, those patients whose liability after the initial discount is in excess of 15% of their annual income, including excess of qualified monetary assets shall be given an additional discount for all amounts over the 15% threshold.
- **Patient with high medical costs:** If a patient meets all of the criteria for a patient with high medical costs, the maximum allowable payment for the service, including that amount paid by insurance, is limited to the estimated amount that the highest government payer would have paid for the services.
- If the insurance has paid more than the estimated payment rate of the highest government payer, then the entire amount of the patient responsibility would be classified as a charity adjustment and no additional collections would occur.
- If the insurance has paid less than the amount from the highest government payer, the amount of the patient responsibility that is over the estimated highest government rate would be classified as a charity adjustment and the facility would be allowed to collect on the remaining balance.
- Patients will be allowed to settle their accounts through a schedule of regular payments up to 30 months. Such payment plan schedules shall be interest-free.

In addition to income, assets need to be taken into consideration when reviewing a person’s ability to pay. A patient is allowed one car (family allowed two cars), one home, and liquid assets up to the following amounts:

**SINGLE:** $5,000  
**FAMILY:** $10,000
Examples of liquid assets include, but are not limited to cash, stocks, and bonds. Assets exceeding these amounts shall be “spent down” to this level before charity/financial assistance would be provided. If a person has more than two cars or a second home, the value of the third car or second home is included with the value of other liquid assets and is then compared to the above allowed amounts. If the total value of their includable assets exceeds the allowed amount, the excess must be spent down before financial assistance is considered.

Approval levels are as follows:

<table>
<thead>
<tr>
<th>Dollar Range</th>
<th>Type of Case</th>
<th>Approval Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40 - $999</td>
<td>Individual Cases</td>
<td>Patient Accounting Supervisor</td>
</tr>
<tr>
<td>$1,000-$9,999</td>
<td>Individual Cases</td>
<td>PFS Director</td>
</tr>
<tr>
<td>$10,000+</td>
<td></td>
<td>CFO</td>
</tr>
</tbody>
</table>

Assignment of Financial Responsibility:

1. Prior to rendering of services, the Financial Counselor will screen the patient’s financial status for potential charity/financial assistance referral.

2. Income on Attachment CC-D refers to total gross earnings from all sources. Sources include but are not limited to: wages, salaries, payments from Social Security, public assistance, unemployment and worker’s compensation, veterans benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property or liquid assets and one-time insurance or compensation payments. The ability to borrow against assets, e.g., a life insurance policy, should also be considered as another source of cash. Food or rent in lieu of wages will also be considered if appropriate documentation is provided. (Note: When the Federal Poverty Guidelines are utilized in determining financial assistance eligibility, the total gross earnings refers to total income from all such sources.)

3. In addition to listing assets, the patient/guarantor will also be asked to provide, if applicable:
   - Documentation representative of current income
   - Copy of social security, disability, or unemployment check or award letter
   - Copy of state AHCCCS/Medicaid Decision/Denial Notice

The patient/guarantor will be asked to return the completed form within ten days for financial assistance consideration.

4. The application form requests specific information for people in household including name, date of birth, income, employer and employee phone number. Consistent with Medicaid guidelines, the applicant may only include people who meet the following criteria within their household:
   - A child or sibling children
Charity Care/Financial Assistance Policy 8610adm-159

- The parents married or unmarried of the sibling children
- The stepparents of the sibling children
- The separate children of either unmarried parent or of the parent or stepparent
- If there are no children, family member means a single person or a married couple
- A caretaker relative or child

5. The Payment Assistance calculation worksheet must be completed for all approved discounts. The worksheet documents the key criteria used in the final calculation of the discount amount.

6. The patient/guarantor will be notified in writing of approval/denial of the financial assistance request within 30 days of receipt of completed application. If a patient/guarantor feels that a denial for financial assistance was made in error, he/she will be instructed to provide additional information that may assist Dominican Hospital in reconsidering the request.

7. When possible, the benefits of Medical, Medi-Cruz and other programs will be explained to the patient at the time of registration. All patients will be requested to apply when appropriate.

8. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. In accordance with EMTALA regulations, in emergency situations, patients will be screened for potential financial assistance referral following rendering of services.

9. A family member, close friend or associate of the family may request consideration for financial assistance consideration. A referral may also be initiated by any member of the medical or facility staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, religious sponsors, or others, who may be aware of the potential need for financial assistance consideration.

10. The need for financial assistance shall be re-evaluated at each subsequent rendering of services, if the last financial evaluation was completed more than a year prior, and at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

C. ADDITIONAL SITUATIONS WHEN CHARITY CARE/FINANCIAL ASSISTANCE MAY APPLY

- Patients covered by a third party payer, who are unable to pay for their deductibles, co-pays, and/or non-covered services, are also eligible for charity care/financial assistance as set forth in this Policy and Procedure.

- Services provided to Medicaid beneficiaries that are medically necessary but are not covered by the respective Medicaid program qualify as charity.
• If a patient is unable to provide required documentation due to clearly being indigent (e.g., homeless), the facility may categorize write-offs as charity if consistent with internal facility procedures (i.e., local Authorization Policy) and so long as the rationale for the decision is documented.

• If a self-pay account (or the self-pay portion of an insurance account) is assigned to a collection agency, and the agency determines that a patient/guarantor is unable to meet their financial obligations to Dominican Hospital, and meets the criteria established in this policy and procedure, the collection agency is instructed to document the review, and then cancel and return the claim with documentation that supports Dominican Hospital guidelines. Dominican will retroactively re-classify the account and the write-off as charity care.

D. ONGOING OUTPATIENT ACCOUNTS:
An ongoing account may remain open and considered active as long as the insurance information, doctor, and diagnosis remain the same. Financial Assistance will be considered every six months after all insurance payments have been received and the remaining unpaid balance is determined to be patient responsibility. Cases will be presented using the same guidelines as outlined in the Charity Care/Financial Assistance Procedure.

E. CLASSIFICATION OF GOVERNMENT AND OTHER PROGRAM SUBSIDIES
In accordance with Dominican’s Community Benefit Policy and Procedure, uncompensated costs for patients who are covered by Medicaid or other government insurance programs will not be reported as charity care. The subsidies for these programs will be classified as “Uncompensated Costs of Medicaid or Other Public Programs,” and will be detailed as such in the annual “Social Accountability Report.”

F. BUDGETING AND REPORTING OF CHARITY ALLOWANCES:
Within Dominican’s Social Accountability Budget, specific dollar amounts and detailed plans for charity care will be included. Charity care data will be disclosed in the annual financial statements.

G. LEVEL OF CHARITY CARE TO BE PROVIDED:
The Hospital is called to meet special needs in the community to the best of its ability. The question of how much charity care is enough in terms of a certain amount of committed dollars requires consideration of a number of factors:

- The extent of unmet need in the community;
- The financial position of the Hospital;
The Hospital will evaluate the effectiveness of its existing special needs programs as it takes these factors into account. The Hospital will include a description of its special needs programs and will quantify the current and upcoming budget year’s anticipated amounts of care for special needs (charity care).

Dollar commitment is only one measure of the Hospital’s mission in addressing special needs. Needs assessment and priority setting are prerequisites to appropriate resource allocation. The extent to which identified needs can be shown to have been met through careful planning and management is a far greater indicator of success in fulfilling the Hospital’s mission than is a standard dollar amount.

Formulated: 5/9/94
Reviewed: 6/95, 4/96, 3/97
Revised: 5/05
Hospital Signage Instruction

Notices regarding the Financial Assistance Program will be posted in the Emergency and main Admitting Departments, and may also be posted in other strategic locations in Catholic Healthcare West facilities written in the primary languages spoken by the residents of the community served by the facility.

Financial Assistance Program

Consistent with its mission, Catholic Healthcare West facilities provide free or reduced cost medical services to persons who are unable to pay for their care.

Please discuss your individual needs with an admitting representative or financial counselor. Upon completion of a Financial Assistance Application Form, along with the submission of all required documents, you may be eligible for financial assistance as defined by Catholic Healthcare West policy.

Catholic Healthcare West

CHW

CHW Policy 4.50
July, 2002
Charity Care/Financial Assistance Policy 8610adm-159

Catholic Healthcare West

Account #__________________________

Patient Name: _______________________

FINANCIAL ASSISTANCE APPLICATION

<table>
<thead>
<tr>
<th>LAST NAME (PATIENT)</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>SOCIAL SECURITY #</th>
<th>BIRTHDATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RESIDENCE ADDRESS (FACILITY ADDRESS IF HOMELESS)</th>
<th>PHONE</th>
<th>HOW LONG</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST NAME (GUARANTOR IF DIFFERENCE FROM ABOVE)</th>
<th>SOCIAL SECURITY #</th>
<th>BIRTHDATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS)</th>
<th>PHONE</th>
<th>MONTHLY GROSS PAY</th>
<th>$</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>OTHER EMPLOYER (NAME AND FULL ADDRESS)</th>
<th>PHONE</th>
<th>MONTHLY GROSS PAY</th>
<th>$</th>
</tr>
</thead>
</table>

IF UNEMPLOYED: NAME OF LAST EMPLOYER AND FULL ADDRESS

<table>
<thead>
<tr>
<th>FAMILY MEMBERS (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER)</th>
<th>BIRTHDATE</th>
<th>RELATIONSHIP</th>
<th>EMPLOYED BY</th>
<th>EMPLOYER PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RENT HOME

<table>
<thead>
<tr>
<th>OWED TO OTHERS</th>
<th>TOWER OWED</th>
<th>PRESENT BALANCE</th>
<th>MONTHLY PAYMENT</th>
<th>ASSETS</th>
<th>BASE NUMBER</th>
<th>ACCOUNT BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RENT/MORTGAGE</td>
<td>CHECKING</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UTILITIES</td>
<td>SAVINGS OR CERTIFICATE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FOOD</td>
<td>403(b) OR 401(k)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUTO LOAN</td>
<td>STOCKS &amp; BONDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CREDIT CARDS</td>
<td>IRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUTO (YEAR &amp; MAKE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUTO (YEAR &amp; MAKE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER OBLIGATIONS</td>
<td>RESIDENCE MARKET VALUE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDITIONAL INFORMATION (SEE BACK)</td>
<td>INSURANCE CASH VALUE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BILLS OWED TO OTHER MEDICAL PROVIDERS</td>
<td>OTHER ASSETS (DESCRIBE E.G., SECOND HOME)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COST OF PRESCRIPTION MEDICATION(S)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL DEBTS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TOTAL ASSETS</td>
</tr>
</tbody>
</table>

SPECIFY SOURCE
I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS APPLICATION FOR FINANCIAL ASSISTANCE CONSIDERATION.

SIGNATURE

DATE

In order for this application to be considered for Financial Assistance, ALL of the following documents are required, if applicable

- Completed Financial Assistance Application Form
- A copy of the prior year tax return
- Documentation representative of current income
- A copy of social security, disability, or unemployment check or award letter
- A copy of a state AHCCS/Medicaid Decision/Denial Notice. You can obtain this by contacting the AHCCS/Medicaid office in the area in which you live. All potentially eligible patients must provide a valid “Notice of Action” from AHCCS/Medicaid stating completion of the application and the reason for acceptance or denial. Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this application for financial assistance.

Please return your completed application with all requested forms in the enclosed self-addressed stamped envelope within 10 days. Contact ____________________________ at ____________________________ if you have any questions.

Please be advised that this is not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation. We look forward to being of assistance to you to resolve your account.

Return by this Date: ____________________________

Account Number: ____________________________Account Balance: ____________________________
<table>
<thead>
<tr>
<th>Responsible Person/Department</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient/Referral Source</td>
<td>Refers to PFS Director as soon as the need is realized</td>
</tr>
</tbody>
</table>
| 2. Financial Counselor/Patient Accounting | Pre-screens for coverage – I/P services and elective OP surgery before or upon admission or at time of service. In accordance with EMTALA regulations, in emergency situations,  
- Patients will be screened for potential charity care/financial assistance referral following the rendering of services. |
| 3. Eligibility Worker/Patient Accounting | Takes application for other government programs including financial statement or determines to make application as a charity case before, during, or after patient stay. If appropriate, and when possible,  
- Will explain the benefits of Medicaid and other public and private programs at the time of registration and  
- Will ask potentially qualified patients/guarantors to apply.  
If application for charity care/financial assistance is considered appropriate,  
- Will facilitate the charity care/financial assistance application process by providing forms and instruction. Refer to Attachment CC-B.  
- Will process completed application utilizing guidelines on pages 3 and 4 of Attachment CC-C.  
- Will approve/deny requests for charity care/financial assistance in accordance with internal facility controls.  
- Will notify the patient in writing of charity (financial assistance) approval/denial and/or set up payment arrangement for any remaining balance. This notification will occur within 30 days of receipt of the completed application. Refer to Attachments CC-E and CC-F.  
- Will disclose charity care data in the annual financial statements and in the quarterly Social Accountability Report. |
<p>| 4. PFS Director/Patient Accounting | Reviews all attached documentation of referral to be sure it meets charity care/financial assistance guidelines. Establishes percent of charity appropriate according to policy. Reviews and approves all cases under $9,999. Approved cases that are $10,000 or greater are forwarded to the CFO for approval. Any “additional adjustments” that exceed $5,000 or 25% of total charges must be approved by the CFO. |</p>
<table>
<thead>
<tr>
<th>Responsible Person/Department</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. CFO</td>
<td>Reviews and approves cases that are $10,000 or greater. CFO also approves any “additional adjustments” that</td>
</tr>
</tbody>
</table>
| 6. Collection Agency/Patient Accounting | If a self-pay account (or the self-pay portion of an insurance account) is assigned to a collection agency, and the agency determines that a patient/guarantor is unable to meet their financial obligations to Dominican, and meets the requirements of Dominican Charity Care/Financial Assistance Policy and Procedure,  
  - The Collection agency will document the review, cancel and return the claim with documentation that supports Dominican’s guidelines to Dominican for re-classification. 
  - Dominican will retroactively re-classify the account and the write-off as charity care. |

The designated hospital staff person provides patient/guarantor with a Financial Assistance Application (Attachment CC-B) to complete and sign. Authorization to check credit history is granted to CHW when the patient/guarantor signs the form.

The application form requests financial information, including a listing of liabilities and assets. Assets include gross income from all sources. Sources include but are not limited to: wages, salaries, payments from Social Security, public assistance, unemployment and worker’s compensation, veterans benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property or liquid assets and one-time insurance or compensation payments. The ability to borrow against assets, e.g., a life insurance policy, should also be considered as another source of cash. Food or rent in lieu of wages will also be considered if appropriate documentation is provided. (Note: When the Federal Poverty Guidelines (Attachment CC-D) are utilized in determining charity care/financial assistance eligibility, the total gross earnings refers to total income from all such sources.)

The Charity Care – Annual Family Income Levels, 200% Federal Poverty Guidelines (Attachment CC-D) may be used to determine an appropriate level of charity care/financial assistance. The standard is based on 200% of the current Federal Poverty Guideline, a percentage used by many counties for determining Medicaid eligibility.
Charity Care/Financial Assistance Application Process (continued)

In addition to income, the following assets are to be considered when reviewing a person’s ability to pay. A patient is allowed one car, one home, and liquid assets up to the following amounts:

- $5,000 (Individual)
- $10,000 (Family)

Examples of liquid assets include, but are not limited to cash, stocks, and bonds. Assets exceeding these amounts shall be “spent down” to this level before financial assistance will be provided. If a person has more than one car or home, the value of the second car or home is included with the value of other liquid assets and is then compared to the above-allowed amounts. If the total value of their includable assets exceeds the allowed amount, the excess must be spent down before charity care/financial assistance is considered.

In addition to listing liabilities and assets, the patient/guarantor will also be asked to provide, if applicable:

- documentation representative of current income
- a copy of social security, disability, or unemployment check or award letter
- a copy of state AHCCS/Medicaid Decision/Denial Notice.

The patient/guarantor will be asked to return the completed form within ten days for charity care/financial assistance consideration.
### 2007 Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100%</th>
<th>200%</th>
<th>350%</th>
<th>500%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,210</td>
<td>$20,420</td>
<td>$35,735</td>
<td>$51,050</td>
</tr>
<tr>
<td>2</td>
<td>$13,690</td>
<td>$27,380</td>
<td>$47,915</td>
<td>$68,450</td>
</tr>
<tr>
<td>3</td>
<td>$17,170</td>
<td>$34,340</td>
<td>$60,095</td>
<td>$85,850</td>
</tr>
<tr>
<td>4</td>
<td>$20,650</td>
<td>$41,300</td>
<td>$72,275</td>
<td>$103,250</td>
</tr>
<tr>
<td>5</td>
<td>$24,130</td>
<td>$48,260</td>
<td>$84,455</td>
<td>$120,650</td>
</tr>
<tr>
<td>6</td>
<td>$27,610</td>
<td>$55,220</td>
<td>$96,635</td>
<td>$138,050</td>
</tr>
<tr>
<td>7</td>
<td>$31,090</td>
<td>$62,180</td>
<td>$108,815</td>
<td>$155,450</td>
</tr>
<tr>
<td>8</td>
<td>$34,570</td>
<td>$69,140</td>
<td>$120,995</td>
<td>$172,850</td>
</tr>
</tbody>
</table>

Note: For households with more than 8 members, add $3,480 per member.
Sample Financial Assistance Approval Letter

Date:

Account Number:

Patient Name:

Balance Due:

Dear _________________________

Upon careful review of your Financial Assistance Application we have approved the request to provide financial assistance to cover hospital charges*. Please note that this decision in no way obligates Catholic Healthcare West to provide financial assistance in the future.

You will be responsible for the amount indicated below:

- Total Account Balance $__________________
- Less Financial Assistance $__________________
- Amount Owed by Patient/Guarantor $__________________

Important Note: Only hospital services are included in this account and the total account balance does not reflect any physician charges.

If you have any questions regarding your account, please direct them to ___________________ at _______________________

Sincerely,

Hospital Designee, Title
Sample Financial Assistance Denial Letter

Date:

Account Number:

Patient Name:

Balance Due:

Dear __________________________

Your Financial Assistance Application and the information you have provided have been carefully evaluated. Regretfully, we have determined that you are not eligible for financial assistance based on the hospital’s Financial Assistance Policy and criteria.

Should you feel that this decision was made in error, and you have additional information that may assist us in reconsidering your request, or if you have any questions regarding your account, please contact __________________________ at __________________________

If your financial information changes in the future you may reapply for financial assistance.

The current balance on your account is $______________________________

Sincerely,

Hospital Designee, Title
POLICY

It is the policy of SMSC and VNA to provide financial assistance to low-income uninsured patients reflecting Sutter Santa Cruz's social accountability to the communities we serve. Providing charity care (financial assistance) to the low-income uninsured, along with other community benefit services is important evidence of Sutter Santa Cruz's mission fulfillment. It is imperative that the determination, reporting, and tracking of charity care are in concert with our not-for-profit mission and community obligation.

Charity care will be based on the individual's ability to pay as defined by Federal Poverty Income Guidelines. Confidentiality of information and individual dignity will be maintained for all that seek charitable services. The handling of personal health information will meet all HIPAA requirements.

PURPOSE

The purpose of this policy is to define the eligibility criteria for charity care services and to provide administrative and accounting guidelines for the identification, classification and reporting of patient accounts as charity care. Charity care provision at SMSC and VNA consists of two components: Charity Care and Access to Care (ATC).

Definition of Charity Care:

A low income uninsured patient is eligible for Charity Care consideration based on meeting the___.

Definition of Access to Care:

An Access to Care patient is a low-income uninsured patient who has___ and ___ to SSC by the MediCruz program and has ___.

Charity / ATC care and discounts provided by this policy are generally not available for "elective procedures"; however, in certain cases an exception may be made. These exceptions require approval by the SSC CFO. Specialized, high-cost services (i.e. experimental procedures, etc.) requiring charity care are also subject to the review of the SSC CFO prior to the provision of service.
Eligibility Criteria:

A. Charity Care Application:

1. A low income uninsured SMSC or VNA patient who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for charity care assistance.

2. The Sutter Health standardized application form, shown as the "Statement of Financial Condition" on attachment A, will be used to document each patient's overall financial situation.

3. A sample of the "Sutter Santa Cruz Charity Care Calculation Worksheet" (see attachment B) is provided to aid the hospital and VNA in determining the amount and type of charity care for which the patient may be eligible.

4. Once a determination has been made a "Notification Form" (see attachment C) will be sent to applicants advising them of the facility's decision.

5. In the case of ATC, the qualification level for MediCruz is lower than the minimum requirements for SSC. Therefore, the completed MediCruz application (format equals attachments A and C) will serve as the basis to determine eligibility and to verify an individual's financial status. MediCruz has agreed to a random periodic audit by SSC to verify the accuracy of the application documentation.

6. A patient's employment status may be taken into consideration when evaluating charity care status as well as potential payments from pending litigation, and third party liens related to the incident of care.

7. The amount and frequency of SSC bills may also be considered.

8. The data used in making a determination concerning eligibility for charity care should be verified to the extent practical in relation to the amount involved.

B. Full Charity Care:

The SMSC and VNA standard for full charity / ATC care write-off will be 350% of the most recent Federal Poverty Income Guidelines.

C. Partial Charity Care:

A patient whose income is above 350% of the most recent Federal Poverty Income Guidelines may be eligible for a partial charity / ATC care write-off in certain circumstances.

D. Catastrophic Charity Care:

In order to qualify for Catastrophic Charity Care Circumstances the uninsured patient must meet the expense qualification as described below:
Expense Qualification:

The patient’s Allowable Medical Expenses must exceed 30 percent of his or her Family Income determined as follows:

i. multiply the Family Income as determined in Section J by 30%

ii. determine the patient’s Allowable Medical Expenses.

iii. compare 30% of the Family Income as determined in Section 3 to the total amount of the patient’s Allowable Medical Expenses. If the total of the Allowable Medical Expenses is greater than 30% of the Family Income, then the patient meets the Catastrophic Charity Care qualification. Subtract 30% of the Family Income from the Allowable Medical Expenses to determine the amount by which the Allowable Medical Expenses exceed the available income; this amount is then eligible for a charity care write-off.

Eligibility Period:

The eligibility period is one year from the date of the initial eligibility determination, unless over the course of that year the patient’s family income or insurance status changes to such an extent that the patient becomes ineligible.

E. Homeless Patients:

Homeless patients without a payment source may be classified as charity if they do not have a job, residence, or insurance.

F. Collection Agency:

If a collection agency identifies a patient meeting SMSC’s or VNA’s charity care eligibility criteria their patient account may be considered charity care, even if they were originally classified as a bad debt. Collection agency patient accounts meeting charity care criteria should be returned to the SSC Charity Liaison and reviewed for charity care eligibility.

G. Special Circumstances:

1. Deceased patients without an estate or third party coverage will be eligible for charity.

2. Patients who are in bankruptcy or recently completed bankruptcy may be eligible for charity.

3. While it is not the policy of SMSC or VNA to routinely waive co-pays and deductibles, a patient’s individual circumstances may be such that while they do not meet the regular charity care criteria in this policy, they do not have the ability to pay their bill. In these situations, with the approval of management, part or all of their cost of care may be written off as charity care. There must be complete documentation of why the decision was made to do so and why the patient did not meet the regular criteria.

H. Governmental Assistance:

1. In determining whether each individual qualifies for charity care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, the Healthy Families Program, Victims of Crime, or California Children Services.
2. SMSC and VNA will require that the individual seeking charity / ATC care apply for MediCal and MediCruz in order to determine if they are eligible for assistance.

3. Persons eligible for programs such as MediCal or MediCruz but whose eligibility status is not established for the period during which the medical services were rendered, may be granted charity care for those services. The granting of charity / ATC care will be contingent upon patient applying for governmental program assistance.

I. Time Requirements for Determination:

1. While it is desirable to determine the amount of charity care for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information.

2. Every effort will be made to determine a patient's eligibility for charity care. In some cases, a patient eligible for charity care may not have been identified prior to initiating external collection action.

3. Patients who are determined either by the Hospital/ VNA staff or the patient to not have the resources to pay the patient balance will be mailed an Access to Care application. Patients have 30 days from receiving the application to complete and return the application to the Access to Care charity liaison. If patients do not return the application within this timeframe, a "30 Day Letter" will be mailed to the patient as a reminder. They will have 30 additional 30 days to complete the application process after receiving the 30 day letter. Patients who fail to respond to the charity application and the 30 day letter can only be transferred to a collections agency after 90 days from the date of discharge.

J. Definition of Income:

1. Annual family earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

2. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates.

K. Approval Matrix of who can grant Charity Care Write-off's:

Refer to attachment E.

L. Accounting for Charity Cam:

Once eligibility for charity status has been determined, the patient's charges will be written off as follows:

VNA: Write off codes  CHARITY DISC. = O/P FULL  "CC" type, Adj 07
                  CHARITY DISC. = O/P PARTIAL "CC" type, Adj 07
SMSC: Write off codes:  
CHARITY DISC. - I/P FULL  191  
CHARITY DISC. - I/P CATASTROPHIC  197  
CHARITY DISC. - I/P PARTIAL  193  
CHARITY DISC. - O/P FULL  192  
CHARITY DISC. - O/P PARTIAL  196

M. Public Notice and Posting:

Public notice of the availability of financial assistance will be made through the following means:

1. Signage will be posted in both English and Spanish in a visible location in all patient access areas. The contact phone number of the SSC Charity Liaison will be included.

2. A letter outlining the requirements of the application process and a business card identifying the direct phone number of the SSC Charity Liaison will be available for all patients who inquire about financial assistance.

N. Tracking of Charity Care Applications:

In accordance with AB774, SMSC and VNA will log all charity care applications sent to patients. Patients who fail to respond will receive a follow up letter after 30 days. If no response is received after another 30-day period elapses, the obligation to attempt to provide financial assistance will be considered satisfied.

Each charity application and 30 day letter sent to patients will be logged in the Access to Care Binder, in addition to notes entered in MS4 or McKesson, each noting the specifics as necessary.

O. Right to Appeal

Any patient who has been denied Charity/ATC has the right to pursue the following appeals process:

1. Upon receipt of denial from SCC Charity Liaison, the patient must submit a written request for reconsideration to the SSC Director of Patient Accounting. The request must be submitted within five business days of receiving notification of denial and should include any documentation that supports the patient’s request for reconsideration. The SSC Director of Patient Accounting will review and respond to the appeal within five business days. If the denial is upheld, the patient has the right to file a second level appeal to the SSC CFO.

2. Within five business days of receipt of the SSC notification confirming the denial has been upheld, the patient must submit a second written request for reconsideration to the SSC Chief Financial Officer. The appeal will be reviewed and decided upon within five business days of receipt by the SSC CFO. If the denial for Charity/ATC benefits is upheld by the SSC CFO, the decision is final and no further appeal will be considered.
STATEMENT OF FINANCIAL CONDITION

PATIENT NAME ____________________  SPouse ____________________
ADDRESS ____________________  PHONE ____________________
ACCOUNT # ____________________  SSN ____________________
(Patient)  (Spouse)

FAMILY STATUS: List all dependents that you support

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EMPLOYMENT AND OCCUPATION

Employer: ____________________  Position: ____________________
Contact Person & Telephone: ____________________
If Self-Employed, Name of Business: ____________________

Spouse Employer: ____________________  Position: ____________________
Contact Person & Telephone: ____________________
If Self-Employed, Name of Business: ____________________

CURRENT MONTHLY INCOME

Gross Pay (before deductions)  Patient  Spouse

Add: Income from Operating Business (if Self-Employed)  _________  _________

Add: Other Income:
  Interest and Dividends
  From Real Estate or Personal Property  _________  _________
  Social Security  _________  _________
  Other (specify):  _________  _________
  Alimony or Support Payments Received  _________  _________

Subtract: Alimony, Support Payments Paid  _________  _________

Equals: Current Monthly Income  _________  _________
  Total Current Monthly Income (add Patient+Spouse
  Income from above)  _________  _________

FAMILY SIZE

Total Family Members  _________
  (add patient, spouse and dependents from above)

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

(Signature of Patient or Guarantor)  (Date)

(Signature of Spouse)  (Date)
Sutter Santa Cruz
Charity Care Calculation Worksheet

Patient Name: ________________________________  Patient Account #: ________________________________

Hospital / VNA: ________________________________  Date: ________________________________

Special Considerations/Circumstances: ________________________________  ________________________________

Does Patient have Insurance?  Yes  No

Is Patient Eligible for Medicare?  Yes  No

Is Patient Eligible for Medi-Cal?  Yes  No

Is Patient Eligible for Other Government Programs (e.g., Crime Victims, etc.)?  Yes  No

Is Patient Self-Pay?  Yes  No

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income
(From Statement of Financial Condition)  $ __________

Family Size (From Statement of Financial Condition)

Qualification for Charity Care/Financial Assistance (circle one):
Full  Catastrophic  No Eligibility
(identify using eligibility guide)

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o):

A. Patient Liability (total charges unless another discount has been applied)  $ __________

B. Annual Income  $ __________

C. Patient Liability as Percent of Annual Income.  $ __________

D. Is Line A divided by Line B greater than .30 (30%)?  Yes  No

E. If no, patient is not eligible for this type of write-off  $ __________

F. If yes, multiply Line B by 30% to identify the patient liability amount  $ __________

E. If yes, Subtract Line F from Line A to identify the write-off amount.  $ __________

Total Amount of Recommended Charity Write-offs(s):  $ __________

Worksheet Completed by: ________________________________  Phone:

Approved by:
(see approval matrix)  ________________________________  Date:

Approved by CFO: ________________________________  Date:

Policies – Attachment B  Page 7 of 10  Poky: 14-284
NOTIFICATION FORM
SUTTER SANTA CRUZ
ELIGIBILITY DETERMINATION FOR CHARITY CARE

Sutter Health has conducted an eligibility determination for charity care for:

PATIENT'S NAME ACCOUNT NUMBER DATE(S) OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on __________
This determination was completed on: _______________________

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

_____ Your request for charity care has been approved for services rendered on
After applying the charity care reduction, the amount owed is $ _______________

_____ Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

________________________________________________________

________________________________________________________

________________________________________________________

Your request for charity care has been denied because:

REASON: _____________________________________________

________________________________________________________

If you have any questions on this determination, please contact:

Charity Liaison
Sutter Santa Cruz
(831) 458-5612
ATTACHMENT D: Sutter Health Federal Poverty Income Guideline Sliding Scale

Eligibility Guide for 2007: Using household income and size as calculated in the Attachment A, identify eligibility for financial discount,

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,230</td>
<td>$851</td>
</tr>
<tr>
<td>2</td>
<td>$13,690</td>
<td>$1,141</td>
</tr>
<tr>
<td>3</td>
<td>$17,170</td>
<td>$1,431</td>
</tr>
<tr>
<td>4</td>
<td>$20,650</td>
<td>$1,721</td>
</tr>
<tr>
<td>5</td>
<td>$24,130</td>
<td>$2,011</td>
</tr>
<tr>
<td>6</td>
<td>$27,810</td>
<td>$2,301</td>
</tr>
<tr>
<td>7</td>
<td>$31,090</td>
<td>$2,591</td>
</tr>
<tr>
<td>8</td>
<td>$34,570</td>
<td>$2,881</td>
</tr>
</tbody>
</table>

For each additional family member add $3,480 for annual income.
SUTTER SANTA CRUZ
APPROVAL MATRIX

CFO

Above $50,000

Patient Financial Services Director

up to $50,000
POLICY STATEMENT:

As a condition of participation in the Medicaid disproportionate share program (if applicable) and to serve the health care needs of our community, Watsonville Community Hospital will provide charity care to self pay patients without financial means to pay for Hospital services.

Charity care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility criteria.

The hospital will make every effort to identify any insurance coverage and/or to assist patients with applying for Medicare, Medi-Cal, Healthy Families, California Children's Services and Charity.

PURPOSE:

To properly identify those patients who are financially indigent or medically indigent, who do not qualify for state and/or government assistance, and to provide assistance with their medical expenses under the guidelines for Charity Care.

ELIGIBILITY FOR CHARITY CARE

I. FINANCIALLY INDIGENT:

A. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

B. To be eligible for Charity care as a financially indigent patient, the patient's total household income shall be at or below 400% of the current Federal Poverty income Guidelines.

C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an
individual's eligibility for charity care as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 400% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the charity care needs of the community.

THE PROCESS

1. Identification of Charity Cases:

A. The hospital maintains posted signs, in English, Exhibit “A” and Spanish, Exhibit “B”, one in each intake area and Registration areas, that inform customers that charity care is available and what the charity care criteria is.

B. All self-pay patients are asked to complete the Financial Assistance form “FA”, Exhibit “C”, during the registration or financial counseling process.

C. All self-pay patients will be provided information in writing and asked to sign an acknowledgement of receipt of information regarding the availability of Charity Care and the availability of a financial counselor, for assistance with screening or applying for Medicare, Medi-Cal and other third party coverage. The patient will be given a copy of the notice and the acknowledgement. The original acknowledgement will be maintained in the patient medical record.

D. All self-pay accounts will be sent a statement for the services rendered and such statement will request insurance information as well as provide information that they may be eligible for Medicare, Medi-Cal, etc AND information regarding availability of Charity Care or Discounted Care AND who to contact regarding the applications.

E. All self-pay accounts balances will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process an “FA” will be
completed if it is determined that the patient does not appear to qualify for coverage under any program, the FA will be used for screening for Charity Care.

F. If the patient appears to qualify for Charity Care, the “FA” will be sent to the Business Office for final determination of Charity Care coverage by the Financial Counselor or Business Office Manager.

G. If the Financial Counselor determines through the application and documented support that the patient qualifies for charity care, she/he will give the completed and approved “FA” to the BOM for final determination of Charity Care coverage by the Financial Counselor or Business Office Manager.

H. The following documents will be required to process the application: copies of current monthly expenses/bills, copies of the previous year’s income tax return, current copy of employers check stub, proof of any other income, copies of all bank statements for prior 3 months, and copies of all other medical bills.

I. The Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account. Once patient has made contact about potential eligibility, we must allow them 60 days before we initiate collection action.

J. Once approved for Charity, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self pay and letter 81 will be mailed to the patient for their portion that they owe.

K. If the “FA” is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.

L. Applications that remain incomplete after 60 days of request for information will be denied.

M. The application may be reopened and reconsidered for charity once the required information is received. The patient will be sent a letter of denial along with reason and process for appeal.

N. All appeals should be directed to the BOM and shall include an explanation of the reason the application should be reconsidered. BOM will review any
additional information. If the information would still result in a denial, BOM will submit the application to the CFO who will make a final determination. The CFO’s decision is final.

O. Once an account has been written off to bad debt, the patient may not apply for Charity assistance that relates to these dates of service.

P. The ‘cost-share’ portion of any Medi-Cal patient cannot be considered under the Charity Care policy and must be collected from the patient.

2. FACTOR TO BE CONSIDERED FOR CHARITY DETERMINATION

A. The following factors are to be considered in determining the eligibility of the patient for charity care:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other monetary resources, excluding retirement and deferred compensation plans, and includes 50% of monetary assets over $10,000.
5. Other financial obligations

B. The income guidelines necessary to determine the eligibility for charity are attached on Exhibit “D”. The current Federal Poverty Guidelines are attached as Exhibit “E” and they include the definition of the following:

1. Family Income
2. Income

C. Patient may qualify for Charity Care if their annual out-of-pocket medical costs incurred exceed 10% of the patient’s family income in the prior 12 months (this can be incurred at any facility). The hospital may consider monetary assets for the person when determining eligibility. Monetary assets exclude retirement or deferred compensation plans and the first $10,000 of a patient’s monetary assets as well as 50% of monetary assets over $10,000.

3. FAILURE TO PROVIDE APPROPRIATE INFORMATION

Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination. The account...
may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt. See 1(M) for more information.

4. TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination. Notification of the approval or denial will be done in writing and so notated in the hospital system in the account(s) notes/comments.

5. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

Once the eligibility determination has been made, the results will be documented in the comments section on the patient’s account and the completed and approved “FA” will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOM will signify their review and approval of the write-off by signing the bottom of the Charity Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments.

6. REPORTING OF CHARITY CARE

Information regarding the amount of charity care provided by the hospital, based on the hospital’s fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

Hospital must submit to the Office of Statewide Health Planning and Development a copy of their Charity Policy at least every other year on January 1, or when a significant change is made. If the facility made no significant change in the policy since the information was previously provided, the Hospital may notify OSHPD of the lack of change to satisfy this requirement.
POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO

Hospital CFO

Corporate VP, Patient Financial Services

Group VP Operations

Date 1/22/07

Date 1/4/07

Date 1/4/07
FINANCIAL ASSISTANCE AVAILABLE

If you do not have adequate insurance coverage, you may be eligible for a reduction of your balance under the hospital's Discount Program.

If you do not have insurance you may be eligible for coverage under various government sponsored health insurance programs or for a reduction in your balance under the hospital Charity Care Program.

Income requirements apply.

To obtain information about these programs or to obtain an application, contact the hospital business office or financial counselor.

California Wealth & Safety Code Section 127410
Exhibit B

ASISTENCIA FINANCIERA DISPONIBLE

Si usted no tiene fondos de seguro médico adecuados, usted puede ser elegible para una reducción de su balance bajo el Programa de Descuento de hospitales.

Si usted no tiene seguro médico, usted puede ser elegible para fondos bajo varios programas de seguro de salud patrocinados por el gobierno o para una reducción de su balance bajo el Programa de Caridad del hospital.

Aplican requisitos de ingreso.

Para obtener información acerca de estos programas o para obtener una aplicación, pongase en contacto con la oficina de negocios del hospital o con un consejero financiero.

Código de Salud y Seguridad de California Sección 127410
Exhibit C
Watsonville Community Hospital
Charity Care/Financial Assistance Program Application

Patient Account Number: ____________________________ Date of Application ____________

PATIENT INFORMATION

Name__________________________________________
Address_______________________________________
City___________________________________________
State/Zip________________________________________
SS#____________________________________________
Employer_______________________________________
Address_______________________________________
City___________________________________________
State/Zip________________________________________
[...]

PARENT/GUARANTOR/SPOUSE

Name__________________________________________
Address_______________________________________
City___________________________________________
State/Zip________________________________________
SS#____________________________________________
Employer_______________________________________
Address_______________________________________
City___________________________________________
State/Zip________________________________________
Work Phone_____________________________________
[...]

RESOURCES

Checking: yes____ no____ Vehicle 1: Yr____ Make______ Model_____
Savings: yes____ no____ Vehicle 2: Yr____ Make______ Model_____
Cash on hand: $____________ Vehicle 3: Yr____ Make______ Model_____

[...]

58
Exhibit C (continued)
Charity Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): __________________________

Spouse/Second Parent:
Wages(monthly): __________________________

Other Income: Child Support: $________
VA Benefits: $________
Workers’ Comp: $________
SSI: $________
Other: $________

Other Income: Child Support: $________
VA Benefits: $________
Workers’ Comp: $________
SSI: $________
Other: $________

LIVING ARRANGEMENTS

Rent_________ Own_________ Other(explain)________________________

Landlord/Mortgage Holder: ____________________________

Phone Number ____________________________ Monthly payment $-___________

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements, Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones), Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant__________________________________________

Hospital Representative Completing Application:________________________

 Approval/Authorization of Charity Write-Off Amount Approved $___________

BOM_________________________ CEO_________________________

CFO_________________________

58
Exhibit D

Income Guidelines For Determining % of Charity Care Discount
(For Financially Indigent Patients)

Based on Current Year's Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>% of Poverty Income</th>
<th>Discount from Gross Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>300% and below</td>
<td>100%</td>
</tr>
<tr>
<td>301% - 320%</td>
<td>90%</td>
</tr>
<tr>
<td>350% - 400%</td>
<td>30%</td>
</tr>
</tbody>
</table>
Exhibit E

2006 Federal Poverty Income Guideline


2006 HHS Poverty Guidelines

<table>
<thead>
<tr>
<th>Persons in Family Unit</th>
<th>48 Contiguous States and D.C.</th>
<th>Alaska</th>
<th>Hawaii</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$9,800</td>
<td>$12,250</td>
<td>$11,270</td>
</tr>
<tr>
<td>2</td>
<td>13,200</td>
<td>16,500</td>
<td>15,180</td>
</tr>
<tr>
<td>3</td>
<td>16,600</td>
<td>20,750</td>
<td>19,090</td>
</tr>
<tr>
<td>4</td>
<td>20,000</td>
<td>25,000</td>
<td>23,000</td>
</tr>
<tr>
<td>5</td>
<td>23,400</td>
<td>29,250</td>
<td>26,910</td>
</tr>
<tr>
<td>6</td>
<td>26,800</td>
<td>33,500</td>
<td>30,820</td>
</tr>
<tr>
<td>7</td>
<td>30,200</td>
<td>37,750</td>
<td>34,730</td>
</tr>
<tr>
<td>8</td>
<td>33,600</td>
<td>42,000</td>
<td>38,640</td>
</tr>
<tr>
<td>For each additional person, add</td>
<td>3,400</td>
<td>4,250</td>
<td>3,910</td>
</tr>
</tbody>
</table>

These guidelines are effective immediately upon publication in the Federal Register. As noted in the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the poverty guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program. To find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.
Santa Cruz Charity Data (Source OSHPD) - % of Charity Care as a Percentage of Gross Charges
Sutter Santa Cruz/Palo Alto Medical Foundation-SC Division 2007 Report

Legislative Issues:

Obviously the Locality 99 designation continues to be a major concern. All the physicians in the County very much appreciate and are proud that Santa Cruz County is the lead claimant in the Medicare lawsuit on behalf of all providers in 180 counties across the United States.

SCHIP also continues to be a great concern for the continuing success of Healthy Families and Healthy Kids. Sutter Maternity and Surgery Center (SMSC) has been an enthusiastic supporter of both and made cash donations of $50,000 directly to Healthy Families and $125,000 to Healthy Kids in 2007. As we all know, these have been tremendously successful programs for our county and a model for the State.

Medical Care Support:

SMSC continues to ensure the availability of OB and Pediatric physicians for County unassigned and incarcerated patients. Neurology Coverage is also supported by SMSC. This support, as well as support to Cabrillo College School of Nursing and other programs, is summarized in the Access to Care report (YTD September 2007) attached here.

The Santa Cruz Medical Foundation (SCMF) has worked in collaboration with the Santa Cruz county Safety Net Clinics and Dominican Hospital to provide care for the patients of Santa Cruz County. SCMF has a full time group of physicians who provide care to patients affiliated with SCMF, as well as to patients who do not have a primary care provider. All payer classes receive the same level of care. There has been a massive effort put forth to improve the care of the under and uninsured population, in an attempt to improve outcomes over a population as well as improve the efficient use of resources in our area. The Hospitalists provide care to all medical patients requiring admission to the hospital and consultative services for patients of the Surgery and other Medical services.

SCMF provides a full time staff of physicians to the 2 hospitals of North Santa Cruz County, DSCH and SMSC. There is one Hospitalist at SMSC available 24 hours a day 365 days per year. At DSCH, there are 3 Hospitalists from 7am to 5pm, 365 days per year, and 2 on-call physicians from 5pm to 7am to provide admitting and consultative services as well as coverage of patients currently admitted to the hospital. The Hospitalists continue to work with the Safety Net Clinics (Emeline Clinic, Planned Parenthood, Women's Health Center) for appropriate followup of patients who need a primary care provider and followup after a hospital stay. It has been challenging but very rewarding for the Hospitalists to see improvement in patient outcomes, improved efficiencies and utilization of resources, and to see many groups come together to provide a community solution for a local issue.

The Visiting Nurse Association entered into an agreement with the County this year to provide home health services to County patients with AIDS. While the number of patients referred for services has been small, the VNA continues to be an available resource for this patient population.

SMSC continues to work closely with the county to ensure access to care for the medically indigent and MediCruz patients. SMSC is currently providing charity care equal to 2.8% of Gross Revenue compared to a State-wide average of a little over 1%. See graph 1.

Physician Recruitment:

There were a total of 22 new physicians plus 5 midlevel providers recruited by SCMC in 2007, a total of 27. The ATMC loan recipients were Drs. Gill (Endocrinology), Muller (IM/HIV) and Wu (Hem-Onc). 11 new physicians were recruited for primary care, 8 of whom were from outside this area. Three of the new Santa Cruz Medical Clinic primary care physicians speak Spanish, and one of the specialists (Dr. Gill in endocrinology and an ATMC recipient) also speaks Spanish. A listing of the new physicians and mid-level providers is attached along with their start dates and locations where they will be practicing.
Electronic Health Record - Epic:

The SCMF implemented the Epic E.H.R. at all its clinic sites in 2007. Not only is this a great advance in ambulatory patient care for Sutter Santa Cruz patients but, because Epic is the same E.H.R. that the County is implementing with all the safety net clinics, this will provide significant connectivity between the safety net clinics and SCMF clinics throughout the County. The ability to easily refer patients for specialty care and share medical information in a very comprehensive and timely fashion will greatly enhance the quality and access to care for all patients. Additionally, SCMF is implementing the PAMF OnLine capability of Epic which allows patients to review their medical record securely on-line and to communicate with their healthcare provider on-line. Sutter Maternity and Surgery Center is also able to access patient information on-line from Epic for patients scheduled for surgery, delivery or other medical admission. The hospital version of the Epic E.H.R. is expected to be implemented at SMSC in 2011 or 2012.

Recognizing that Salud Para La Gente is a very important health care provider in the south county and was facing some particularly difficult financial challenges, the Santa Cruz Division of the Palo Alto Medical Foundation facilitated a $200,000 grant from Sutter Health to Salud Para La Gente to support their ability to implement the Epic ehr along with the other safety net clinics. The grant will be administered by the Community Foundation of Santa Cruz County for the benefit of Salud.

PAMF Medical Group Integration:

Effective January 1, 2008, the Santa Cruz Medical Clinic, the Camino Medical Group and the Palo Alto Medical Clinic will be merged to form one 850 physician group serving a large area of the South Bay and Santa Cruz. This will enable a patient of the SCMF living in Santa Cruz but working “over the hill” to access health care close to work or close to home. It also enhances access to more subspecialty care for Santa Cruz patients.

Facilities Improvements/Additions:

In early 2007, a multiphase construction project commenced to improve accessibility for patients (parking and public toilets) at the Main Clinic on Soquel Ave. Two departments; Ophthalmology and Pediatrics, will be completely remodeled with new exam and waiting rooms. The remaining departments will be refreshed with new flooring, paint, casework along with ergonomic workstations for reception and medical assistants. Gastroenterology will move its offices to the new Commercial crossing location creating more office and exam room space at the Main Clinic for more primary care physicians.

In September, a new satellite office was opened on Commercial Crossing to address the shortage of physician specialists and improve patient access. Gastroenterology will have its offices there as will the new hematology/Oncology physicians. Infusion Therapy will be added to the site in 2008. Community Service and Loan agreements were successfully used to recruit Michael Wu, M.D., (December 07), and Glen Wong, MD, (August 08), hematologist and oncologists, and Joe Palasack, MD, (March 08), a gastroenterologist.

A Commercial Development Permit has been submitted for the construction of a two story 19,640 sf MOB on Chanticleer Ave. across from SMSC. The building will house the SCMF orthopedists and podiatrists on the 1st floor and other surgeons on the 2nd floor. Completion of the new MOB is anticipated for late 2009. Relocation of the orthopedists and podiatrists will open up space within the hospital for expansion of special procedures rooms and related support services.

In September, the city of Watsonville processed a preliminary planning submittal to expand the current SCMF Watsonville MOB by over 10,000sf. The expansion is intended to add more primary care physicians (family medicine, Ob-Gyn) and an endocrinologist, Sharon Gill, MD, as part of the Community Service and Loan program.