



2012 Community Benefit Report

Improving the health of the communities
we serve with quality and compassion.



JOHN MUIR
HEALTH

Prepared May 2013

The John Muir Health vision for a healthy community for all residents of Contra Costa County is:

- All residents achieve and maintain optimal physical and mental.
- Children succeed in school and reach their full potential.
- Residents are economically independent and have access to adequate, affordable housing.
- Neighborhoods are safe.
- Violence, discrimination and injustice are eliminated.
- The air, water and food are clean, safe and sufficient.
- Residents are civically engaged and connected to their community.

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Executive Summary

John Muir Health is a not-for-profit, community-based organization that is governed locally. Our focus remains firmly on improving the health of the people of Contra Costa County. As a not-for-profit organization, there are no shareholders who benefit from our financial surpluses. Instead, we reinvest our surpluses into the community with new program implementation, advanced technology, community services and building projects. John Muir Medical Center, Walnut Creek campus also serves as Contra Costa County's only trauma center, which represents an enormous financial and service commitment to the entire region.

As a not-for-profit health system, John Muir Health also has an obligation to make a charitable contribution to the community, but our commitment to keeping the communities we serve healthy goes far deeper than that. John Muir Health's mission to *improve the health of the communities we serve with quality and compassion* accurately reflects our community health efforts as a corporate leader and community partner. Most of John Muir Health's community benefit activities are specifically targeted to those individuals and families that experience social and economic barriers that preclude their access to necessary health care services.

Through collaborative partnerships, John Muir Health addresses the long and short-term goals of creating healthy communities within its service area. It is the expertise provided by these community-based organizations, coupled with John Muir Health's resources and commitment to serve the community, that provide the greatest opportunity for success in addressing the many unmet health needs and health disparities in Central and Eastern Contra Costa County.

Community benefit is a term used to describe the many health programs and medical services supported totally or in part by John Muir Health that provide tangible benefits to the community and improve the health of its residents. John Muir Health adopted the guidelines developed by the Catholic Healthcare Association and VHA Inc. for reporting the economic value of its community benefits contributions in 2006.

During Fiscal Year 2012, John Muir Health made over \$82 million in community benefit contributions.

In Thousands of Dollars (000's)	
Charity Care	24,353
Government Sponsored Health Care (Medi-Cal shortfall)	38,104
Subsidized Health Services	1,424
Health Improvement	8,396
Community Building	663
Financial and In-Kind Contributions, Grants	2,856
Health Professions Education	4,275
Research	1,373
Community Benefits Operations	1,269
Total	82,713

In addition, John Muir Health provided care to Medicare inpatients and outpatients whose estimated costs exceeded payments made by the Medicare Program. The

Medicare shortfall, the difference between the cost of care for Medicare beneficiaries and the payments for those services, was over \$226 million. This is not included in the above total. These categories are also consistent with IRS Form 990 Schedule H for Hospitals definitions.

For consistency with California Senate Bill 697 reporting, John Muir Health community benefit contributions are also displayed here highlighting the activities for vulnerable populations and the broader community population.

In Thousands of Dollars (000s)	
Charity Care	24,353
Medi-Cal Shortfall	38,104
Vulnerable Populations	9,669
Broader Population	4,939
Health Professions Education and Research	5,648
Total Benefits Reported	82,713

Community benefit contributions include programs at John Muir Medical Center – Walnut Creek, John Muir Medical Center – Concord, John Muir Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network. A separate 2012 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Behavioral Health Center.

Our local commitment is expressed in the many initiatives we deliver to the community at large, including medical services for vulnerable populations in the county.

In addition to this direct delivery of care, John Muir Health provides broad financial and technical support to promote community wellness. The organization contributes more than \$1 million to the John Muir/Mt. Diablo Community Fund each year, whose goal is to foster systemic change that improves the health of people in Central and East Contra Costa County who are most likely to experience health care disparities. By working with leading community groups, John Muir Health has helped foster many innovative health care programs, including our Mobile Health Clinic, the Dental Collaborative of Contra Costa which operates a mobile dental clinic, Senior Services, the Faith and Health Partnership and the Community Nursing Program.

In 2012, our community benefit activities further focused on those with disparities in health outcomes. We continued our partnerships with La Clinica de la Raza and the Contra Costa Health Services Department to serve low-income residents through the John Muir Mobile Health Clinic, the Dental Collaborative of Contra Costa, and the La Clinica-John Muir Health Specialty Care program. We continued our Teen Pregnancy Resource program to educate low-income pregnant teens and to encourage appropriate pre- and post-natal care for the mother and infant. We collaborated with local schools to fund nurses in low-income area schools who work to advance lifelong achievement of students through promotion of health and safety, health problem intervention, care management services and connections to community resources.

John Muir Health outreach also seeks to serve at-risk older adults in the community. We support the Caring Hands Volunteer Caregiver Program, which creates one-to-one matches between volunteers and seniors who are frail, isolated, and/or disabled. Free, non-medical in-home assistance enables these seniors to stay in their homes and remain independent and safe. We also support the Fall Prevention Program of Contra Costa County, which works with senior groups to generate awareness and reduce injuries due to falls through home safety assessments and home modifications for low income seniors. Our Senior Services Department also offers an array of programs including memory screening, geriatric care coordination and medication assistance for

low income seniors who too often have to choose between their medications and other life necessities. For additional information on our community programs for vulnerable populations, refer to page 15 of the 2012 Community Benefit Report or www.johnmuirhealth.com.

All of us within John Muir Health are proud of the benefits we provide to the community, including charity care and a vast array of other services. We look forward to continuing to work with our community partners to play an integral role in helping to meet the health care needs of the communities we serve.

Who is John Muir Health?

Mission, Vision, Values

John Muir Health, a private, not-for-profit health care organization, is guided by its charitable mission. The John Muir Health mission serves as the foundation for directing the organization's community benefit activities. Adopted in 1997, our mission states:

"We are dedicated to improving the health of the communities we serve with quality and compassion."

John Muir Health's eight core values that guide the Board of Directors, management and employees in their efforts are: *Excellence, Honesty and Integrity, Mutual Respect and Teamwork, Caring and Compassion, Commitment to Patient Safety, Continuous Improvement, Stewardship of Resources, and Access to Care*. The mission and core values guide the activities within and outside of the organization's campuses.

The "Community Health Guiding Principles," approved by the John Muir Health Board of Directors in 2000, and updated in 2008, include the John Muir Health vision for all the communities of Contra Costa County and provide the framework for current and future community health priorities and initiatives.

The John Muir Health Vision for a Healthy Community for all residents of Contra Costa County is:

- ▶ *All residents achieve and maintain optimal physical and mental health.*
- ▶ *Children succeed in school and reach their full potential.*
- ▶ *Residents are economically independent and have access to adequate, affordable housing.*
- ▶ *Neighborhoods are safe.*
- ▶ *Violence, discrimination and injustice are eliminated.*
- ▶ *The air, water and food are clean, safe and sufficient.*
- ▶ *Residents are civically engaged and connected to their community.*

Most importantly, the "...purpose of the John Muir Health community health initiatives is to increase the capacity of the communities it serves to build partnerships and the ability of individuals to make healthy decisions, which can achieve the vision of a healthy community."¹

John Muir Health also recognizes the broad diversity of the communities it services and works hard to bring culturally and linguistically appropriate services to the community.

See attachment A: John Muir Health Community Health Guiding Principles

Structure

John Muir Health consists of two acute care hospitals, a behavioral health center, four urgent care centers, two outpatient facilities and a physician network of primary care and specialty physicians in Contra Costa County. The Community Health Alliance and the Community Health Fund deliver John Muir Health's community benefit programs.

¹ JMMDHS Community Health Guiding Principles. Purpose Statement. Fall 2000. p. 3.

John Muir Medical Center, Walnut Creek
1601 Ygnacio Valley Road, Walnut Creek, CA

John Muir Medical Center, Walnut Creek is a 572-bed acute care facility designated as the only trauma center for Contra Costa County and portions of Solano County. Recognized as one of the region's premier health care providers by *U.S. News and World Report*, areas of specialty include high and low-risk obstetrics, orthopedics, rehabilitation, neurosciences, cardiac care, emergency care and cancer care. John Muir Medical Center, Walnut Creek is accredited by The Joint Commission, a national surveyor of quality patient care. President and Chief Administrative Officer is Jane Willemsen.

John Muir Medical Center, Concord
2540 East Street, Concord, CA

John Muir Medical Center, Concord is a 313-bed acute care facility that serves Contra Costa County and southern Solano County. Recognized as one of the region's premier health care providers by *U.S. News and World Report*, the medical center has long been known as a preeminent center for cancer care and cardiac care, including open heart surgery and interventional cardiology. Other areas of specialty include general surgery, orthopedic and neurology programs. John Muir Medical Center, Concord is accredited by The Joint Commission. President and Chief Administrative Officer is Michael Thomas.

John Muir Health Behavioral Health Center
2740 Grant Street, Concord, CA

John Muir Health offers complete inpatient and outpatient behavioral health programs and services through the John Muir Health Behavioral Health Center, our fully accredited, 73-bed psychiatric hospital located in Concord. The John Muir Health Behavioral Health Center offers psychiatric treatment for adults, children and adolescents experiencing emotional or behavioral problems. For those who are dependent on alcohol or drugs, we offer a full array of chemical dependency treatment programs. John Muir Health Behavioral Health Center is accredited by the Joint Commission. Chief Operating Officer is Liz Stallings.

John Muir Health Outpatient Center, Brentwood
2400 Balfour Road, Brentwood, CA

This state-of-the-art facility offers a variety of outpatient services to residents of Brentwood, Antioch, Oakley, Discovery Bay, Byron, Knightsen, Bethel Island and surrounding areas. Services offered include family practice physicians and pediatricians; urgent care; outpatient surgery; digital medical imaging, including mammography, CT, and MRI; laboratory services; rehabilitation services, including PT and OT; cardiac conditioning (rehabilitation and education) and pulmonary rehabilitation. Independent physician offices are also in the building as well as more than two dozen medical specialists who either have permanent offices or see patients in our "Timeshare" Suites. Senior Services offers

information and referral and geriatric care coordination services. Other programs available include the Behavioral Health Partial Hospitalization Program, and the Women's Health Program, offering classes on child birth and parenting. Administrator is Bazil Fonseca.

John Muir Health Outpatient Center, Tice Valley/Rossmoor
1220 Rossmoor Parkway, Walnut Creek, CA

John Muir Health Outpatient Center, Tice Valley/Rossmoor is a comprehensive outpatient medical facility offering a wide range of physician and clinical services. This 30,000 square foot outpatient facility is located outside the entrance to the Rossmoor residential area in Walnut Creek and is open to the public. John Muir Medical Group internists are the exclusive providers of primary care services at this location. More than 25 physician specialists in 15 specialties see patients at the facility on a regularly scheduled basis each week. Outpatient services offered include laboratory, medical imaging and physical and occupational therapy. Senior Services offers information and referral and geriatric care coordination services. A patient's ordering physician does not have to be at this facility to use these services. Full time dental, optical and hearing aid services are also available as well as community education classes. Administrator is Bazil Fonseca.

John Muir Physician Network
1350 Treat Boulevard, Suite 450, Walnut Creek, CA

The John Muir Physician Network is a not-for-profit public benefit corporation, whose sole corporate member is John Muir Health. Since its inception in 1996, it has become one of the largest medical groups in Northern California, with more than 950 primary care and specialty physicians who deliver coordinated patient care. Physicians associated with the Physician Network belong to either John Muir Medical Group (JMMG) or Muir Medical Group IPA, Inc. The Physician Network owns and operates primary care practices staffed by JMMG physicians in 23 locations from Brentwood to Pleasanton. The Group also provides hospitalists (in-patient medical services) at John Muir Health's two hospitals. The Physician Network is active in community service, health education and clinical research. The Physician Network currently holds contracts with six major health plans for more than 63,000 commercial and senior HMO members. Additionally, the Physician Network provides a physician panel, medical management and claims services for more than 6,000 John Muir Health employees and dependents participating in the Exclusive Provider Organization health plan. The Physician Network manages health plan contracting for John Muir Health and its hospitals and engages in physician recruitment to meet community needs.

Other important components within the John Muir Health organization include four urgent care centers and three other entities that serve the two medical centers in Concord and Walnut Creek: John Muir Medical Center, Walnut Creek Auxiliary, John Muir Medical Center, Concord Volunteers and John Muir Health Foundation. President and Chief Operations Officer is Harold Huskins Jr.

John Muir Health delivers its community benefit programs through the Community Health Alliance and Community Health Fund.

John Muir Health Community Health Alliance
1341 Galaxy Way, Suite D, Concord, CA

John Muir Health created the Community Health Alliance to assist the community in achieving optimal health through education, collaboration and health and wellness services. The John Muir Health Community Health Alliance brings to the community an array of resources, including health care professionals, mobile health services, and information and education services. The John Muir Health Community Health Alliance also works in partnership with local communities, other nonprofit health systems, public health providers, nonprofit organizations and school districts to identify and address unmet health needs among uninsured and vulnerable populations. Serving as a steward for John Muir Health's charitable purposes, the Community Health Alliance's main roles are to coordinate the John Muir Health community benefit planning process and act as the liaison to the community-at-large. By aligning resources through interdepartmental planning and collaboration, John Muir Health is better able to impact its goal of creating healthy communities.

Programs managed directly by the John Muir Health Community Health Alliance include the Mobile Health Clinic, the Mobile Dental Clinic, Faith and Health Partnership and Community Nursing.

In addition to funding from John Muir Health, the Community Health Alliance received grant funds for the Dental Collaborative of Contra Costa, which operates the Ronald McDonald Care Mobile® from Wells Fargo, Los Medanos Community Hospital District, Safeway Foundation and Ronald McDonald House Charities. We are grateful for their support and recognition of the critical needs of our community. We are also grateful for funding for outreach programs to address disparities in health outcomes in Pittsburg and Bay Point, California from the Los Medanos Community Health care District, Heffernan Insurance Brokers, Vesper Society and the Department of Health and Human Services Office of Women's Health. Director of Community Health Improvement is Christy Kaplan, who reports to Lisa Fallert, Senior VP, Care Coordination, John Muir Health.

John Muir/Mt. Diablo Community Health Fund
1399 Ygnacio Valley Road, Suite 36, Walnut Creek, CA

The John Muir/Mt. Diablo Community Health Fund distributes grants to community-based, nonprofit organizations whose health care capabilities and trusted relationships with uninsured and under-served populations expand and enhance health care services for those who need them most in Central and East Contra Costa County. The Community Health Fund distributes grants through a unique process that nurtures long-term partnerships with and among community-based nonprofits, and which results in sustainable health initiatives and systematic change.

Many programs that receive their start from the Community Health Fund continue past the grant periods to deliver critical health care services. Consequently, thousands of Contra Costa County residents who may have slipped through the cracks in our health care system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support

services for a wide range of conditions. Our mission is to deliver the same kinds of results to the many more in central and east Contra Costa County who still struggle to find adequate care. More detailed information about the Fund, its governance, grant program and community benefit reports can found on its website: www.jmmdcommunityhealthfund.com. Interim President is Lillian Roselin.

John Muir Health Highlights

	2010	2011	2012
Patient Beds	716	958	912
Admissions	29,226	29,661	30,416
Emergency patients or visits	89,166	92,508	95,996
Urgent Care patients	78,917	84,085	78,733
Newborns	2,199	2,188	2,229
Surgeries	11,951	12,510	12,621
Laboratory tests	3,714,906	3,713,473	3,661,636
Diagnostic Imaging procedures	337,983	343,097	328,222
Radiation Therapy	54,021	56,877	54,416
Cardiac Catheterization procedures	4,046	4,165	4,581
Respiratory Procedures	227,770	247,222	258,625
Physical Rehabilitation visits	593,737	552,733	562,402
Home Health visits	70,722	69,669	74,333
Mobile Health Clinic visits	3,960	3,240	3,543
Mobile Dental Clinic visits	1,502	1,454	1,393
Employees	6,186	6,217	6,402
Physicians	874	923	927
Volunteers	1,600	1,600	1,600
Volunteer hours	202,744	205,795	192,669

Attached are the following:

John Muir Health Organizational Chart (Attachment B)

Board lists (Attachment C) for

- John Muir Health
- John Muir Physician Network
- John Muir/Mt. Diablo Community Health Fund

How Do We Define Our Community?

John Muir Health's primary and secondary service area extends from Southern Solano County into Eastern Contra Costa County and South to San Ramon in Southern Contra Costa County. The communities that comprise the primary service area include Concord, Walnut Creek, Pleasant Hill, Martinez, Lafayette, Danville, Alamo, Orinda, Moraga and Clayton. The communities that comprise the secondary service area include Brentwood, Oakley, Discovery Bay, Byron, Knightsen, Bethel Island, Benicia, Pittsburg, Bay Point, Antioch and San Ramon. John Muir Health's Trauma Center serves all of Contra Costa County, as well as Southern Solano County and is the backup Trauma Center for Alameda County.

The primary focus of our community benefit programs is on the needs of vulnerable populations. We define vulnerable populations as those with evidenced-based disparities in health outcomes, significant barriers to care and the economically disadvantaged. These criteria result in a primary Community Benefit Service Area that includes the communities of the Monument area in Concord and the Eastern Contra Costa County cities of Bay Point, Pittsburg, Antioch, Oakley, Brentwood and the far east parts of unincorporated Contra Costa County.

What Are the Needs of Our Community?

Community Assessment

As part of the SB697 triennial cycle, a comprehensive community assessment was completed in 2010. The 2010 community assessment was completed through a collaborative process initiated by the Hospital Council of Northern and Central California and community hospitals in Contra Costa County. Participants included John Muir Health, Kaiser Permanente and Sutter Delta Medical Center. Conducted by the Community Health Assessment, Planning and Evaluation Group of Contra Costa Health Services (CHAPE), the 2010 quantitative assessment compiled existing data based on collaborative objectives. Based on the 2010 Community Health Indicators in Contra Costa County, Attachment I includes health disparities identified in the John Muir Health Community Benefit service area.

In addition to the quantitative portion of the community assessment, John Muir Health and Kaiser Permanente conducted a community survey through community based organizations serving vulnerable populations with over 1,000 responses. Notable responses in the report are covered under the Community Input section of this report.

Community assessments are made available to the public as a community benefit. The full report is available on the website of John Muir Health, Contra Costa Health Services, and the Hospital Council of Northern and Central California. It was also shared with community organization members of the various coalitions in which the community hospitals and County Health Service Department participate.

The Community Assessment was approved by the Board of Directors in December 2011. The Assessment, included as Attachment I, includes a description of the community demographics, disparities in health outcomes and the John Muir Health process for selecting priorities for its community benefit programming.

The map of the John Muir Health service area is included in Attachment D.

In 2012, John Muir Health updated its Community Benefit Plan goals, priorities and strategies in light of the 2010 community assessment. The goals, priorities and tactics make up our Community Benefit Plan or Implementation Strategy and are included in Attachment E and F.

Community Input

John Muir Health used various mechanisms to incorporate community input into the annual Community Benefit Plan. During 2012, John Muir Health kept abreast of current

health issues of importance to the community by active participation within the Monument Community Partnership, Dental Collaborative of Contra Costa, Contra Costa Council Health Task Force, East County Access Action Team, Contra Costa County Safety Net Innovation Network, Bay Point Family Partnership, Contra Costa Health Ministries Network, Families CAN and other ongoing collaborations with community-based organizations. These sources of information provide current information regarding community health status and also help identify emerging needs in the service area population.

Community organizations also seek out John Muir Health as a partner. The Community Nurse program developed out of the 2007 community assessment, which identified childhood overweight and diabetes prevention as areas of focus. Subsequently a second school district asked John Muir Health to expand its community nursing program during 2010.

John Muir Health is fortunate to benefit from the input and expertise of the County Health Services Department in a number of ways. The triennial Community Health Indicator Report is completed on behalf of the community hospitals by the Public Health Division of the Contra Costa Health Services Department (CCHS). CCHS is a partner in many of our partnerships: Mobile Health Clinic, Mobile Dental Clinic, Tel-Assurance remote monitoring for low income seniors with chronic illnesses, Fall Prevention Program of Contra Costa, Concord ED Referral Liaison and the Monument Community Partnership. CCHS is also a partner in most of the collaborative groups mentioned above.

In 2010, John Muir Health and Kaiser Permanente undertook a written community survey through community-based organization partners who serve the low income residents of Contra Costa County.

Community Survey Highlights

- 33 percent of respondents between the ages of 21 and 64 indicated that they, or someone in their family, are uninsured.
- Respondents over 65 years of age reported a lower overall health status.
- 84 percent of respondents indicated that they, or someone in their family, had been diagnosed with a chronic condition.
- 85 percent of respondents indicated obtaining free or low-cost health care services and transportation as the top barriers to accessing care.
- Over 50 percent of respondents ranked affordable health care services among their top health concerns.
- Respondents from East Contra Costa County and African Americans respondents were more likely to find healthy food to be too expensive relative to less healthy options and were less likely to report living in a safe and easy place to walk and be active.
- 21 percent of respondents indicated that they, or a family member, needed mental health services in the past year; over one third did not find the mental health services available when needed.

Where are the needs greatest?

The 2010 Community Health Indicator Report identified several health disparities in Central and Eastern Contra Costa County. Attachment I highlights health outcomes and disparities specific to the John Muir Health service area. Health issues where the incidence or prevalence has gotten worse and where the city rates are worse than the county as a whole are considered a significant need.

Where Is John Muir Health Focusing Its Efforts?

John Muir Health selects its focus areas based on the community assessment, internal data and community partner input. Since 2007, new programs have specifically focused on programs which address the needs of vulnerable populations using three funding criteria.

The first funding criterion is that the program serves **vulnerable populations** defined as having one or more of the following characteristics:

- Evidenced-based disparities in health outcomes, e.g. African Americans with heart disease, African American women with breast cancer and African Americans and Latinos with diabetes.
- Significant barriers to care, e.g. the isolated or frail elderly, those with language or cultural barriers to effective care, those with barriers to appropriate and timely health care due to lack of health insurance, those with transportation or mobility barriers, those with limitations on their capacity to voice their needs in the health care system such as children.
- Economically disadvantaged, e.g. low income, uninsured, underinsured and/or working poor residents.

Our second funding criterion requires that programs are delivered through **partnerships** with community based organizations, other providers, public agencies or business organizations. John Muir Health acknowledges that it can maximize the impact of its investment by partnering with organizations whose expertise complements that of John Muir Health. These partnerships are managed by internal department champions and take advantage of the clinical and technical expertise of John Muir Health.

Our third funding criterion calls for selecting programs that will positively **impact the health of the community** in a measurable way. Our program evaluations answer the following questions:

- How much did we do?
- How well did we do it?
- Did we make a difference?

An internal, multi-disciplinary Community Benefits Advisory Committee representing the various parts of John Muir Health reviewed the 2011 community assessment data, program evaluations and requests for new programs using our funding criteria. The Committee made recommendations for program funding in the annual budget process.

As we have in the past, our criteria for selecting focus areas and programs will start with the three funding criteria described above: needs of vulnerable populations, programs that will have a measurable impact and delivered in partnership with community based organizations. John Muir Health acknowledges that the health needs of vulnerable

residents in Central and East Contra Costa County cannot be met by any one public or private organization. John Muir Health selects focus areas based on its clinical and organizational strengths, the availability and willingness of appropriate community organization partners, the incidence and prevalence of the need, the potential for making a positive impact and available financial and staff resources.

John Muir Health is also committed to supporting and complementing effective community programs with staff expertise, technical assistance or financial resources in order to avoid duplication or undertaking programs for which other organizations are better suited to succeed and make a difference.

Multiyear Goals & Strategies

In 2011, John Muir Health undertook a review of its community benefit strategies and focus areas using the 2010 Community Health Indicators in Contra Costa report while also considering the changes in the delivery system in Contra Costa County under health care reform and reductions in Medicare reimbursement. These changes will require all hospital systems to make strategic choices to focus community benefit contributions on the greatest needs in the community and to maximize the positive impact of those contributions.

We developed multiyear goals, strategies and focus areas for 2012-2014. This plan will now only inform community benefit investments through 2013 because we are currently undergoing the Community Health Needs Assessment (CHNA) process in response to the new federal requirements outlined by the Affordable Care Act. The new CHNA will identify the community's prioritized health needs. An implementation plan will be adopted in 2013 in response to the CHNA results and will outline new multiyear goals and strategies for 2014 to 2016.

2012 Community Benefit Plan Year End Results

The John Muir Health 2012 Community Benefit Plan, Attachment E, outlines specific strategies, tactics and outcomes for 2012 under each Community Benefit Plan goal, all of which were developed in cooperation with John Muir Health's management, as well as appropriate physicians, service line staff and community partners.

For many hospitals, much of the charity care costs recorded in annual community benefit reports is generated in the course of regular Emergency Department operations. In 2010 John Muir Health began tracking charity care costs generated by specific, proactive community benefit programs. Of our total 2012 charity care costs reported in our economic inventory of contributions, \$2,126,453 was provided through the Operation Access, Mobile Health Clinic, Every Women Counts and La Clinica-John Muir Health Specialty Care program.

The John Muir/Mt. Diablo Community Health Fund made planning, program implementation, capacity building and evaluation grants to Operation Access, La Clinica, Planned Parenthood, and Food Bank of Contra Costa and Solano Counties.

For additional details on the Community Health fund, visit their website at www.jmmdcommunityhealthfund.com.

2012 Community Benefit Program Impact Highlights

Below are highlights of some of the 2012 John Muir Health Community Benefit programs and activities which address health disparities in the John Muir Health service area of Contra Costa County:

Program	Description/Highlight	Impact Statements
Strategy 1: Increase direct care, charity care and subsidized care		
Goal 1: To improve access to health care for low income residents		
Goal 2: To have measurable impact on the health of the community		
Operation Access (OA)	<p>John Muir Health (JMH) delivers free outpatient surgeries and procedures to uninsured patients through Operation Access (the other Contra Costa County hospitals are Kaiser Permanente Richmond, Walnut Creek and Antioch,). JMH collaborates with the Community Clinic Consortium of Contra Costa County to donate surgical care to low-income, uninsured county residents. The process for providing surgical resources, laboratory services, and pharmaceuticals begins with the patient presenting themselves at any of the consortium member community clinics. The community clinic medical provider identifies patients who are candidates to receive surgery and makes a referral directly to Operation Access. Operation Access screens the patients for financial eligibility. For those who qualify; a consultation with a volunteer surgeon from JMH is arranged at no charge. If the surgeon finds the case appropriate, the surgery is scheduled. Other medical services associated with the surgery such as diagnostic tests and pre-operative labs are also completed by volunteer JMH specialists at no cost to the patient. After the surgery, the patient attends a post-operative visit and then returns to the referring clinic for ongoing medical care.</p> <p>Success Story: <i>Maria was referred to Operation Access from La Clinica de La Raza for painful gallbladder stones. Maria found herself ill, unemployed and caring for three children. She was ready to give up when she was finally referred to Dr. Gregory Rhodes at Bay Area Surgical Specialists through Operation Access for a cholecystectomy. Dr. Rhodes began volunteering with Operation Access in 2005, since then he has recruited several of his colleagues to volunteer. Maria describes Dr. Rhodes as "kind and generous," and she is grateful to have access to dedicated expert volunteer physicians. Maria is now fully recovered and able to care for her children without having to worry about any serious health complications.</i></p>	<ul style="list-style-type: none"> • JMH provided 64 surgical procedures, which accounted for 46% of Operation Access surgical services in Contra Costa County. This represents a 25% increase from 2011. • JMH surgeons provided an additional 52 minor radiology procedures and 39 specialist evaluations. • In 2012, JMH physicians contributed over \$2,800,000 in services to OA patients, based on gross waived charges. • Patients rated their overall satisfaction with Operation Access 4.9 out of 5.0. • Patients rated their satisfaction with result of services 4.9 out of 5.0 • 100% of patients reported improved health and 97% reported improved quality of life because of the OA services.
Specialty	One of the greatest needs in the County is specialty care for uninsured, low income	<ul style="list-style-type: none"> • SCP accepted 183

<p>Care Program (SCP)</p>	<p>residents. The County Health Services Department is no longer accepting undocumented adults who need care due to their budget constraints. In Central and East Contra Costa there are very few community clinics who provide primary care and those clinics do not have sufficient specialty care options for their patients who need specialty consultations, diagnostic studies and inpatient treatment. Low income, uninsured patients referred by a primary care provider from La Clinica de la Raza in Concord, Pittsburg or Oakley will receive diagnostic and inpatient care at JMH facilities from JMH affiliated physicians. The program is based in the Cancer Institute and address needs for breast, cervical, lung and gastroenterology services. Diagnostic care provided will be for symptomatic patients rather than screening studies. JMH is contributing the hospital component of care as a community benefit program.</p> <p>A Physician's Letter: <i>"I am writing this letter in support of the JMH Specialty Care Program, which has been helping our uninsured patients by providing specialty care. I am clinician at La Clinica Monument at Concord. I wanted to share some of my experiences with this program.</i></p> <p><i>About three years ago something profoundly disturbing happened when adults without legal residency were denied routine health care services in Contra Costa County public facilities. That meant that at La Clinica we started to serve many of those who were turned down by the public hospital. These patients were the most vulnerable people in this community: immigrants without any English proficiency, isolated, with low-income, and of course no insurance. Some of them are just in need of preventive services or chronic disease management but there are also patients who are in need of more than basic care. Some patients are so sick that they require procedures for diagnosis or treatment and consultation with specialists in a timely fashion to assure good care.</i></p> <p><i>It is in this situation that JMH Specialty Care Program started to offer some specialty care for those without access, and for that I am grateful. Through this program many of my patients have gotten to know Dr. Fang who is the gastroenterologist in this program. For example, Walter, an 80-year old man, illustrates how helpful Dr. Fang has been. Several months ago, I was done for the day finishing my notes when the secretary informed me that Walter was at the front desk and wanted to talk to me. He is a very stoic man who usually comes with his wife who speaks for him. This time he came alone. He has not been feeling well. He complained of dizziness</i></p>	<p>referrals for patients in need of specialty care, which exceeded their goal of 24 referrals.</p> <ul style="list-style-type: none"> • In 2012, 54 specialists were recruited in addition to the hospital based groups, which is a 42% increase from 2011 year end. The program added urology to specialty offerings. • 223 referrals were made to specialists for 183 patients, which is an average 1.2 referrals per patient. A patient often needs multiple referrals when diagnosed with cancer. • In 2012, the SCP provided 307 procedures and interventions. • In 2012, the specialists diagnosed 17 patients (9%) with cancer. Patients receive comprehensive following up care from medical oncologists, radiation oncologists, surgeons and other specialists as needed.
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	<p>after working on his car on a very hot day in Concord. His blood work up showed a new onset anemia with very low hemoglobin level. I sent him to the emergency room in Martinez first because of his symptoms and also hoping this would expedite his work up, since he is undocumented, did not have health insurance or the ability to pay out of pocket. However, he was just sent back to me with ferrous sulfate pills. Nothing was done for him in terms of connecting him with gastroenterology to further evaluate him for bleeding. I was very worried and concerned that something bad was going to happen to him. I ended up advising him to move to another county but then the Specialty Care Program started. Dr. Fang evaluated him and Walter received the work up that he needed. He also helped Walter with Hepatitis C cirrhosis after a blood transfusion, and with difficulty in swallowing because of cancer. It is worth mentioning that besides providing excellent care, this program is an example of efficiency.</p> <p>Thus, I am really thankful, and at La Clinica our patients and the clinicians appreciate the commitment and dedication of Dr. Fang and all the people behind this program who provide care for our community's sick, destitute and excluded.”</p>	
<p>Mobile Health Clinic</p>	<p>The Mobile Health Clinic (MHC) operates Saturdays in Brentwood and East County, providing free preventive and urgent medical care. More than 60 doctors, nurses and support staff from John Muir Health and the John Muir Physician Network volunteer their time to provide these services. Mobile health services provide a link for patients to a medical care system through referrals and collaboration with area health care providers including La Clinica de la Raza and Contra Costa Health Services. In addition, the MHC also operates two days a week in the Monument Corridor area of Concord, one day in Bay Point and one day in Antioch with the Contra Costa County Public Health Department. The Public Health Department provides bilingual clinical and support staff while John Muir Health provides the MHC and the driver. The MHC operates on Thursday evenings and on the fourth Tuesday of every month in Concord supporting the Concord Rotary's RotaCare Clinic.</p> <p>Success Story: <i>Celia came into the mobile health clinic early in October with Type 1 diabetes. Celia had lost her Medi-Cal when she married because her husband's income put them over the limit for eligibility. She had been diabetic since she was 12 years old and was taking Lantus once a day to manage her diabetes. Celia was now having difficulty affording her medication because she was uninsured. Celia had not seen a provider for over 6 months. The</i></p>	<ul style="list-style-type: none"> • The MHC served 578 patients through the JMHSaturday Clinic. • The MHC served 2966 through partnerships in 2012, in addition to the Saturday JMHSaturday clinic. • The MHC made 136 referrals. The referrals were made for patients that required more urgent care, specialty care services and/or chronic disease management. • In 2012, 100% of patients were very satisfied with services offered and received on the MHC. • In 2012, 38% reported that they would have gone to the Emergency Room to seek medical care if the MHC was not available. • In 2012, 7% of patients were seen for urgent health needs. An urgent visit is a proxy for an emergency room visit avoided because the MHC patients are uninsured and

	<i>Mobile Health Clinic volunteer providers obtained Lantus samples for the patient until she was connected with a primary care provider at La Clinica de la Raza. They also provided labs and education. Celia was able to get connected with resources and manage her diabetes because of the care provided by the Mobile Health Clinic.</i>	<p>have no source of ongoing primary care.</p> <ul style="list-style-type: none"> The estimated ED costs avoided by use of the Mobile Health Clinic (including partnerships) in 2012 is \$313,536.
Mobile Dental Clinic (MDC)	<p>The Mobile Dental Clinic offers free dental services through the Dental Collaborative of Contra Costa, which includes Ronald McDonald House Charities, the County's Children's Oral Health Program, La Clinica de La Raza, Brookside Community Health Center, and John Muir Community Health Alliance. Each partner provides a critical part of the service. Ronald McDonald House Charities provided the fully equipped clinic with 2 operatories including x-rays. The Children's Oral Health Program (COHP) provides screening and triage in low income schools. La Clinica de la Raza and Brookside Community Health Center provide the dental care, patient registration, assistance with enrollment in programs for which the patient may be eligible and assistance in identifying and establishing a connection to a dental and medical home for the child and the family. The role of John Muir Health is to provide program management and coordination, including grant writing, site contracts, maintaining collaborative relationships as well as responsibility for the Mobile Clinic driver, Care Mobile maintenance, equipment and supplies.</p> <p>This program serves schools in Contra Costa County participating in the Free School Lunch Program and focuses its efforts in schools with the highest number of students participating in this program. COHP also provides screening and education at health fairs, juvenile detention facilities, teen homeless shelters and First 5 Centers. Through COHP children are screened and referred for subsequent examination and treatment.</p>	<ul style="list-style-type: none"> The MDC provided oral health services to 460 children through 1393 visits, of which 66% were preventative. In schools: <ul style="list-style-type: none"> 9,492 received dental education 7,880 received dental assessments 7,405 received fluoride 1,347 received sealants In 2012, 67 % of patients seeking care were in need of enrollment assistance. A total of 309 families were provided with insurance enrollment assistance. In 2012, 90% of patients seen through the MDC were connected to a dental home through the MDC's referral partnerships with community clinics. In 2012, 100% of patients reported that they would recommend the MDC to someone they knew and reported high levels of quality and satisfaction with the services offered and received. In 2012, 34% of the patients seen at the MDC would not have sought care if the MDC was not available.
Strategy 2: Increase access to care through enrollment programs		
Goal 1: To improve access to health care for low income residents		
Goal 2: To have measurable impact on the health of the community		
Emergency Department (ED) Referral Liaison	The ED Referral Liaison interacts with patients in the Emergency Department at John Muir Medical Center, Concord. For patients with a non-urgent diagnosis who have no primary care physician or insurance, the program helps them find appropriate community resources and a medical	<ul style="list-style-type: none"> In 2012, the ED Referral Liaison contacted 8,923 patients, a 10% increase from 2011. Issued 6,588 referrals in

Program	home for future primary care needs.	the following categories: insurance assistance, health service and community resource.
Complex Community Care Coordination (CCCC)	<p>Complex Community Care Coordination is an innovative hospital and community case management program modeled after a ten-year-old program the Hospital Council of Northern and Central California operates in Santa Clara County. The CCCC model of care is an intensive hospital and community case management intervention that targets our frequent users in the emergency departments on both campuses. These individuals face barriers in accessing medical care, housing, mental health care, and substance abuse treatment, which contribute to their frequent emergency department visits.</p> <p>JMH employs a Social Work Case Manager and LVN Case Manager on the Concord Campus that manage a total of 30-40 of our most frequent ED users. The Case Manager is responsible for assisting the identified patients with the following:</p> <ul style="list-style-type: none"> • Access to health care • Access to transportation • Assessment of safety and health issues at home • Access to financial assistance and health insurance • Assistance in accessing employment and training services • Assistance in finding and adjusting to permanent housing • Determination of the appropriate level of care for those who are unsafe at home alone <p>Success Story: <i>Courtney is a 60-year-old woman who was seen in the JMH ED 15 times in 2012. She has a history of depression with suicidal ideation, drug and alcohol abuse, painful chronic conditions, and domestic violence. Multiple needs were identified at the initial contact with Courtney including the need for food, medical care, follow-up psychiatric care, prescription refills, assistance with basic household chores, transportation, home heating and energy assistance, and a means to communicate with service providers. The case manager met with Courtney over a dozen times within a few months to help her with her issues. The case manager provided Courtney with emergency food supplies, transportation vouchers, and connections to in-home supportive services, meals on wheels services, energy assistance programs, and Alcoholics Anonymous. She also connected Courtney to a primary care physician and psychiatrist who</i></p>	<ul style="list-style-type: none"> • In 2012, 27 clients were enrolled in the CCCC program. • The following interventions were provided: <ul style="list-style-type: none"> - Appointment Scheduling/Appointment Reminders/Appointment Accompaniment - Home Visits - Telephone Follow-up - Assistance with Advance Directives - APS Reports - Medi-Cal/Medicare Referrals - Care Plan Development - Counseling - Referrals to IHSS, mental health resources, county benefits - Transportation assistance/referrals - Collaboration with family, providers and community agencies - Suicide Assessment/Facilitation of 5150 placement

helped her obtain her necessary prescriptions. The social worker is counseling Courtney on how to manage her budget on a fixed and limited income, prioritizing necessities, paying off past due amounts, and saving whatever she can for unexpected expenses. Courtney admits she does not know how to budget and states that she has always just spent her money. Courtney admitted that she had received a refund in the mail and that she planned to pay her past due bill with Comcast so her cable service could be restored; she plans to order a basic cable service and to save money for future expenses.

Strategy 3: Support prevention, early diagnosis and early intervention

Goal 1: To improve access to health care for low income residents

Goal 2: To have measurable impact on the health of the community

SCREENING

Every Woman Counts (EWWC)

John Muir Health has a unique model of providing free breast and cervical cancer screening and diagnostic services through the State of California’s “Every Woman Counts” Program. John Muir Cancer Institute developed “one-stop shopping” monthly Clinics in which most breast health services are provided at one location on the same day to low income, uninsured women at risk for breast cancer with a focus on underserved populations. In 2010, John Muir Health added cervical cancer screening to the Every Woman Counts Program.

At the Clinics, patients receive culturally appropriate education and information on early detection, breast self exam instruction, Clinical Breast Exams, pelvic exams, and pap smears by physicians and/or nurse practitioners with expertise in breast cancer, screening and diagnostic mammography, ultrasound and same day ultrasound guided core breast biopsy may also be provided. Interpreters are available at every Clinic, and transportation can also be arranged. Providing culturally sensitive, seamless quality breast health services on the same day requires the collaboration and resources of multiple John Muir Health system departments and community agencies in an effort to decrease barriers for women, prevent loss to follow-up and diagnose breast cancer as early as possible.

Success Story: Laura’s Story: *“It is the morning after my excisional biopsy with Dr. Cardoza. I am well and feeling pretty good really. I have been thinking of all of you [JMH staff] often in the last month or so since something was noticed on my mammogram that you so lovingly provided for me. I think lovingly/loving are the words I use to describe my experiences during my exams and*

- In 2012, there were 17 Cervical Cancer Screening Clinics and 17 Breast Cancer Clinics.
- In 2012, 567 patients were seen through the 34 Every Woman Counts clinics.
- In 2012, 45% of breast cancer patients were new patients.
- Out of the 567 patients served, 48% identified as Hispanic and 43% identify having a language barrier.
- 30 African American women were screened in 2012.
- In 2012, 81 % of patients were screened within 18 months of their last screening.
- In 2012, 89% of patients were provided with “one stop” breast services.
- 15 women served were diagnosed with Breast Cancer and provided with the appropriate follow-up and treatment necessary to monitor their diagnosis. 2 women served were further evaluated and treated for Cervical Cancer.
- Of the diagnosed women, 87% were new patients and the majority (33%) was diagnosed with Stage

	<p><i>procedures at you office and John Muir Concord. The staff was nothing less than amazing. The way everyone worked together with joy and with me...The care I received was just, "loving", period. I feel very blessed and thank you for all of you and especially for your organization. I appreciated so much being the woman that counted."</i></p>	<p>0. If they had not been diagnosed by Every Woman Counts, it is very possible that their Breast Cancer would have been diagnosed at a later stage or never detected.</p>
<p>Faith and Health Partnership (FHP)</p>	<p>The Faith and Health Partnership creates opportunities for faith communities and surrounding neighborhoods to collaborate with JMH and other health and social service agencies to develop and implement needed health education programs, preventive screening, chronic disease education, and resource referrals in an effort to promote healthy living, reduce health disparities, and save lives. Leaders and members of faith and community-based organizations have a relationship with their congregation that is built on trust. This relationship allows them to communicate important health information, mentor, and model healthy lifestyles. The congregations served by FHP are diverse in denomination, size, race, ethnicity, and income level. FHP assists each congregation in developing their unique vision for health and wellness by customizing support and implementing plans to sustain their vision.</p> <p>Success Story: <i>Faith and Health Partnership staff provided Grace Temple Church of God in Christ with the information and contacts for the Summer Food Program, assisted them with the application process, and the procurement of equipment to meet the requirements of the program. Grace Temple Church of God in Christ participation in the federal Summer Food Program was featured in an article published online by Edsource a source of education information, research and analysis highlighting strategies that support student success in California. The church offers healthy meals funded by the federal program along with after-school programs that include nutrition based curriculum provided by John Muir Health to the community's children. The summer program was such a success that the church applied and has allowed them to extend the program to dinner during the school year.</i></p>	<ul style="list-style-type: none"> • FHP increased the number of faith communities with which it collaborates by 20 % in 2012 • The FPH partners with 38 faith communities, reaching 10,318 congregants through health campaigns, 39,046 congregants through health ministry activities, and 11,101 congregants through change projects. • In 2012, FHP's community outreach activities served over 2000 people at community health fairs, barber shops/salons, and at workshops, trainings and events. • In 2012, 5 faith communities conducted health screenings with the assistance of FHP. • In 2012, 15 faith communities implemented change projects for a total of 270 change projects. Change project are activities or actions implemented by the congregation to promote health. • In 2012, Faith Community Nurses provided 123 total interventions to congregants. • In 2012, Faith Community Nurses made 340 referrals to health resources. • In 2012, 122 congregants reported significant health improvement as a result of the intervention and referral.

<p>Lung Cancer Screening Program</p>	<p>The Lung Cancer Screening program offered by the John Muir Clinical Research Center in conjunction with John Muir Health Cancer Institute, provides low-dose, non-contrast computerized tomogram (CT) scans of the lungs to people at high risk of developing lung cancer. With early detection of lung cancer, better treatment options are available to the patient, ultimately leading to improved survival and quality of life for this population. Patients receive appropriate education and information about early detection and results of the CT scan are provided along with recommendations for any follow up if required. If an abnormality is found on the initial scan, the patient will be counseled about recommended follow up. Patients requiring additional studies will be closely followed by their primary care physician and the research team at John Muir Health.</p> <p>Success Story: <i>Rebecca has been participating in the study since 2008 and qualified because she was a current smoker with a pack history greater than 10 years. She chose to continue the yearly scans. Her scan this year showed a new suspicious nodule that the radiologist recommended for follow-up studies. After various tests, Rebecca was relieved to find out that she did not have cancer. She is very proactive for early detection and plans to continue monitoring this nodule closely to ensure there are no changes. The best news of all is that she immediately quit smoking after the new suspicious nodule was found, Rebecca has also become a “stop smoking” advocate for her friends that are currently smoking and has been providing information and support for them to also quit smoking.</i></p>	<ul style="list-style-type: none"> • In 2012, 38 screenings were conducted. • Of the total participants receiving screens in 2012, 32% lived in households with incomes less than 200% of the Federal Poverty. • In 2012, 100% of participants were provided scan results with 10 working days. • When participants were asked about their overall experience as a subject in the research study, 86% rated their experience as “excellent” and 14% as “very good.” None of the participants rated their experience as poor, fair or good. • 100% of participants reported increased knowledge about their health condition and 93% feel more engaged in their healthcare as a result of the education and services provided. • 85% of participants reported that they are more likely to make lifestyle changes as a result of the education and services received.
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SENIORS

<p>Medication Assistance Program</p>	<p>Senior Services staff help eligible low- income Medicare patients receiving care from a John Muir Health physician complete the enrollment process for pharmaceutical companies’ patient assistance programs. The goal is to assist low-income older adults in obtaining free brand name prescription medications thereby enabling them to follow the treatment plan recommended by their physician and improve or maintain their health and quality of life.</p> <p>Success Story: <i>Mrs. Johnson is a 70 year old Caucasian woman who suffers from Chronic Obstructive Pulmonary Disease and Parkinson’s disease. She lives with her husband, who is her sole caregiver. Mr. and Mrs. Johnson’s income consists entirely of Social Security and falls just over 200% of the federal poverty level. As Mrs. Johnson’s Parkinson’s progressed, tremors in</i></p>	<ul style="list-style-type: none"> • In 2012, 57 Medicare patients who have medication costs that exceed their ability to pay were served from Central and East Contra Costa County. The 57 patients were provided with 402 prescriptions. • In 2012, the Medication Assistance program provided \$223,885 worth of prescription medications. • In 2012, 91% of the persons served obtained multiple medications. • In 2012, 53 people (93%)
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	<p><i>her arms and legs became more pronounced and her aching muscles began to produce pain in her body, which required a high dose of an expensive medication to control. The medication was only partially covered by her prescription drug coverage. Her COPD also required an expensive medication that must be taken on a daily basis, and also with a high co-pay. With her diseases progressing, the Johnsons' had a grim realization that their limited income might interfere with all aspects of Mrs. Johnson's health and independence, which greatly concerned them.</i></p> <p><i>Midway through 2012, the Johnsons were referred to the Senior Services Patient Assistance Program which immediately analyzed her medication list to determine programs the patient might qualify for. On behalf of the patient, the Program partnered with the patient's physician, pharmaceutical patient assistance programs as well as a local pharmacy to enable the patient to continue with her essential treatment and remain independent. She qualified for assistance with three high cost medications. By the end of 2012, the patient received this medication, a value of \$2,340. She was also approved for two COPD medications worth \$3,040, and is breathing easier. Since the pharmacy was too far away, and a great hardship for the Johnsons to get to, the Senior Services Patient Assistance Program authorized the pharmacy to mail the medications directly to the patient, at no charge.</i></p>	<p>assisted in this program had incomes of 200% or less of the Federal Poverty Level.</p>
<p>Fall Prevention Program of Contra Costa County (FPP)</p>	<p>The Fall Prevention Program of Contra Costa County strives to reduce deaths, preventable injuries, and loss of independence associated with falls of seniors and persons with disabilities. The program provides educational support and home safety repairs.</p> <p>Success Stories:</p> <p><u>Mr. Oliver:</u> <i>Mr. Oliver is an 80-year-old male with only Social Security income. He was referred to the FPP after a series of falls. His wife suffered from back problems and was no longer able to provide the care he needed. He was unable to climb into the bathtub to take a shower. The Home Safety Program provided two grab bars and a hand-held-shower. Mr. Oliver can now get safely into the tub and bathe or shower with confidence. His wife no longer has to risk her own safety to assist him. These modifications improved the standard of living for Mr. Oliver and his wife.</i></p> <p><u>Ms. Saucedo:</u> <i>Ms. Saucedo, a 64-year-old woman living in Antioch, recently received 2 grab bars, a shower chair, a hand-held shower, a</i></p>	<ul style="list-style-type: none"> • In 2012, 1,446 people were served by FPP through community outreach events and educational presentations. • In 2012, 4 county-wide Fall Prevention coalition meetings were held and on average 31 attendees and 29 agencies attended. Since May 2008, nearly 150 agencies have attended a quarterly coalition meeting • In 2012, FPPCCC received 219 referrals and conducted home safety assessments and modifications in 130 homes for 205 low income older adult residents of Central and East Contra Costa County.

	<p><i>carbon monoxide alarm & a fire extinguisher from the Fall Prevention Program. She is almost blind and finds it hard to get out of her home. She had no equipment in her bathtub and no family to assist her. These modifications made her feel less afraid of falling and more confident in her home. She also received a home assessment from an Occupational Therapist, which she found “very informative.” She learned new information about preventing falls and rates her overall experience with the program as “excellent.”</i></p>	<ul style="list-style-type: none"> • In 2012, the majority of home modifications were conducted for older adults with household incomes 175%, 100% and 125% of the Federal Poverty Guidelines. • Results from the 2012 Home Assessment and Modification Satisfaction Survey indicate that older adults who received a home assessment and modification are very satisfied with the services and information received. <ul style="list-style-type: none"> - 95% of older adults feel less likely to fall - 91% of older adults feel that they learned new information about falls. • In 2012, 95% of older adults report having a greater awareness about why falls happen and learned something new about preventing falls as a result of the presentations provided by FPP. • Older Adults who received in home assessment and modifications in 2012 report high quality of life improvements. Of these older adults, 92% report that they have not fallen since the intervention.
<p>Intensive Fall Prevention Program (IFPP)</p>	<p>The Intensive/In-Home Exercise Program targets seniors who are most vulnerable to falling in their homes and adds additional services for frail elders to the Fall Prevention Program of Contra Costa County currently funded. For the most vulnerable, those who qualify as “frequent fallers”, joining a group exercise class outside of the home may not be an option because of location, limited mobility, transportation limitations, chronic health conditions, or other factors. Therefore, an individualized, in-home program is essential to reducing their risk of falling. Currently no program is available in Contra Costa County to address these needs.</p> <p>IFPP was patterned after the Life Elder Care program in Fremont, CA, sponsored by Meals on Wheels. Life Elder Care has provided individualized exercise programming in the home</p>	<ul style="list-style-type: none"> • Between June and December 2012, 22 participants enrolled and 18 participants completed the program. • In 2012, 100% of participants reported that the program made a difference in their daily lives. • In 2012, 39% of participants decreased their risk of falling • In 2012, 79% of participants showed positive results around self efficacy and daily activities.

	<p>for seven years. Program data shows proven, sustainable results. The program uses student nurses to deliver the exercises in the home. IFPP program was implemented for older adult seniors living in Central and East Contra Costa County with emphasis on Antioch, Pittsburg, Concord, and Walnut Creek. It is a partnership among nursing programs providing nursing students for a ten-week period to deliver the in-home exercises, John Muir Health, and the Fall Prevention Program of Contra Costa County.</p> <p>Success Stories: <i>John: John, 67-year old male from Concord came into the Intensive/In-Home Exercise Program with a history of falls, weakness due to stroke, and depression. John seemed a bit skeptical of what the program could do for him, but he agreed to try. Three months after the program concluded, he was still exercising 6 -7 days per week and feels that the program has made a difference in his daily life. Also, he has not had a fall since participating in the program. When asked if he would like to participate in the next session, John replied "Let's do it!"</i></p> <p><i>Carmen: Carmen, 64-year-old female from Moraga had fallen and was recovering from a broken foot and needed to regain her strength in her left leg. Also, her balance was poor. As a result of the Intensive/In-Home Exercise Program, Carmen feels "fantastic" and describes her current physical activity level as "excellent." She is walking regularly in her neighborhood in addition to maintaining the exercises that were recommended to her in the program. Carmen also participates in Tai Chi & Yoga classes at a nearby senior center!</i></p>	<ul style="list-style-type: none"> • In 2012, 72% of clients reported an increase in mood-a decrease of mood scale results. • All nine participants of the first session report exercising 90 days after the program. Eight are using the recommended exercises. All twelve of the second session report exercising 90 days after program. All clients across the board report after 30 days that the program is still making a difference in their daily life.
<p>Caring Hands Volunteer Caregivers</p>	<p>Our life-enhancing services include: transportation and escort to medical appointments and other needed services, assistance with shopping and errands, friendly phone calling (in conjunction with any other service), friendly visiting and companionship, respite care (or rest for the family caregiver), reading mail and letter writing, light household tasks and light meal preparation, minor home repairs and yard work. All services are generally provided 1 – 3 hours per week to meet a long term need and are based on the availability of volunteers.</p> <p>Success Story: <i>Jeanne and Charlene were matched in 2006. Charlene lives in Pittsburg and needed a volunteer to help with transportation, errands and shopping. Jeanne lives in Brentwood, an area where the program often has a difficult time finding enough volunteers. Jeanne gladly agreed. Since 2006, Jeanne has</i></p>	<ul style="list-style-type: none"> • In 2012, Caring Hands served 218 seniors. • The seniors were served by 187 Caring Hands Volunteers. • In 2012, 70% of seniors responding to our surveys indicated it is more convenient to get to medical appointments because of Caring Hands. • In 2012, 59% of seniors responding to our surveys indicated they had enough or a lot of social interaction after participating in the program. • In 2012, 81% of seniors surveyed perceive their quality of life as "good"

	<p><i>volunteered over 1100 hours with Charlene. Charlene is obese and has had many hospital stays and many appointments that have required extra long trips for Jeanne. Jeanne has gone over and above and says Charlene is her good friend and she won't give up on her. Charlene takes a special medication that is prescribed by a specialist in Pinole which is over a 60 mile trip but Jeanne gladly takes her. Charlene now is scheduled for a special heart surgery in San Francisco. Jeanne will visit with her there and has also made a strong connection with the family.</i></p>	<p>and “excellent” after participating in Caring Hands.</p>
<p>Senior Transportation Program (STP)</p>	<p>The Senior Transportation Program of Caring Hands utilizes volunteer drivers to serve frail, isolated, and disabled individuals over the age of 60 with transportation services to medical appointments. The goal of STP is to provide transportation to medical appointments for frail, isolated, and disabled seniors by utilizing volunteer drivers.</p>	<ul style="list-style-type: none"> • In 2012, STP served 121 seniors. • In 2012, STP provided a total of 940 one-way assisted rides. • In 2012, utilization of transportation services by seniors increased. On average, each senior was given 8 rides compared to 7 rides in 2011. • Of the seniors surveyed, 72% reported that prior to utilizing STP’s transportation services, getting to doctors appointments was “somewhat inconvenient” to “very inconvenient.” The transportation services provided by STP, made getting to doctors appointments “convenient,” “somewhat convenient,” and “very convenient” for 93% of the seniors surveyed.
<p>Chronic Care for low income frail elderly</p>	<p>The JMPN Transforming Chronic Care (TCC) Programs are comprised of four programs to address the fragmentation of the health system by improving the coordination of care for patients through telephonic support and site visits. The patients eligible for this report fall mainly into the first two programs and occasionally extend to the last two.</p> <ul style="list-style-type: none"> • <u>Care Transitions Interventions (CTI)</u> is a program that supports the patient in the phase of care from the end of hospitalization until they are stable at home, by utilizing nurses and nursing students to reconcile medications help the patient produce a Personal Health Record, and coach the patients about their condition. Patients are evaluated at the end of four weeks and 	<ul style="list-style-type: none"> • In 2012, Tel-assurance Program contacted 100% of all referrals through phone calls or participation packet mailers. • A total of 445 low income patients were engaged in all programs in 2012, a 25% increase from 2011. • Of the participants surveyed, an average of 89% reported high levels of satisfaction. • In 2012, the programs were able to demonstrate that they reduced inpatient

	<p>assessed for continuing case management needs.</p> <ul style="list-style-type: none"> • <u>Tel-Assurance</u> (TA) is a program that helps monitor the status of patients with CHF and COPD between visits. Patients call in daily to an automated service and answer approximately six short questions. Nurses monitor the responses and follow-up with patients who signal a significant change in condition to determine the appropriate course of action (e.g., diet modification, medication adherence or adjustment, or physician intervention). • Patients who need education and support are referred to the <u>Disease Management</u> program and receive patient education materials regarding their specific illness and phone calls from a JMPN Case Manager on a quarterly schedule or as needed to assess the level of self-management skills. • The more severely ill patients are referred to the <u>Complex Case Management</u> program and receive monthly or weekly phone calls from a JMPN Case Manager who provides education, support and coordination of care. <p>Success Story: <i>Mrs. Ruiz. is a 66 year old retired nurse with a very limited income. She lives independently in her own home, however she cannot drive, and has no family in the area. She has diabetes with peripheral neuropathy, severe coronary artery disease, and COPD. She has been in the Tele-monitoring program since 2009. In Tele-monitoring, patients are screened monthly for depression. Her monthly depression screening results were shared with her PCP, which were addressed during her regular office visits. Any change in her condition prompts an alert to the case manager. Through a case management referral Mrs. Ruiz was visited by Senior Services who assisted her with transportation options so she could get back and forth to her doctor appointments. She was referred to the Friendly Visitor program, and received regular contacts by them to help decrease her isolation. Through disease management efforts, including sending her educational material and discussing the importance of maintaining her hemoglobin A1C in appropriate range, her levels decreased from 14.6 to 8.3 within 12 months. Mrs. Ruiz remains independent in her home, now has reliable transportation, her depression is being managed, and has avoided trips to the emergency department through improved management of her COPD.</i></p>	<p>readmissions for participating patients.</p> <ul style="list-style-type: none"> • The CTI patient readmission rate for 2012 was 5.3%. • The 2012 readmission rate for CHF patients in Tel-Assurance was 12.5%, less than control group rate of 16.7%. • The 2012 readmission rate for COPD patients in Tel-Assurance was 7.7%, less than the control group rate of 18.2%.
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<p>Monument Community Senior Services Outreach Program (MCSSO)</p>	<p>The Monument Community Senior Services Outreach Program provides outreach, case management and advocacy to promote safety, health and social wellbeing among seniors living in the Monument Corridor or attend the activities for seniors in the Monument Corridor neighborhood. Activities include outreach efforts, individual case management and organizing seniors to become involved in their community.</p> <p>Success Story: <i>In October, 2011 Mr. Reyes was staying at a homeless care program after having brain surgery. A MCSSO case manager visited the shelter and assisted him with food stamps and unemployment. Two months later he was transferred to the regular homeless shelter and helped to move to a room in Martinez. A year later, he was in permanent housing in the Monument Community and was again referred to MCSSO because he was laid off after two months on a job. He had been working 12 hour days to make ends meet, but now he was without food and medication. His MediCal application was denied and he was referred to free clinic to obtain a prescription. The MCSSO case manager was able to obtain payment for the prescriptions through a local church and helped to connect him with food assistance. Mr. Reyes was also four months behind on his rent. When he began a new job, he was able to pay his upcoming rent. A housing counselor help Mr. Reyes make an arrangement with the landlord for the remaining balance. He is now much less stressed and with assistance from the MCSSO program, housing program and other agencies.</i></p>	<ul style="list-style-type: none"> • In 2012, a total of 686 older adults were referred to MCSSO. • In 2012, 40 older adults were provided with individual case management services, exceeding the objective by 33%. • In 2012, 55 health related presentations were conducted within the community and a total of 1085 older adults attended the presentations. • In 2012, MCSSO made a total of 786 referrals to community resources, the majority of which were too health resources such as community clinics and screenings. • 85% of case management clients achieved 1 or more goals identified in their success plan. • In 2012, 30 older adults were involved in neighborhood civic or community projects. • In 2012, 66% of older adults reported that they are well aware or aware of community resources and can find most services compared to the 22% in the pre-test. • According to services post-test, only 28% of older adults reported that they have an immediate health care need as compared to 38% in the pre-test.
<p>Geriatric Care Coordination (GCC)</p>	<p>Geriatric Care Coordination provides assistance to older adults and family members with concerns regarding health and aging through in-home assessments, phone consultations and family meetings. Information and referrals for JMH and community programs and services are provided to patients, families and caregivers. The program supports independence and health for older adults and provides support and guidance to caregivers. The Geriatric Care Coordinator also assists JMH physicians and other health care professionals as they address</p>	<ul style="list-style-type: none"> • Referrals in 2012 to the GCC Program totaled 1,646 , an increase of 24% from 2011. • In 2012, 97% of all patients surveyed reported being very satisfied or satisfied with the GCC program. • In 2012, 92% of participating patients

	<p>aging and health concerns of older adult patients. A care plan addressing the patient's situation is developed and services coordinated with the primary care physician and other health care professionals.</p> <p>Success Story: <i>Mr. Thomas is an 85-year-old gentleman who cared for his wife of 65 years right up until her death in June, 2012. Mr. Thomas was lost without his "only love" and he was not managing well living alone. Mr. Thomas was depressed and isolated in his home. His doctor referred him to the GCC program and he agreed to a home assessment. Mr. Thomas had been losing weight, not eating well, not exercising, and seemed to have given up. When the GCC met with Mr. Thomas, he opened up and began to talk about his loss and gradually he agreed to have more support. The GCC communicated with the referring physician and together they addressed Mr. Thomas's depression. The plan was to try community supports and counseling first and if that did not improve the depression the doctor would prescribe a medication to improve his mood. Mr. Thomas liked that approach since he did not want any more medications unless absolutely necessary. During the next few months, Mr. Thomas accepted help from a senior peer counselor and started going to a couple of activities at the senior center. He made the decision he did want to stay in his home but understood it was not good for him to be alone so much. He started going to the senior center once a week and slowly feels he is coping better. Now six months later he is adjusting to his loss and able to cope better with his sadness. He is considering getting a dog.</i></p>	<p>reported that they are more effectively using the health care system.</p> <ul style="list-style-type: none"> As a result of the services provided by the GCC program, 12 hospitalizations, 11 readmissions, and 40 emergency department visits were avoided in 2012.
<p>Patient Navigator</p>	<p>The Patient Navigator Program assists physicians and patients by providing individualized health resource information and assistance coordinating services. Patients age 65 and older receive a Senior Health Questionnaire, a validated tool to predict a person's likelihood of experiencing adverse health consequences including hospital admission within the next four years. The results are tabulated, compared with national benchmarks and formatted into a Senior Health Profile for each patient. The Patient Navigator reviews the health profiles with the physician and staff, identifying patients who would benefit from health education materials, community resources, and additional supportive services. The overall goal of the risk assessment is to maintain patients at the highest level of functioning while minimizing unnecessary hospital admissions, readmissions and emergency department visits.</p>	<ul style="list-style-type: none"> In 2012, information was provided to 1037 seniors by either mail or phone. A total of 3031 resources were provided to the 1037 seniors. In 2012 the Patient Navigator program had 1887 patient interactions providing assistance. In 2012, 94% of the cases referred were resolved. In 2012, patients reported high levels of satisfaction with the services received by the Patient Navigator Program. In 2012, 58% of respondents reported that

	<p>The Patient Navigator Program also provides in-depth assistance to patients, families and caregivers who call the Senior Services department. The Patient Navigator serves as a link to obtain and coordinate information regarding John Muir Health services and community resources.</p> <p>Success Story: <i>Mr. & Mrs. Sutter lost their savings due to the market crash and had to move from a large home into a small apartment. While unpacking Mrs. Sutter began experiencing severe headaches and was taken to JMMC emergency room and diagnosed with a frontal brain mass. Following surgery she was released but had difficulty managing bills and paperwork. Mrs. Sutter's bills with John Muir Health totaled \$500,000. Medicare denied payment and Mrs. Sutter received overdue notices. To make matters worse, Mrs. Sutter became the primary money manager in her family because her husband began experiencing memory loss. She was referred to the Patient Navigator for assistance clarifying her bills with John Muir Health and other providers.</i></p> <p><i>The problem grew increasingly difficult to solve because Medicare had the last digit in her social security number wrong and she was now listed as a deceased male. Mrs. Sutter was afraid of being sent to collections because of the nonpayment of her bills. The stress of their combined health conditions and financial situation were almost too much to bear.</i></p> <p><i>Following many lengthy conference calls to Medicare & Social Security, speaking with supervisors, the number on her card was changed. Payment was made and Mrs. Sutter's Medicare number was corrected, avoiding future problems. Because of Mr. and Mrs. Sutter's cognitive limitations, the Patient Navigator was directly responsible for easing their worries.</i></p>	<p>their stress level related to medical bills has improved as a result of the Patient Navigator Program</p> <ul style="list-style-type: none"> • In 2012, 87% of respondents reported that their confidence in handling their issue is better as a result of the Patient Navigator Program. • In 2012, 41% of respondents reported that their quality of life is better as a result of the Patient Navigator Program • In 2012, 60% of patients reported that their health habits changed or improved based on the information they received
<p>Cardiac Outpatient Education Program (COPE)</p>	<p>COPE is an outpatient secondary preventative approach to conventional Cardiac Rehabilitation. Cardiac Rehabilitation staff will establish a therapeutic alliance with the patient through collaborative goal setting and assistance with risk factor modification. Patients have the option of exercising at home or participating in the cardiac gym for 8 supervised sessions. Staff provides direction, feedback, and motivation.</p>	<ul style="list-style-type: none"> • In 2012, 30 patients were referred, 18 signed-up and 7 completed the 8 session program (38% engagement). • The 8 patients that completed the program continue to exercise.
<p>YOUTH</p>		
<p>Community Nurse</p>	<p>The Community Nurse Program funds nurses in low income area schools, where the majority of students are eligible for the Federally Qualified School Lunch Program. The Community Nurse advances the well being, academic success, and life-long achievement of students through</p>	<ul style="list-style-type: none"> • From August 2011 to June 2012, a total of 558 referrals were received by the Community Nurse. The Community Nurse

	<p>promoting health and safety, intervening with health problems, providing care management services and actively connecting the students and their families with community resources to build student/family capacity for a healthy life.</p> <p>Success Story: <i>After winter break a fifth grade teacher reported that she suspected a female student of cutting herself. The student had not shown this behavior earlier in the school year. The student was called in to see the Community Nurse. She admitted to cutting her hand and wrist. The student showed the cuts, some cuts were healed and some appeared new. No other signs of cutting were noted. The student tearfully explained that her family had recently moved to a new apartment complex. She was being harassed, left out and suffering from low self esteem and social isolation. By the end of the first meeting the student entered into a verbal contract to not cut or harm herself. The principal, teacher, school psychologist, and parents were notified of the situation. It was agreed that the student was allowed to visit the Community Nurse anytime she needed. Upon meeting with the student's parents it was noted that they were hesitant to let the student see a therapist as recommended; they preferred the student see their priest. After explaining self-mutilation disorder / cutting disorders and the possibility of the behavior intensifying with the added stress of middle school, the parents agreed to counseling. Assistance was provided to the student's mother with a mental health referral, arranging for an interpreter, and with making the initial appointment. The student continued to meet with the Community Nurse and the school psychologist. The student was required to complete a daily log noting her feelings and if she felt like self-mutilating. She attended counseling sessions through mental health and with the family priest. At the end of the school year she had not cut herself for 3 months and she was able to identify coping skills. After a year end conference, the student's parents reported that the behavior / mood had greatly improved and they had not noticed cutting. They were very thankful for the assistance and education.</i></p>	<p>received referrals from teachers, staff, family and students.</p> <ul style="list-style-type: none"> • The referrals /requests received and made during the 2011-2012 school year resulted in 5,223 interventions. • In 2011-2012, 100% of K, 2nd and 5th graders received the mandated screenings. • The majority of interventions resulted in improved health status (62%). Improved health status includes: follow through with medical appointments, having appropriate medications and authorizations at school, obtaining eye exams and glasses, and results from first-aid and other interventions. • In 2012, 100% of the students with missing immunizations completed their requirements by year-end.
<p>Beyond Violence</p>	<p>The Beyond Violence program was launched in 2010 in the cities of Richmond and Antioch with the collaboration of John Muir Health's Trauma Department, Contra Costa Health Services (CCHS) and community based organizations. JMH identifies trauma patients between the ages of 14-25 who are victims of intentional injuries (e.g. knife assault, gunshot, assault) and reside in the cities of Antioch or Richmond. Identified patients are referred to a Beyond Violence Intervention Specialist (IS) from their community.</p>	<ul style="list-style-type: none"> • In 2012, a total of 25 patients were identified by JMH staff as eligible for the Beyond Violence program. • In 2012, John Muir Health Social Workers obtained consents a total of 25 patients who referred to the Beyond Violence

The IS supports the injured patient and their family and friends cope with the injury, and assists the patient with follow-up care and connects them to community resources to promote healthy choices and avoid re-injury and involvement law enforcement.

Success Stories

Eddie: Eddie is an 18 year old, African American father who was shot in the leg at an Antioch house party. He is healing physically, but is unable to walk without with the assistance of a walker. The Beyond Violence Intervention Specialist provided rides to many of his doctor's appointments. At mentoring sessions, Eddie and the Intervention Specialist discussed Eddie's understanding of the streets, his upbringing in a family with a history of violence and in foster care, and the importance of shifting his energy to being a father for his 3-month-old child. Eddie was receptive to developing a plan for how he is going to provide for his child and to continue his education at a Continuation School. Eddie is challenged by living back with his mother in a home where other young adult relatives live. The house sees lots of young people coming and going and "just hanging around all day." This makes studying and life-planning, difficult. In response, the Intervention Specialist connected Eddie with a tutor at the local community college. Eddie's progress is slow but steady. He is a thoughtful young man who is opening up slowly to the support and services offered. Eddie expresses appreciation for this. The Intervention Specialist sees a lot of potential for Eddie to break a cycle of violence and lead a positive productive lifestyle.

Angela: Angela is a 19-year-old young women who was the victim of multiple stab wounds (6) committed by a male friend desiring to have an intimate relationship with her. She resides with her mother who is battling a mental disorder. Since her release from JMH and her work with an Intervention Specialist, Angela is now employed at clothing store at the mall. Angela has completed her 12-month Individual Service Strategy and GOAL Plan. Already a high school graduate, Angela is now enrolled at a local community college, taking her General Education studies. The Intervention Specialist partnered with Contra Costa County Children and Family Services on her behalf, and supplied her with monthly bus passes to ensure her transportation to and from school and work. Unfortunately, Angela still suffers severely from PTSD. The Intervention Specialist is currently working diligently with local service providers to identify a

program in 2012.

- Intervention Specialists made 2,237 contacts with patients and their communities in 2012.
- 100% of eligible patients consented to participate in the program with the interventionists.
- 56% of clients who were engaged after 3 months remain engaged at 6 months.
- Of those still engaged 100% remain alive and avoided re-injury at the 6 month follow-up.
- Of those engaged 100% were not involved in a criminal incident at the 6 month follow-up.

	<i>mental health resource for Angela. Physically, Angela's injuries are healing well. Emotionally and psychologically, she has more work ahead of her. This is not unexpected for a victim of violence. For Angela, she has done very well for herself by getting a job, enrolling in college, and accepting help for what she needs.</i>	
Teen Pregnancy Resource Program	The Teen Pregnancy Resource Program offered by the John Muir Women's Health Center, provides free educational classes for pregnant teens in the Central and East Contra Costa County. Through partnerships with community school and agencies in the following cities: Antioch, Brentwood, Pittsburg, Concord, Byron, Oakley, Bay Point, Walnut Creek and San Ramon. The program includes emotional support and free educational classes including Online Childbirth Class, Childbirth Personal Class, Infant and Child CPR and Safety, Infant Breastfeeding, Newborn Care Financial Literacy and Car Seat Safety Check. Post Partum classes include mom's groups and breastfeeding support.	<ul style="list-style-type: none"> • In 2012, a total of 58 community organizations and physicians offices were identified as participating referral sites. • In 2012, 41 teens were referred and participated in the program. • Pre and post tests indicate significant increases in knowledge as a result of participation in the classes offered. • Of participant respondents, 100% of the teens found the program to be very valuable. • Of those who have delivered, 100% delivered full term without complications. • Of those who have delivered, 100% were breastfeeding after 3 weeks with no one requiring lactation support.
Healthy and Active Before 5	Healthy and Active before 5 is dedicated to creating healthy food and activity environments in neighborhoods and organizations that support children 0-5 and their families. The collaborative includes an 8 member executive committee, and 45 Leadership council and community members who wrote a comprehensive action plan based on research and best practices. The Leadership council and Executive Committee members represent almost all stakeholders impacting low income children in Contra Costa, including government, health care, children's services, the faith community, businesses, education, public safety and non-profit organizations. These leaders have not only guided the collaborative's efforts but also have committed to making sustainable changes within their organizations so that programs, policies and practices are in alignment with the Healthy and Active Before 5 Action Plan and Policy agenda.	<ul style="list-style-type: none"> • HAB45 inspired 10 Contra Costa agencies to consider new healthy food and/or beverage policies. Seven agencies formally adopted policies and others are still implementing. • HAB45 helped implement 17 organizational policies at local agencies. • 10 organizations were provided with technical assistance on a reoccurring basis. • HAB45 helped to train over 100 physicians and community health workers in breastfeeding support.

<p>Foster a Dream</p>	<p>The partnership between Foster A Dream and John Muir Health helps East Bay foster children navigate a critical period in their lives; their transition to adulthood and independence. An unsuccessful transition can lead to homelessness, physical and mental health issues, and increased risk of unlawful activity. Foster youth who are prepared academically with career goals, life management skills, and knowledge of resources are more likely to succeed and thrive. Foster A Dream’s goal to provide programs and resources that build the hopes, dreams and futures of Bay Area foster children; and be a guiding source for successful transition into the adult world.</p> <p>Success Story: <i>This was the fifth year that the “Dare to Dream” academic scholarship was awarded to a foster youth. The Dare to Dream Scholarship was awarded to JP. JP is currently a college student in Southern California. JP describes his college experience thus far, “College is great so far, I am potentially transferring to the east coast if I get in. Possibly Tufts University or Purdue University. I currently am back in school. We are in an Interterm right now, spring semester starts January 31. I got straight Bs, wish I could have got an A, but it’s my goal this semester. I finished my football season 4 wins and 5 losses. The scholarship helped me pay for my first semester. It came in handy particularly with my housing costs.”</i></p>	<ul style="list-style-type: none"> • In 2012, 2,329 backpacks were donated to Foster A Dream; 966 of those backpacks came from JMH. • In 2012, 12 youth participated in the Get Set Program, which prepares youth for emancipation out of foster care by getting them thinking about their future. All youth identified goals. • Staff volunteers increased by 45% and mentorship participation increased by 64%. • In 2012, 20 female foster youth participated in the JMH Young Women’s Empowerment Day.
<p>COORDINATION</p>		
<p>Monument Community Partnership</p>	<p>In 2012, Monument Community Partnership (MCP) merged with 2012 the Michael Chavez Center (MCC). The agencies serve similar populations in the same geographic area with different services. MCC focuses on economic, career, and technological development for residents while MCP leads community engagement, health and family service efforts. Both agencies strongly believe in resident leadership development. The new mission follows: <i>We actively engage with the Monument Community to provide training and tools, in order for people to become economically self-sufficient, healthy and safe, civically engaged, connected to each other and committed to lifelong learning.</i> The merged agency has two Monument locations. Programs now offered, with specific aligning activities, include Healthy Community, Civic Engagement, Technology, Day Labor, and Career Development. Our Healthy Community efforts in particular – including training and support for community promotores, the Monument Community Health Fair, facilitating access to health care, and promoting healthy eating and active living.</p>	<ul style="list-style-type: none"> • In 2012, 525 residents were trained in economic development programs. • In 2012, 381 families were served in 2012, by 25 volunteers at 2 sites. • In 2012, 2 new residents became leaders and certified Zumba instructors. • In 2012, 3 new youth leaders have emerged from Go Get It, an afterschool mentoring and tutoring college bound program. • In 2012, 25 parents volunteer to “drive” walking School Bus. • In 2012, 15 residents participated in a walkability audit addressing needs along a

	<p>Success Story: <i>A participant of the Day Labor & Technology program comments, "I first joined the Chavez Center in the Day Labor & Civic Engagement program, and I progressed through each of the programs. As a Day Laborer I went out to work regularly, meeting my basic day-to-day needs with this little bit of income, but this was not enough. Along with other members, I decided that the power of technology skills could be a huge advantage. Along with other students, we took it upon ourselves to find a teacher and hold classes. These classes developed into what today is the Technology Empowerment program, which trains more than 800 people annually in computer skills. In fact, as I progressed through the courses, I was even hired to teach classes, a position that I really wanted!"</i></p>	<p>busy street.</p> <ul style="list-style-type: none"> • In 2012, MCP case management served 476 participants looking for resources and specific services from housing to legal help. • In 2012, 520 residents were engaged in learning about healthy lifestyles and relationships.
<p>Respite Care Shelter for Homeless Patients</p>	<p>The Respite Care Shelter for Homeless Patients is a 24-bed respite program, the only one of its kind in Contra Costa County. The Respite Center is located next door to the County Homeless Shelter in Concord. It was developed in cooperation with local hospitals, the Contra Costa County Health Services Homeless Program and the Healthcare for the Homeless program. The program provides recuperative care to medically fragile homeless adult individuals who are discharging from hospitals and have no permanent residence nor can return to the streets. The Respite Center also has on-site Mental Health and Substance Abuse Counselors that assist in resources for treatment and care. There is also a Case Manager who assists with many types of Social needs, including, obtaining CA-ID, applying for SSI, SSDI, Government Assistance, Food Stamps, Veteran Services, and formulating a housing plan.</p>	<ul style="list-style-type: none"> • From the opening in June 2010 to December 2012, JMH referred 214 patients to the respite center. • In 2012, 124 patients were referred by JMH, which represented 25% of all referrals. • In 2012, 70% of the patients JMH referred patients were accepted, 33% were admitted to respite. • In 2012, admitted patients were provided with almost 9 medical linkages and stayed in the program for an average of 47.55 days. • It is estimated that for every patient admitted to the Respite Center, 4 acute hospital days are saved. Therefore, the total admitted patients (132) avoided 528 hospital days.
<p>Putnam Clubhouse</p>	<p>Incorporated in April 2007, The Contra Costa Clubhouses, Inc. opened Putnam Clubhouse in 2008 in Concord to fill critical gaps in Contra Costa County's continuum of care for adults recovering from severe mental illness through provision of an evidence-based, cost-effective, peer support, and vocational rehabilitation intervention. Few options exist beyond emergency services or hospital treatment, increasing vulnerability to homelessness, unemployment, and incarceration. The Clubhouse intervention, based upon the 36 International Standards promulgated by the International Center for Clubhouse Development</p>	<ul style="list-style-type: none"> • In 2012, there were a total of 257 members who participated in program activities during the year. • In 2012, the Clubhouse achieved an average daily attendance of 30 members, which was the target goal. Members spent a total of 42,169 hours participating in Clubhouse activities, 5% greater than the goal set

(ICCD), originated in New York in 1948 and has since been replicated at more than 300 sites in some 29 countries. In 2011, the ICCD Clubhouse Model was added to the United States Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence Based Practices and Programs. Documented research on ICCD clubhouse programs indicates both participants (called members) and their communities benefit from higher employment rates, a decrease in hospitalization, reduced incarceration, improved well-being, and reduced cost of services in comparison to other programs. Also during 2011, following a rigorous multi-year review process, ICCD certified Putnam Clubhouse for a three year period as a credentialed ICCD program. Certification involved a comprehensive evaluation in terms of fidelity to the 36 International standards of the ICCD Clubhouse Model. Putnam Clubhouse is the first program in Northern California to achieve ICCD accreditation.

Success Story: *A veteran, Putnam Clubhouse member Stephen, was first hospitalized for psychotic symptoms in Korea after serving there in the US Army. Upon returning to the US with nothing more than the clothes on his back, he felt hopeless and had lost his will to live. In his early thirties, after being hospitalized many more times, Stephen finally became stable with the help of medication. But he was having a hard time finding positive and meaningful activities to do each day. Stephen was isolating himself from the outside world. "I felt like I would never find my purpose in life or work again," he said.*

Stephen was encouraged to attend Putnam Clubhouse by his doctor and by a family friend. "Once I finally gave the Clubhouse a try, my life significantly changed for the better. The people at the Clubhouse validated my strengths, helped me to improve upon my weak points, and most importantly gave me a sense of purpose." In the process of volunteering alongside peers and staff to help run all aspects of the Clubhouse—everything from office work to video production—Stephen's confidence increased. "I feel like I did before I knew I had a mental illness," he said. Stephen's leadership abilities flourished at the Clubhouse and he became a member of The Contra Costa Clubhouses, Inc., which operates the Clubhouses, and in 2012, Stephen was selected by the Board to serve as treasurer.

While attending the Clubhouse, Stephen started to believe that he would be able to work again. As a first step toward achieving this goal, the Clubhouse placed him in a paid, transitional employment (TE) position at a Concord area

for the year.

- In 2012, 51 weekly young adult meetings were held during which young adult members planned and held a variety of recreational activities for themselves.
- In 2012, 94% of respondents agreed or strongly agreed that they were satisfied with the Clubhouse activities they attended during the past year.
- In 2012, 82% of respondents agreed or strongly agreed that their independence increased during the year.
- In 2012, 87% of respondents reported that their emotional well-being had increased and 92% reported that their mental well-being, each well above the objective 4 target goal of 80%.
- During 2012, 23 members gained jobs in unsubsidized employment at an average (unsubsidized) wage of \$12.60 per hour, 48% greater than the target.
- Overall, 38 members worked in paid employment during 2012 and were given support by the Clubhouse for staying employed.
- In 2012, 25 members returned to school.
- In 2012, 85% of members who provided hospitalization data showed a decrease in hospitalizations or maintained zero hospitalizations.
- Before Clubhouse membership, members were hospitalized or in out-of-home placements on average 76 days; after Clubhouse membership,

	<p><i>business. Upon completion of TE, with Clubhouse encouragement and support Stephen enrolled in a peer-specialist training program, SPIRIT. He graduated as valedictorian of his class. Most recently, Stephen achieved his goal of having a fulltime paid position when he was hired by Contra Costa County's office for Consumer Empowerment where he now works as a community mental health support worker.</i></p>	<p>average number of days members were hospitalized or in out-of-home placements decreased to 5 days.</p>
<p>Community Health Fund</p>	<p>The John Muir/Mt. Diablo Community Health Fund performs one of John Muir Health's most important community benefit functions: Distributing grants to community-based, nonprofit organizations whose health care capabilities and trusted relationships with uninsured and underserved populations expand and enhance health care services for those who need them most in central and east Contra Costa County. The Community Health Fund' distributes that money through a unique process that nurtures long-term partnerships with and among community-based nonprofits, and which results in sustainable health initiatives and systemic change.</p> <p>Many programs that receive their start from us continue long past the grant periods and to this day deliver critical health care services. Consequently, many thousands of Contra Costa residents who might have slipped through the cracks in our health care system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support services for conditions that range from cancer and chronic disease through dental caries and mental illness.</p> <p>It is our mission to deliver the same kinds of results to the many in Central and East Contra Costa who still struggle to find adequate care. More detailed information about the Fund, its governance, grant program and community benefit reports can found on its website: www.jmmdcommunityhealthfund.com.</p>	<ul style="list-style-type: none"> • For complete details of Community Health Fund partners, funding and activities, please visit: www.jmmdcommunityhealthfund.com

2013 Community Benefit Plan/Implementation Strategy

The 2013 Community Benefit Plan, which includes only programs for vulnerable populations, is included as Attachment F. It outlines our objectives for 2013.

Economic Valuation of Community Benefits

Community Benefit—What Does It Mean?

Community benefit is a term used to describe the many health programs and medical services supported totally or in part by John Muir Health that provide tangible benefits to the community and improve the health of its residents. In 2012, John Muir Health contributed more than \$82.7 million in community benefits. These benefits cover the entire spectrum of health care including high-tech procedures, trauma services, primary care, educational classes, health screening and support groups. They are services to the community for which we receive little or no payment.

The economic valuation of community benefit contributions includes community benefit activities provided by all John Muir Health entities: the Behavioral Health Center, the Community Health Alliance, the Community Health Fund, John Muir Medical Center-Concord and Walnut Creek and the John Muir Physician Network. Contributions are shown for Fiscal Year 2012 in total and then detailed by nine program categories. These categories are the same as those reported in the IRS Form 990, Schedule H for Hospitals.

During Fiscal Year 2012, John Muir Health contributed over \$82.7 million in community benefits. These contributions include:

Purpose	Description	In Thousands (000s)
Charity Care	The largest proportion of our community benefit services are devoted to the most vulnerable individuals of our community. This means we provide health care through John Muir Medical Center – Concord and Walnut Creek and the John Muir Physician Network for people regardless of their ability to pay. This includes the critical emergency and trauma services at our medical center campuses. Charity care is a community benefit, providing health care services for those that have no insurance and are otherwise unable to pay. <i>Amounts listed here are costs not charges.</i> We believe that a portion of our bad debts would be classified as charity care if we had more complete information from our patients regarding their economic status. Bad debts are not included here.	24,353
Government Sponsored Health Care (Medi-Cal shortfall)	We provide care for patients who participate in government-sponsored programs such as Medi-Cal. The payment we receive from these programs rarely covers the full cost of services provided to these patients. As a community benefit, John Muir Health absorbs the difference between <i>the cost (not charges)</i> and the payment. In addition Medicare does not cover all the health care costs for patients over 65 years old. The Medicare costs are not included here.	38,104
Subsidized Health Services	These services are underwritten by John Muir Health. In some cases services are provided by John Muir Health even at a loss because the service is only available to the community at John Muir Health. We consider these losses a community benefit. Subsidized services include the Emergency Medical Services ambulance base station for the county	1,424

	at the Walnut Creek campus.	
Health Improvement	John Muir Health also supports a wide range of activities and resources that promote health and wellness, including health education, libraries, health fairs, screening and support groups. The John Muir Community Health Alliance brings to the community an array of resources from John Muir Health, including health care professionals, mobile health services, information and education services. The John Muir Community Health Alliance also works in partnership with local communities, other nonprofit health systems, public health providers, nonprofit organizations and school districts to identify and address unmet health needs among uninsured and underserved populations.	8,396
Community Building	This includes workforce development activities and community collaborative development. It includes John Muir Health support for the Monument Community Partnership.	663
Financial and In-Kind Contributions, Grants	The John Muir/Mt. Diablo Community Health Fund is a unique grant program that provides funds for health projects and initiatives conducted by community-based organizations. With an annual contribution of over \$1 million from John Muir Health, and through partnerships with other grant making foundations, the Community Health Fund focuses on ways to achieve fundamental improvements in the health status of uninsured, underserved and overlooked families, children and seniors. Also included in this area are donations to community based-organizations focusing on diseases such as heart, cancer, stroke and diabetes and in-kind donations of supplies, facilities and staff time.	2,856
Health Professions Education	Community benefits also include health professions education programs in the areas of nursing, physical therapy, ultrasound technology, radiologic technology, rehabilitation, clinical pastoral care and other health professions.	4,275
Research	Clinical research funded by government agency or tax exempt organizations where findings are available to the public.	1,373
Community Benefits Operations	In order to coordinate our community benefit planning and execution of programs to maximize their impact, we also support a small dedicated staff and their office operations.	1,269
Total		82,713

In addition, John Muir Health provided care to Medicare inpatients and outpatients whose estimated costs exceeded payments made by the Medicare Program. The Medicare shortfall, the difference between the cost of care for Medicare beneficiaries and the payments for those services, was over \$226 million. This is not included in the above total.

As required by California Senate Bill 697 reporting, John Muir Health community benefit contributions are also displayed here highlighting the activities for vulnerable populations.

In Thousands of Dollars (000s)	
Charity Care	24,353
Medi-Cal Shortfall	38,104
Vulnerable Populations	9,669
Broader Population	4,939
Health Professions Education and Research	5,648
Total Benefits Reported	82,713

Community benefit contributions include programs at John Muir Medical Center – Walnut Creek, John Muir Medical Center – Concord, John Muir Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network. A separate 2012 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Behavioral Health Center.

Attachments

Attachment A – John Muir Health Community Health Guiding Principles

John Muir Health Community Health Guiding Principles

Introduction

John Muir Health, a non-profit health organization, is guided by a community-based charitable charge. Although John Muir Health's first priority is to provide quality medical care and promote patient safety, as a corporate leader, John Muir Health recognizes the positive and critical impact of its community health initiatives for the residents of Central and Eastern Contra Costa County.

John Muir Health continually strives to improve the health of the communities it serves through community benefit planning and implementation. Even during periods of challenges for health care organizations and providers, John Muir Health has an ongoing commitment, above and beyond the provision of acute, clinical care, to provide and support services and programs dedicated to creating healthier communities. John Muir Health carries out its commitment in a variety of ways and venues through its hospitals, John Muir Behavioral Health Center, John Muir Physician Network, Community Health Alliance and Community Health Fund.

John Muir Health fosters an organizational culture that respects employees and supports skill development; its unique internal culture elevates and builds on employees' strengths. John Muir Health seeks to foster the same culture in the external community by consciously recognizing, respecting and building on the communities' expertise, insight and participation to further advance the organization's mission, vision, guiding principles and values.

Context

John Muir Health has clearly articulated its commitment to improve the health of the communities it serves in its mission, visions and strategies:

Mission:

We are dedicated to improving the health of the communities we serve with quality and compassion.

Strategic Vision:

We will exceed our patients' expectations for seamless, consistently positive experiences with all aspects of John Muir Health.

Related Strategic Guiding Principle:

Build alliances that create healthier communities.

Related Core Value:

Access to Care

John Muir Health Healthy Community Vision

The following vision statement represents a general framework for John Muir Health activities and includes concepts from the World Health Organization, the National

Conference of Cities and the Bay Area Partnership. John Muir Health's vision for all residents of Central and Eastern Contra Costa County is that:

- *All residents achieve and maintain optimal physical and mental health.*
- *Children succeed in school and reach their full potential.*
- *Residents are economically independent and have access to adequate, affordable housing.*
- *Neighborhoods are safe.*
- *Violence, discrimination and injustice are eliminated.*
- *The air and water are clean.*
- *Residents are politically, socially and culturally active.*

As with any vision, it is not fully achievable in the short-term nor is it the work of one organization. As a corporate, community and health care leader, it is John Muir Health's responsibility to contribute to the progress toward the vision for all the communities it serves.

Philosophy

It is the philosophy of John Muir Health to:

- Partner and collaborate with public and private organizations to support John Muir Health's vision of a healthy community,
- Ensure that all entities in John Muir Health contribute to the achievement of John Muir Health vision in an appropriate way, and
- Impact the health status of the community through a long-term sustained commitment.

Program Funding Guidelines

The purpose of John Muir Health community health initiatives is to increase the capacity of the communities it serves to build partnerships and increase the ability of individuals to make healthy decisions. To support its purpose, specific community benefit plan goals, strategies and tactics are developed and indicators are selected to measure progress after a thorough review of the data.

John Muir Health uses internal and external data to identify unmet health needs and to select specific areas for community health initiatives.

External data services used include:

- Healthy People 2010
The Healthy People 2010 goals are national targets that are updated each decade. Based on scientific data and analysis, the 467 objectives in 28 focus areas in Healthy People 2010 represent a comprehensive, nationwide health promotion and disease prevention agenda. Further, Healthy People 2010 goals are designed to serve as a roadmap and provide health improvement opportunities for the next decade.
- Triennial Community Assessment

An assessment is done every three years in conjunction with other non-profit hospitals in Contra Costa County and the County Public Health Department. The report tracks disparities in health outcomes in various areas of the County.

Given the competitive environment and financial restraints facing all health organizations, John Muir Health has adopted guidelines to select health initiatives that will maximize potential change and impact on the health of vulnerable populations in the communities we serve.

John Muir Health Community Benefit Funding Guidelines include:

1. Program addresses needs of a **vulnerable population** defined as a population with one or more of the following characteristics:
 - i. Evidenced-based disparities in health outcomes, e.g. African Americans with heart disease, African American women with breast cancer and African Americans and Latinos with diabetes.
 - ii. Significant Barriers to Care, e.g. the isolated or frail elderly, those with language or cultural barriers to effective care, those with barriers to appropriate and timely health care due to lack of health insurance, those with transportation or mobility barriers, those with limitations on their capacity to voice their needs in the health care system such as children.
 - iii. Economically Disadvantaged; e.g. uninsured, underinsured and/or working poor residents.
2. The program is delivered through **partnerships** with community based organizations, other providers, public agencies or business organizations.
3. The program positively **impacts the health of the community** in a measurable way. (How much did we do? How well did we do it? Did we make a difference?)

An internal Community Benefits Advisory Committee has developed program selection criteria in these three areas and uses these criteria to recommend programs for funding in the annual budget processes.

Evaluation

John Muir Health will use appropriate techniques to evaluate the effectiveness of the largest community programs. Periodic reports will be made to the Board of Directors reflecting ways the program has positively impacted the health of the community in a measurable way.

In addition, and consistent with its Senate Bill 697 obligation, John Muir Health will report the economic value of implementing the community health initiatives as community benefit activities. John Muir Health has adopted the Catholic Health Association/VHA reporting guidelines and reports the economic value of John Muir Health's community benefit contributions in the following categories:

1. *Charity Care*: Charity Care is the cost of free or discounted health services provided to persons who cannot afford to pay and who meet John Muir Health's criteria for financial assistance.
2. *Government Sponsored Health Care*: Government Sponsored Health Care community benefits include unpaid costs of public programs; the cost shortfall

created when a facility receives payments that are less than the cost of caring for public program beneficiaries.

3. *Subsidized Health Services*: Subsidized Health services are clinical services that are provided despite a financial loss and the financial losses are so significant that negative margins remain after removing the effects of charity care and Medi-Cal shortfalls.
4. *Community Health Improvement Services*: Community Health Improvement Services are activities carried out to improve community health and subsidized by John Muir Health.
5. *Community Building Activities*: Community building activities include programs that, while not directly related to health care, provide opportunities to address the root causes of health problems. These activities support community assets by offering the expertise and resources of John Muir Health.
6. *Financial and In-Kind Donations*: This category includes any in-kind services donated to individuals of the community at large.
7. *Health Professions' Education*: This category includes costs associated with preparing persons for future health care professions.
8. *Research*: Research includes clinical and community health research, as well as studies on health care delivery that are shared with others outside the organization.
9. *Community Benefit Operations*: Community Benefit Operations include costs associated with staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategies and operations.

Annually, John Muir Health submits a report of community benefit activities to the California Office of Statewide Health Planning and Development. The report details all community benefit activities undertaken by John Muir Health and reports the monetary amount of each community benefit.

Conclusion

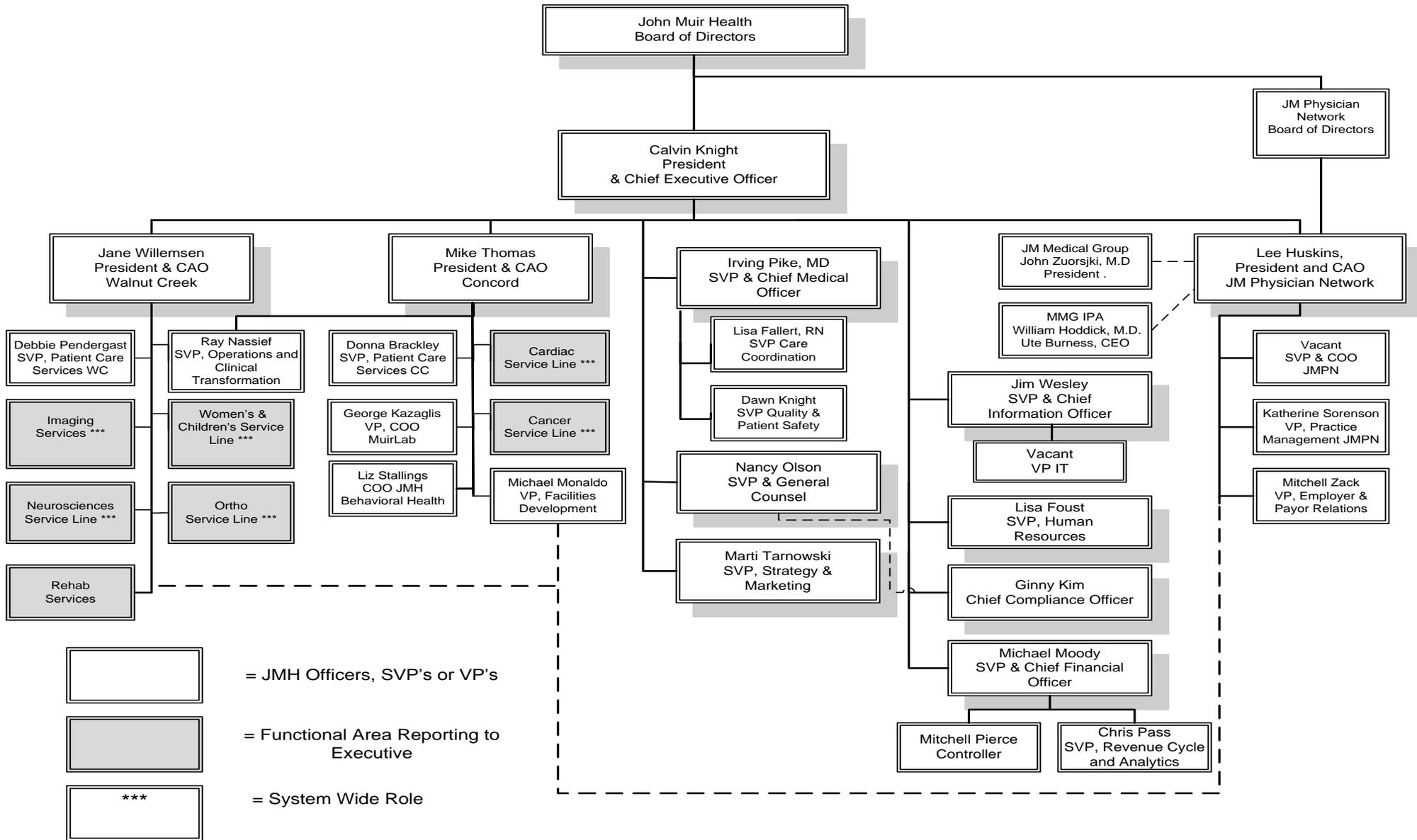
In order to fulfill its commitment to improving the health of the communities it serves, John Muir Health utilizes the expertise of its hospitals, Community Health Alliance, Community Health Fund and Physician Network. The hospitals and Physician Network focus on programs that utilize the clinical expertise and programs of John Muir Health staff. The Community Health Alliance focuses on developing and implementing collaborative solutions to health concerns of the local community with community partners. The Community Health Fund, a tax-exempt 501(c)(3) supporting organization to John Muir Health, awards grants for community-based health partnerships that increase access to and utilization of quality, affordable, and culturally and linguistically competent health care and related services for uninsured and underserved populations identified as most at-risk for poor health in relation to this county's leading health indicators and disparities.

Finally, all John Muir Health entities work cooperatively to leverage John Muir Health financial investments in community health initiatives by seeking collaborative support from other public and private philanthropic foundations wherever possible and appropriate. As a steward of local health resources, John Muir Health is committed to supporting community organizations that serve the primary and preventive care needs of the vulnerable populations and contribute to the organization's goal of creating healthier communities.

Originally Approved by John Muir Health Board of Directors - September 2000
Revision Approved by John Muir Health Board of Directors - May 2008

Attachment B – John Muir Health Organizational Chart

John Muir Health



- = JMH Officers, SVP's or VP's
- = Functional Area Reporting to Executive
- *** = System Wide Role

Attachment C – Board Lists

John Muir Health 2013 Board of Directors

OFFICERS

David L. Goldsmith, *Chair*

Thomas G. Rundall, Ph.D., *Vice Chair*

Phillip J. Batchelor, *Treasurer*

William F. (Rick) Cronk, *Secretary*

Nancy Olson, *Assistant Secretary*

DIRECTORS

F. Ryan Anderson, M.D.

Linda Best

Patricia E. Curtin

Robert E. Edmondson

John (Tim) Ganey, M.D.

Marilyn M. Gardner

William K. Hoddick, M.D.

Deborah L. Kerlin, M.D.

Calvin Knight

Ronald K. Mullin

Stuart B. Shikora, M.D.

Thomas Tighe, M.D.

San S. Yuan, M.D.

John D. Zuorski, M.D.

John Muir Physician Network 2013 Board of Directors

OFFICERS

Michael Robinson, *Chair*

Arlene Sargent, *Secretary*

Nancy Moschel, *Treasurer*

DIRECTORS

Kenneth Bowers, M.D.

William Dow, PhD

William Hoddick, M.D.

Ravi Hundal, M.D.

Lee Huskins

Calvin Knight

Kathleen Odne

John Zuorski, M.D.

(1 Vacant Slot)

NON-VOTING REPRESENTATIVES

Taejoon Ahn, M.D.

Edward Becker, M.D.

Michael Kern, M.D.

John Muir/Mt. Diablo Community Health Fund 2013 Board of Directors

The Community Health Fund is governed by an independent, ten-member, appointed board of directors, with five members appointed by the Mt. Diablo Health Care District and the other five appointed by the John Muir Association.

OFFICERS:

Tom Noble, *Chair*

Susan Woods, *Vice Chair*

Arthur Shingleton, *Treasurer*

Ernesto Avila, *Secretary*

DIRECTORS:

Linda Best

David Durant

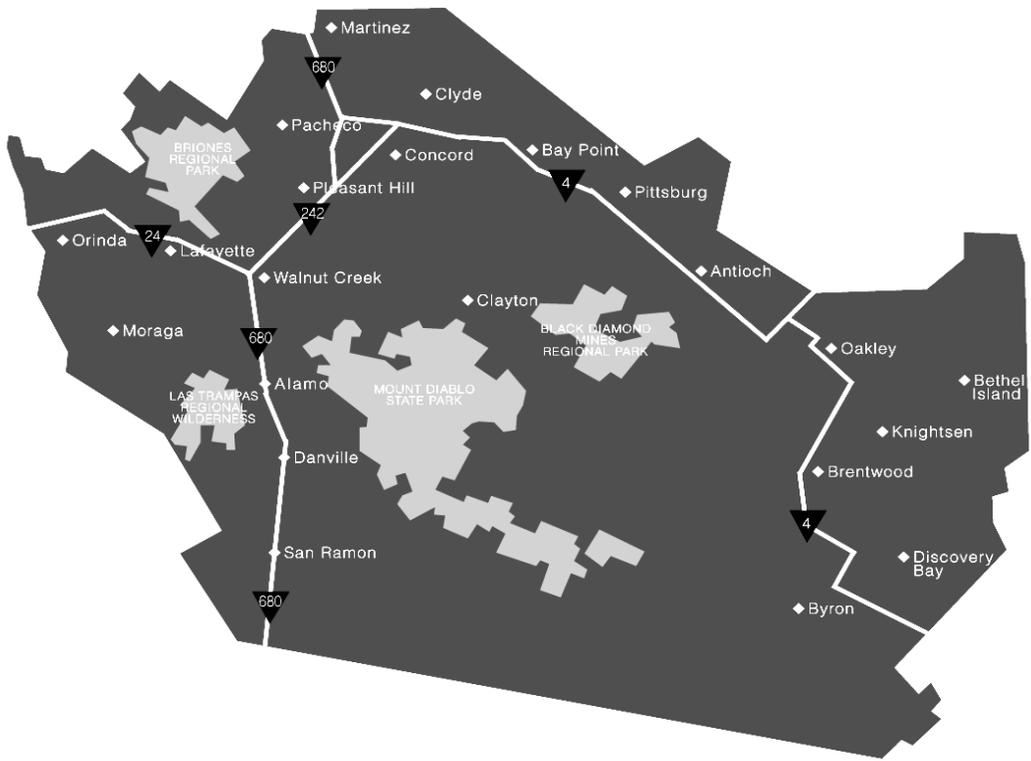
Bill Gram-Reefer

Laura Hoffmeister

Rina Shah, M.D.

Jack Weir

Attachment D – Map of Service Area



**Attachment E – John Muir Health 2012
Community Benefit Plan - Year End Results**

**John Muir Health
2012 Community Benefit Plan – Year End Report**

Healthy Community Vision: All residents achieve and maintain optimal physical and mental health. Children succeed in school and reach their full potential. Residents are economically independent and have access to adequate, affordable housing. Neighborhoods are safe. Violence, discrimination and in justice are eliminated. The air and water are clean. Residents are politically, socially and culturally active.

- Goal 1:** To improve access to health care for low income residents
Goal 2: To have measurable impact on the health of the community

Strategy 1: Increase direct care, charity care and subsidized care

Tactic 1: Provide low risk outpatient surgery through Operation Access.

FY 07 Baseline: 16 surgical services provided by JMH to predominately Latino patients (87%). 100% of patients reported improved health after surgical procedure

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Increase the number of surgical services provided by JMH by 10 percent over 2011. 2. Operation Access will provide surgical services to underrepresented minority patients in Contra Costa County. 3. Contra Costa patients will report high levels of satisfaction with the surgical services offered by Operation Access. 4. Contra Costa patients will report improved quality of life as reported by patient surveys 	<ul style="list-style-type: none"> • 46% of Operation Access surgical services in Contra Costa County were provided by John Muir Health. This amounted to a total of 64 surgical procedures provided by JMH surgeons, all of which were provided in a JMH operating room. This represents a 25% increase from 2011. In addition, JMH surgeons provided an additional 52 minor radiology procedures and 39 specialist evaluations. • The number of Latino patients receiving surgical services in Contra Costa County remained steady at 92%, with African Americans and Caucasians representing 3% and 5%, respectively. • Patient's report that their overall experience with Operation Access increased as did their satisfaction with the results of the surgery. • 100% of patients reported improved health and 97% reported improved quality of life because of the OA services.

Tactic 2: Provide specialty care to low-income, uninsured patients referred by community clinics.

FY 11 Baseline: 12 accepted referrals of patients in need of specialty care with 91% indicated Spanish as a preferred language. 38 specialists were recruited, in addition to hospital based physician groups.

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Recruit specialists to participate in the program as needed to meet the needs of the referred patients. 2. Provide specialty charity care as budgeted. 	<ul style="list-style-type: none"> • 54 specialists were recruited in addition to the hospital based groups, which is a 42% increase from 2011 year end. The program added urology to specialty offerings. • SCP accepted 183 referrals for patients in need of specialty care, which exceeds their goal of 24 referrals.

Tactic 3: Provide primary care via the Mobile Health Clinic for the uninsured in Brentwood and Far East County on Saturdays.

FY 07 Baseline: Served 260 patients through the Saturday Clinic. 17% of patients presented with an urgent health need and 8% reported that they would have gone to the ED if the MHC was unavailable

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. The Mobile Health Clinic will serve at least 600 patients in the 2012 Saturday clinic. 2. The Mobile Health Clinic will provide patients with referrals for ongoing primary medical care. 3. The Mobile Health Clinic will maintain high levels of patient satisfaction. 4. The Mobile Health Clinic will reduce the number of avoidable Emergency Department visits. 	<ul style="list-style-type: none"> • The MHC served 578 patients through the Saturday Clinic. • The MHC made 136 referrals. The referrals were made for patients that required more urgent care, specialty care services and/or chronic disease management. • Of the 136 referrals, the majority (70%) were concentrated in health agencies, particularly La Clinica- Oakley and Brentwood Health Center. • 100% of patients were satisfied with services received on the MHC. • 38% reported that they would have gone to the Emergency Room to seek medical care if the MHC was not available. • 7% of patients were seen for urgent health needs. An urgent visit is a proxy for an emergency room visit avoided because the MHC patients are uninsured and have no source of ongoing primary care. The estimated ED costs avoided by use of the Mobile Health Clinic (including partnerships) in 2012 is \$313,536.

Tactic 4: The Mobile Dental Clinic will provide preventative and restorative dental care for underserved children.

FY 07 Baseline: Provided oral health services to 466 children and enrollment assistance to 53 families. A total of 875 patient visits. 63% of the patients seen were connected to a dental home. 100% of patients reported high levels of quality and satisfaction with the services offered. 58% of the patients seen at the Mobile Dental Clinic previously had no access to dental care.

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. The Mobile Dental Clinic will provide oral health services to a minimum of 600 children. 2. The Mobile Dental Clinic will provide enrollment assistance to eligible patients. 3. The Mobile Dental Clinic will identify and establish a dental home for patients. 4. The Mobile Dental Clinic will maintain high levels of patient satisfaction. 5. The Mobile Dental Clinic will have increased access to dental care. 	<ul style="list-style-type: none"> • The MDC saw 460 children and provided 1393 visits. • 67 % of patients seeking care were in need of enrollment assistance. A total of 309 families were provided with insurance enrollment assistance. • 90% of patients seen through the MDC were connected to a dental home through the MDC's referral partnerships with community clinics. • 100% of patients reported that they would recommend the MDC to someone they knew and reported high levels of quality and satisfaction with the services offered and received. • 34% of the patients seen at the MDC would not have sought care if the MDC was not available.

Tactic 6: Support Concord RotaCare Free Clinic.

FY 10 Baseline: 14 Clinics have been held and 258 patient served

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Provide the Mobile Health Clinic for evening use by the Concord RotaCare Clinic 2. Provide lab and X-Ray services at discounted rates 3. Provide technical assistance as requested 	<ul style="list-style-type: none"> • 57 clinics held; JMH provided the driver. • \$60,369 in ancillary testing was provided to 214 patients. • Advised on planning for new clinic and access to resources.

Tactic 7: Mobile Health Clinic partnership expansion with RotaCare, CCHS and other community partners.

FY 11 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Collect and evaluated ED use rates from hypertension, diabetes and asthma 2. Assess programs to address findings including mobile health clinic, community clinic and health education programs as appropriate 	<ul style="list-style-type: none"> • Collected and reviewed data. Data showed that not enough evidence of ED use exists to warrant expansion of mobile health services. • Objective put on hold.

- 3. Based on assessment, develop implementation plan and budget for 2013
 - Objective put on hold.

Strategy 2: Increase access to care through enrollment programs

Tactic 1: Support East County efforts to increase access to primary care.

FY 10 Baseline: A Health Access Enrollment Manager was hired

2012 Objectives	Outcomes
1. Continue to work with East and Central County Access Action Team and East and Central County provider CEOs to develop collaborative programs to increase access to care	<ul style="list-style-type: none"> • Funded through collaboration an instructional MediCal enrollment video for county-wide use.

Tactic 2: Implement JMCC ED Referral Liaison Program to connect the uninsured to a medical home and other support services.

FY 09 Baseline: The ED Referral Liaison contacted 6,509 eligible patients and issued 6,793 referrals; a referral rate of 93%. 80% of patients referred reported a successful follow-up outcome and only 0.8% revisited the ED in less than 3 months for a non-urgent reason

2012 Objectives	Outcomes
1. Continue to identify and contact patients with no primary care physician or insurance who present at the ED for non-urgent reasons 2. Provide contacted patients with appropriate health services, insurance assistance and community referral. 3. Maintain a referral rate of 70% 4. Revisit rates of patients who return to the ED for non urgent reasons in less than 3 months, 6 months and 12 months from the time of their last visit will remain below 1% 5. At least 70% of patients who were issued a referral will report successful follow-up outcomes	<ul style="list-style-type: none"> • Identified and contacted 8,923 patients, a 10% increase from 2011. • Issued 6,588 referrals in the following categories: insurance assistance, health service and community resource (annualized because full data set not yet input). • Data collected but not currently available. • Data collected but not currently available. • Data collected but not currently available.

Tactic 3: Reduce avoidable ED visits and hospitalizations for frequent users through the Complex Community Care Coordination program.

FY 12 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
<ol style="list-style-type: none">1. The CCCC Program will be implemented Fall 20122. The frequent users will report better outcomes related to healthcare, housing, transportation, mental health, substance abuse, and employment.3. In 2012-2013, the CCCC Program will identify 30-40 high risk frequent users to JMH.	<ul style="list-style-type: none">• The CCCC Program was implemented at the end of September 2012. One of the existing JMH Per Diem Social Workers was hired September 2012 and a full-time Social Worker Case Manager & a LVN Case Manager were hired October 2012. Various presentations were conducted for staff throughout the organization to orient them on the program, timeline and objectives.• Enrolled clients were notified via a telephone call, mailed letter and/or conversation regarding the transition. All active clients agreed to participate and were successfully transitioned.• There are currently 27 active clients. An additional five were discharged from the program for the following reasons: 2 expired, 1 met all goals, 1 decided to discontinue participation, 1 changed their contact information and we were unable to locate.

Strategy 3: Support prevention, early diagnosis and early intervention

Screening

Tactic 1: Every Woman Counts Programs will provide free breast and cervical cancer screenings for low income women 25 years of age or older for cervical cancer and 40 years of age or older for breast cancer screening

FY 07 Baseline for Breast Cancer Screening: Served 350 women; 67% were Hispanic and 4% were African American. 92% returned for rescreening in 18 months. 89% of patients provided with "one stop" services

FY 11 Baseline for Cervical Cancer Screening: Served 19 women.

2012 Objectives	Outcomes
<ol style="list-style-type: none">1. Every Woman Counts will increase the number patients served by 6 percent.2. Every Woman Counts will continue to support efforts to diversify the demographics of the patient population through expanded service reach.	<ul style="list-style-type: none">• A total of 567 patients were seen through the 34 Every Woman Counts clinics (breast cancer and cervical cancer) that were held in 2012, which represents an 8% increase from 2011.• Out of the 567 patients served, 48% identified as Hispanic.

3. Every Woman Counts will increase African American women seen by 5 percent through outreach efforts.
4. Within 18 months of their initial screening date, 80 percent of returning breast cancer screening patients will be re-screened.
5. Every Woman Counts will provide 90 percent of breast cancer patients with “one stop” services.
6. Every Woman Counts will provide cervical cancer screening patients with appropriate referrals for gynecological issues detected.
7. Every Woman Counts will enroll diagnosed patients in the Breast and Cervical Cancer Treatment Program (BCCTP) and refer to community partners for treatment.

- A total of 30 African American women were screened in 2012 compared to 37 in 2011.
- 81 % of patients were screened within 18 months of their last screening.
- 89% of patients were provided with “one stop” breast services.
- 2 women served were further evaluated and treated for Cervical Cancer.
- 15 women served were diagnosed with Breast Cancer and provided with the appropriate follow-up and treatment necessary to monitor their diagnosis.

Tactic 2: Support faith communities healthy ministries through the Faith and Health Partnership (FHP) Program.

FY 09 Baseline: 16 churches in relations with FHP, reached over 6,000 members. 225 newsletters distributed and 16 health campaigns conducted. 155 health events conducted among 16 churches. 533 screenings provided; 216 were abnormal and all referred appropriately.

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. FHP programs focus on program Development will result in: <ol style="list-style-type: none"> a. An increase in the number of faith communities in Phase I-Development from 9 to 15. (current = 11 in Development phase, goal =15) b. 7 of the 2011 faith communities in Phase I-Development will advance to the Phase II-Program Growth phase (current = 16 in Program Growth phase, goal =21) c. 2 faith communities from Phase I -Development, Phase II-Program Growth and Phase III-Sustainability will advance to Phase IV-Self-sufficiency (current =1, goal = 3) d. 23 of the faith communities in Phases I-Development, Phase II-Program Growth and Phase III-Sustainability will implement Change projects (current = 15 faith communities have implemented Change projects, goal = 23) 2. Faith communities health ministry programs will become sustainable and self-sufficient as evidenced by <ol style="list-style-type: none"> a. 6 of the 11 faith communities in Phase I-Development will apply for support funds 	<ul style="list-style-type: none"> • 15 faith communities achieved Phase I. • 9 faith communities advanced from Phase I to Phase II • 4 faith communities advanced to Phase IV-Self- Sufficiency. • 15 faith communities implemented change projects in 2012. • 17 faith communities in Phase I applied for support funds. • 9 faith communities in Phase II applied for funding from other sources. • 12 faith communities in Phase III were provided with grant writing

- (current = 16 in Program Growth have applied for support funds, goal = 22)
- b. 3 faith communities in Phase II-Program Growth will report applying for funds from other sources (current in Phase III-Sustainability who have applied for funds from other sources = 3, goal = 6)
 - c. 10 of the 19 faith communities in Phase II-Program Growth and Phase III-Sustainability will be assisted in obtaining grant writing skills
 - d. 1 faith communities in Phase III-Sustainability will establish a Faith Community Nurse position (current = 6, goal = 7)
3. In 2012, faith communities will conduct health screenings to detect adverse conditions:
 - a. Three faith communities in Phase II-Program Growth will offer screening events to detect potential health risks
 - b. 16 of the 19 faith communities in Phase II-Program Growth and Phase III-Sustainability will provide FHP data related to the number of health ministry events that resulted in detection of abnormal screenings and their disposition
 4. FHP will survey faith communities in Phase II-Program Growth, Phase III –Sustainability, and Phase IV-Self Sufficiency to obtain data on the following:
 - a. The status of the health ministry to date
 - b. Health status of membership
 - c. Assets and needs of the faith community
 5. FHP will hold the following education programs:
 - a. A Faith Community Nurse certification course
 - b. Faith Community Nurses workshop to enhance his or her practice with 10 continuing education units
 - c. Two workshops for lay health ministers
 - d. Nine outreach education campaigns on health topics such as obesity, diabetes, and heart disease for faith communities, community-based organizations such as the First 5 of Contra Costa County and beauty salons
 - e. Conferences addressing Emergency Preparedness, Domestic Violence, and Mental Illness

skills

- 8 faith communities in Phase III established a Faith Community Nurse position.
-
- Five faith communities conducted health screenings.
 - 19 faith communities in Phase II-Program Growth and Phase III-Sustainability provide FHP data on their health ministry activities and events.
-
- Completed
-
- FHP offered a Faith Nurse certification course. 13 RN's attended, 4 from Contra Costa County.
 - 13 nurses from 4 from FHP churches attended CEU workshops provided by JMH.
 - FHP offered two workshops for lay health ministers: Family history 9/12, Jump for your heart May – June; 568 participants.
 - Nine outreach education campaigns were conducted that and 10,318 people were reached
 - FHP collaborated with community partners to convene the following conferences:
 - Emergency preparedness for which the American Red

- 6. In 2012 the FHP program will participate in the following community sponsored health fairs:
 - a. Unity for Community – Bay Point
 - b. Juneteenth African American Health Summit – Pittsburg
 - c. Monument Health Fair – Concord
- 7. In 2012 the FHP program will co-sponsor two events with health promotion agencies, such as the Heels N Hearts Fashion show and the Celebrity Chef cooking class in partnership with health agency partners

- Cross was the partner. 50 people attended
- Mental Illness - National Alliance for Mental Illness partner -70 people attended
- JMH participated in Unity for Community with 140 attendees.
- JMH participated in Juneteenth African American Health Summit with 123 attendees.
- JMH participated in the Monument Community Health Fair with 640 attendees.
- The Heels N Hearts fashion show held on 2/27/2012 in the Summerville Mall in collaboration with the American Heart Association.
- The fourth Annual Celebrity Chef cooking event was held on October 6 in collaboration with the American Health Association.

Tactic 3: Provide lung cancer CT screening services to people at high risk of developing lung cancer in an effort to decrease barriers to accessing appropriate and timely diagnosis and treatment of lung cancer.

FY 10 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. The Lung Cancer Screening Program will perform at least 100 CT screening exams for low income less than 200% of the Federal Poverty Level (FPL). 2. The Lung Cancer Screening Program will diversify the demographics of the population served through partnership development with community clinics, physicians and expanding the program outreach to the low income, underinsured populations. 3. The Lung Cancer Screening Program will provide scan results and recommendations within 10 working days to 95% of the participants. 4. Participants will highly rate their overall experience as a subject in the research study. 	<ul style="list-style-type: none"> ● 38 lung cancer screenings were conducted. ● Information regarding the Lung Cancer Screening Program is provided to physician offices and community agencies to increase recruitment of participant from diverse backgrounds. ● Of the participants who disclosed their demographic information, the majority identified as Caucasian, with Asians being the largest minority group to participate. ● 77% were 60 years of age or older ● <u>100%</u> of participants were provided scan results with 10 working days, up 22% from 2011. ● 86% rated their experience as “excellent” and 14% as “very good.” None of the participants rated their experience as poor, fair or good.

5. 80% of the participants will report increased knowledge and engagement in their healthcare as a result of the services provided by the Lung Cancer Screening Program.
6. Participants will report positive lifestyle changes as a result of the education and services received.
7. Participants of the Lung Cancer Screening program will receive appropriate treatment and follow-up services, which are proxies for lives saved or extended.

- 100% of participants reported increased knowledge about their health condition and 93% feel more engaged in their healthcare as a result of the education and services provided.
- 85% of participants reported that they are more likely to make lifestyle changes as a result of the education and services received.
- As a result of the screenings provided, 17 participants were recommended for follow-up care, 1 participant received a biopsy and treatment and none were diagnosed.

Seniors

Tactic 4: The Medication Assistance Program will provide low-income patients with free or low-cost medications.

FY 09 Baseline: 35 low-income Medicare patients were provided free or low-cost medications, saved patients a total of \$144,209 in medication costs

2012 Objectives

1. Medication Assistance Program will track total number of prescriptions obtained and value of medications received.
2. Medication Assistance Program will track referral sources for new program participants.
3. Medication Assistance Program will track the number of medications received per person and their value.
4. Medication Assistance Program will identify monthly income of program participants in relation to percentage of federal poverty guidelines.

Outcomes

- 57 Medicare patients who have medication costs that exceed their ability to pay were provided with 402 prescriptions valued at \$223,885.
- The top three referral sources included Senior Services (45%), Case Managers (23%), and Home Health (14%)
- 91% of the persons served obtained multiple medications.
- 53 people assisted in this program had incomes of 200% or less of the Federal Poverty Level.

Tactic 5: The Fall Prevention Program (FPP) will provide safety training and education for seniors.

FY 08 Baseline: Participated in 24 outreach events and conducted 8 presentations. 22 in-home assessments and modifications were conducted for 31 seniors

2012 Objectives

1. FPP will continue to participate in community outreach events every month to increase awareness of fall prevention to seniors, persons with disabilities and care providers.

Outcomes

- At least 824 people were served through community outreach events.
- 622 were served through educational presentations.

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| <ol style="list-style-type: none"> 2. FPP will maintain a county-wide Fall Prevention Coalition to provide information and resources that make a difference in fall prevention activities within agencies and for individuals. 3. FPP will continue to conduct home assessments and modifications for low income older adult residents of central and east Contra Costa County based on available funds. 4. Older adults who attended a FPP presentation will report that they have a greater awareness about why falls happen as reported by the post presentation survey. 5. Older adults who received a home assessment and modification will report that they are satisfied with the home improvements and recommendations. 6. Fall Prevention Coalition members will report that the meetings are useful and informative. 7. 85% of older adults who received a home assessment and modification will report that they have not fallen since the intervention. 8. Older adults who attended a FPP presentation will report increased knowledge about fall risk factors; knowledge obtained is a proxy for preventing falls and serious injuries. 9. In collaboration with In Home Support Services (IHSS) FPP will explore providing fall prevention training materials to IHSS program participants and caregivers with evaluation of the effectiveness of the materials. 10. Fall prevention materials will be provided to all MOW home delivered meals program participants with follow-up survey to determine their benefit from the information. | <ul style="list-style-type: none"> • 4 coalition meetings were held and on average 31 attendees and 29 agencies attended. Since May 2008, nearly 150 agencies have attended a quarterly coalition meeting • FPP received 219 referrals and conducted home safety assessments and modifications in 130 homes for 205 low-income older adult residents of Central and East Contra Costa County. • 95% of older adults report having a greater awareness about why falls happen and learned something new about preventing falls as a result of the presentations provided by FPP. • Older adults who received a home assessment and modification are very satisfied with the services and information received. • 73% of Coalition members report that the meetings are useful in their line of work. • 92% report that they have not fallen since the intervention. • Participating seniors reported increased knowledge about fall risk factors and learned how to get up after a fall. • Fall Prevention Trainings were provided for IHSS caregivers in West, Central and East County, a total of 25 people attended. There are not pre/post tests available from the presentations. • A 'Steps for Fall Prevention' brochure was placed in all of the billing for the Meals on Wheels routes, the brochure went out to 765 people receiving home delivered meals. |
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Tactic 7: Promote independence and enhance the quality of life of seniors through the Caring Hands Volunteer Caregivers Program.

FY 07 Baseline: 267 seniors served, 13% were seniors of color. 81% reported satisfaction with services received and 84% perceived quality of life "good" and "excellent" after participating

2012 Objectives	Outcomes
1. Caring Hands will serve 350 seniors.	<ul style="list-style-type: none"> • Caring Hands served 218 seniors.

2. Caring Hands will increase the number of Hispanic seniors served by 2 percent.
3. 85% of seniors will report increased convenience in getting to medical appointments and social interaction as a result of their involvement with Caring Hands service.
4. At least 75% of seniors who participated in Caring Hands will report their quality of life as “good” and “excellent” in the 2012 Quality of Life Survey.

- Of the seniors served, 4% were Hispanic, representing a 2% decrease from 2011.
- 70% of seniors indicated it is more convenient to get to medical appointments compared to 61% in 2011.
- 59% of seniors indicated they had enough or a lot of social interaction after participating in the program compared to 52% in 2011.
- 81% of seniors surveyed perceive their quality of life as “good” and “excellent” after participating in Caring Hands.

Tactic 8: The Senior Transportation Program (STP) will provide transportation to medical appointments for frail, isolated seniors.

FY 08 Baseline: Provided 264 on-way rides to 74 seniors

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Enable at least 140 frail, isolated, and disabled seniors get to medical appointments. 2. At least 18% of the seniors served will be Spanish speaking 3. STP will provide at least 1000 one-way assisted rides. 4. Seniors will utilize STP’s transportation services on average of 10 times per year. 5. 90% of seniors will report increased accessibility to medical services and prescription pick-up as a result of STP rides. 6. A separate STP survey will be distributed and tabulated to better assess whether patient needs are being met. 	<ul style="list-style-type: none"> • STP served 121 seniors. • 17% of senior served are Spanish speaking. • STP provided a total of 940 one-way assisted rides. • Utilization of transportation services by seniors increased. On average, each senior was given 8 rides in 2012. • The transportation services provided by STP, made getting to doctors appointments “convenient,” “somewhat convenient,” and “very convenient” for 93% of the seniors surveyed. • The transportation services has made picking up prescriptions “convenient,” to “very convenient” for 39% of seniors surveyed. Many more seniors are ordering prescriptions online. 61% reported this category as N/A. • Scheduled for completion in 2013

Tactic 9: Provide chronic care management for low income, frail elderly.

FY 09 Baseline: 268 low income seniors served. 90% of participating seniors reported that they are more knowledgeable about condition. 30 day readmit rate

for Care Transitions Intervention (CTI) patients was 6.09% and for Tel-Assurance (TA) patients it was 0%

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Continue to contact 100% of patients referred by CCHP and all other referral sources. 2. Increase the number of engaged patients by 25% in one or more of the Case Management programs (e.g. increase from 140 patients in Tel-Assurance to 175 patients) 3. Maintain 85-90% patient satisfaction scores for the Tel-Assurance and Care Transitions programs. 4. Demonstrate low hospital re-admissions for patient who participate in the TA and CTI programs as compared to patients who do not participate in these programs. 5. Define and report level of participation (patients contacted and patients engaged). 	<ul style="list-style-type: none"> • Tel-assurance Program contacted 100% of all referrals through phone calls or participation packet mailers. • A total of 445 low income patients were engaged in all programs in 2012, a 25% increase from 2011 (356). • Of the participants surveyed, an average of 89% reported high levels of satisfaction. • The 2012 readmission rate for CHF patients in Tel-Assurance increased from 2011 (11.2% to 12.5%) and was less than control group rate of 16.7%. • The 2012 readmission rate for COPD patients in Tel-Assurance increased from 2011 (6.0% to 7.7%) and was less than the control group rate of 18.2%. • 128 patients were engaged in TA. • 290 patients were engaged in CTI. • 27 patients were engaged in Case Management.

Tactic 10: Connect seniors in the Monument community with programs and services to address their safety, health and social well-being.

FY 11 Baseline: 658 older adults were referred to the MCSSO. 65 older adults were provided with individual case management services. A total of 448 referrals were made to community resources.

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. MCSSO will receive referrals from community partners and Monument Corridor residents. 2. Individual case management services will be provided to 30 isolated older adults. 3. 10 health related presentations will be provided at St. Francis Church and other community locations. 4. MCSSO will provide appropriate referrals to participating older adults 5. 85% of the older adults who have completed case management 	<ul style="list-style-type: none"> • 686 older adults were referred to MCSSO. The majority of referrals came from agencies and churches/faith communities. • 40 older adults were provided with individual case management services, exceeding the objective by 33%. • 55 presentations were conducted within the community and a total of 1085 older adults attended the presentations. • A total of 786 referrals were made to community resources. • Out of the 40 older adults who completed case management

services will have achieved 1 or more goals identified in their success plan.

6. At least 20 older adults will report involvement in neighborhood civic or community projects.
7. Participating older adults will report increased knowledge of community resources as a result of the presentations attended and education received
8. Older adults will report improved health outcomes as a result of the services received.

services (closed cases), 85% achieved 1 or more goals identified in their success plan.

- 30 older adults were involved in neighborhood civic or community projects.
- 66% of older adults reported that they are well aware or aware of community resources and can find most services compared to the 22% in the pre-test.
- According to the post-test, only 28% of older adults reported that they have an immediate health care need as compared to 38% in the pre-test.

Tactic 11: The Geriatric Care Coordination (GCC) program will enable older adults, families and caregivers to access all medical, health and community services that may assist in promoting best quality of life.

FY 07 Baseline: Received 1003 referrals, 787 referrals were from JMH providers. 90% of patients reported high satisfaction. 78% of patients reported more effectively managing activities of daily living

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Referrals to the GCC program will be 1,440 per year or greater. 2. GCC will increase the number of referrals from John Muir Health providers as measured the monthly GCC log, spreadsheet, and MIDAS reports. 3. 60% or more of patients receiving in-home assessments will have income less than 350% of Federal Poverty Guidelines. 4. Participating patients will report a satisfaction rate of 95% or higher with the overall program as measured by the patient satisfaction survey. 5. Physicians with patients who have received services from the GCC program will report high satisfaction with the overall program as measured by the most recent physician satisfaction survey. 6. Participating patients in the GCC program will report that they are more effectively using the health care system as reported by the patient satisfaction survey. 	<ul style="list-style-type: none"> • Referrals in 2012 to the GCC Program totaled 1,646 , an increase of 24%. • Referrals from John Muir Health providers for 2012 were 1339, an increase of 20 % (227 referrals). • 82% of patients receiving in home assessment, who were agreeable to disclosing their incomes, had incomes less than 350% of the Federal Poverty Guidelines. • 97% of all patients surveyed reported being very satisfied or satisfied with the GCC program. • Physicians reported a 100 % satisfaction rate. • 92% of participating patients reported that they are more effectively using the health care system as reported by the patient satisfaction survey.

7. GCC will demonstrate avoided emergency department visits, hospital admissions and readmissions for participating patients and will quantify each.

- As a result of the services provided by the GCC program, 12 hospitalizations, 11 readmissions, and 40 emergency department visits were avoided in 2012.

Tactic 12: Partner with La Clinica and CCHP/CCHS to provide cardiac outpatient education for low-income patients unable to attend a traditional cardiac rehab program.

FY 10 Baseline: Program began June 2010, 26 patients referred, 18 enrolled. 60% reported increase in fitness levels and 50% reported increase in their exercise abilities

2012 Objectives	Outcomes
<ol style="list-style-type: none"> COPE will provide secondary rehabilitation to low income patients with cardiovascular conditions. COPE will measure program adherence, percentage of patients who complete the program. Participating patients will experience increased exercise frequency, duration and/or intensity, as measured through fitness testing in the first 3 months. Participating patients will identify one change in eating behavior. Participating patients will select a 3rd risk factor (smoking, blood sugars, stress) and create a plan to implement change, with the assistance of the trainer. We will give COPE patients the opportunity to attend 8 exercise sessions in the Phase III Cardiac 	<ul style="list-style-type: none"> 30 patients were referred, 18 signed-up and 7 completed the 8 session program. 38% of patients enrolled in the program completed. 2012 data no yet obtained. No data obtained. No data obtained. 8 participants completed 8 exercise sessions.

Tactic 13: Explore frequent faller program partnership with Fall Prevention Collaborative, Meals on Wheels, AMR, CCHS and other community providers and organizations working with seniors.

FY 11 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
<ol style="list-style-type: none"> Recruit approximately 20 participants from the Fall Prevention Program of Contra Costa County to participate in the In-Home Exercise program. Recruited individuals (20 participants) will receive in-home assessments by an Occupational Therapist and home modifications by a licensed contractor. 	<ul style="list-style-type: none"> 22 participants enrolled. 18 unduplicated participants completed the program.

3. Participants will report that the program made a difference in their daily life.
4. Participants will lower their fall risk scores.

5. Participants will demonstrate increased balance and strength.

6. Participants will report an elevated level of self efficacy around fall prevention and daily activities.
7. Participants will report an increased lift in their mood.
8. Participants will continue to exercise for 30 days, 60 days and 90 days post program.

- 100% of participants reported that the program made a difference in their daily lives.
- 67% of participants had lowered FRAST Scores.
- 39% decreased their risk of falling by moving from high to medium or medium to low.
- 64% of participants showed improvement on Single Leg Stance
- 39% of participants showed increase in balance and gait as per the Tinetti tests moving between categories
- 79% of participants showed positive results around self-efficacy and daily activities.
- 72% of clients reported an increase in mood
- All nine participants of the first session report exercising 90 days after program. Eight are using the recommended exercises. All twelve of second session report exercising 90 days after program. All clients at the board report after 30 days that the program is still be making a difference in their daily life.

Youth

Tactic 14: Provide a Community Nurse in low-income schools in the Monument area of Concord and Pittsburg.

MDUSD 08-09 Baseline: Community nurse hired, 495 referrals made to community nurse resulting in 1,708 interventions. Interventions resulted in completed immunizations (49%), improved health status (46%) and positive behavior change (5%). 2 playground stencils purchased , 25 activity baskets disseminated, 7 food pyramids games given to kindergarten classrooms and 4 classrooms have incorporated nutrition education lessons once a month into their classrooms

PUSD FY 09-10 Baseline: Community nurse hired, working with 5 elementary schools. CATCH program implemented at 3 preschools, 120 students participating

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. The Community Nurse will track all referrals received and issued. 2. The Community Nurse will provide appropriate interventions for all 	<ul style="list-style-type: none"> • A total of 558 referrals were received by the Community Nurse from teachers, staff, family and students. • There was a 29% increase in the number of referrals made by the Community Nurse during the 2011-2012 school year. The increase is attributed to the continued presence of a Community Nurse in the PUSD. • The referrals /requests received and made during the 2011-2012

referrals received.

3. 100% of K, 2nd, and 5th grades will receive mandated screenings.
4. Students contacted by the Community Nurse will report resulting outcomes from the interventions received.

5. 100% of the students with missing immunizations at the start of the school year will complete their immunizations by the end of the school year.
6. Healthy nutrition and exercise will be promoted through various programs, activities, classroom lessons and parent education.
7. The Community Nurse will coordinate asthma management classes for selected students.
8. The Community Nurse will identify and develop a plan of care for identified asthmatic students in assigned schools.
9. The Community Nurse will identify and develop a plan of care for identified diabetic in assigned schools.
10. The Community Nurse will track and report on all interventions and report resulting outcomes for diabetic and asthmatic students.

school year resulted in a total of 5,223 interventions.

- As in the previous school year, the majority of interventions were concentrated in first aid (28%), notification letters (22%), and screenings (17%).
- 100% of K, 2nd and 5th graders received the mandated screenings.
- 19% of interventions resulted in behavior change.
- 25% of interventions resulted in immunizations
- The majority of interventions resulted in improved health status (62%). Improved health status includes: follow through with medical appointments, having appropriate medications and authorizations at school, obtaining eye exams and glasses, and results from first-aid and other interventions. The outcomes reported by students that pertain to improved health status are a proxy for improved attendance and ability to learn in class. Emergency department visits may also have been avoided.
- 100% of the students with missing immunizations completed their requirements by year end.

- The Community Nurse program provided 67 nutrition/obesity classes; 15 asthma classes; 5 first aid classes; 3 hygiene classes and 2 diabetes education classes for a total of 1850 participants.
- 15 asthma classes were provided.

- Completed.
- Completed.
- Completed.

Tactic 15: Reduce recidivism and retaliation by connecting victims of intentional injuries to the Beyond Violence Program.

FY 10 Baseline: JMH social workers obtained consents from 93% of eligible patients. Interventionists obtained 100% of consents from referred patients. 90% of clients remained engaged after 3 months, 69% after 6 months. 100% of clients remained alive, avoided re-injury and were not involved in a criminal incident after 3 and 6 months of participating in the program.

2012 Objectives

Outcomes

<ol style="list-style-type: none"> 1. JMH social workers will obtain signed consents from 85% of eligible patients 2. Interventionists will obtain signed consents from 75% of referred patients 3. 70% of clients will remain engaged in the program for at least 6 months 4. 90% of clients will still be alive in 6 and 12 months from the time they were enrolled in Beyond Violence. 5. 75% of clients will not have been involved in a criminal incident or re-injured in 6 and 12 months from the time they were enrolled in Beyond Violence. 	<ul style="list-style-type: none"> • 100% of eligible patients consented to participate in the program with the social workers. • 100% of eligible patients consented to participate in the program with the interventionists. • 56% of clients who were engaged after 3 months remain engaged at 6 months • Of those still engaged 100% remain alive and avoided re-injury at the 6 month follow-up. • Of those engaged 100% were not involved in a criminal incident at the 6 month follow-up.
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Tactic 16: The Teen Pregnancy Resource Program will provide childbirth preparation for pregnant teens.
 FY 08 Baseline: 9 participating sites and 26 teen participants. 2 out of 5 classes had 100% completion rates. 100% teens had full term birth without complications and 88% were still breastfeeding one month after delivery

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Teen Pregnancy Resource Program will maintain relationships with current participating sites. 2. Teen Pregnancy Resource Program will maintain the number of teen participants. 3. Teen Pregnancy Resource Program will provide comprehensive prenatal and parenting educational classes to participating teens from Central and East Contra Costa County. 4. The teen participants will report increased knowledge as a result of their participation in the classes offered. 5. The teen participants will report high levels of satisfaction with the services offered by the Teen Pregnancy Resource Program. 6. 80% of teen participants will deliver at full term without complications 7. 80% of teen participants will report that they are breastfeeding 3 week after delivery. 	<ul style="list-style-type: none"> • A total of 58 community organizations and physicians offices were identified as participating sites; an increase of 7 sites from the previous year. • 41 participants enrolled in classes. • Participants enrolled in one or more of the following classes: Online Childbirth, Convenience Childbirth, Infant Breastfeeding, Newborn Care, Infant and Child CPR and Safety, Car Seat and Safety Check. • Pre and post tests indicate significant increases in knowledge as a result of participation in the classes offered. • Of participant respondents, 100% of the teens found the program to be very valuable. • Of those who have delivered, 100% delivered full tern without complications. • Of those who have delivered, 100% were breastfeeding after 3

weeks with no one requiring lactation support.

Tactic 17: Create healthy food and activity environments in neighborhoods and organizations that support children 0-5 and their families through the collaborative work of Healthy and Active Before Five (HAB45).

FY 10 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
<ol style="list-style-type: none">1. Convene at least 2 collaborative membership meetings to inspire progress among local organizations serving young children in Contra Costa in implementing the action plan and policy agenda.2. Demonstrate measurable change in 10 Contra Costa organizational programs, policies, practices and partnerships that impact rates of obesity for young children in Contra Costa.3. Provide technical assistance to 10 community partners in efforts to promote healthy changes in organizational practices. Include technical assistance to John Muir Nutritional Services resulting 2 practice policy changes around catering practices for department/physician meetings.4. Present conference sessions about the Healthy and Active Before 5 collaborative to at least 3 interested professional groups working with John Muir Health, such as medical staff, administrative leadership committee or nursing administration.5. Build collaboration among HAB45, John Muir and community partners that results in 3 local agencies or businesses adopting practices, policies and/or creating lactation spaces consistent with HAB45's breastfeeding-friendly standards. Implement breastfeeding-friendly standards into JMH policy for lactation accommodation.	<ul style="list-style-type: none">• One collaborative meeting was held in addition to a presentation on HAB45 work at American Public Health Association Annual Conference in San Francisco.• HAB45 inspired 10 Contra Costa agencies to consider new healthy food and/or beverage policies. Seven agencies formally adopted policies and others are still implementing.• HAB45 helped implement 17 organizational policy at local agencies.• 10 organizations were provided with technical assistance on a reoccurring basis. • 2 conference sessions were presented to John Muir nutritional services management and nursing administration. • Concord WIC office is now pilot testing 2 new programs in breastfeeding accommodation• WIC sponsored a breastfeeding tent at the Monument Community "Health Carnival"• HAB45 helped to train over 100 physicians and community health workers in breastfeeding support using JMH coaches.

Tactic 18: Support Foster A Dream which provides bridge services and mentoring opportunities for foster youth who are transitioning to emancipation.

FY 08 Baseline: 400 backpacks filled and distributed. 3 career related workshops conducted and 62 youth participated. 5 mentors and 2 board members recruited. 1 foster youth awarded "Dare to Dream" academic scholarship

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Fill and distribute 500 backpacks 2. Foster youth will be supported in their transition to emancipation by participating in Get Set programs 3. Foster A Dream will expand mentor and volunteer capacity by recruiting new volunteers 4. Foster A Dream will expand overall mentoring program to include “Foster Link” 5. Youth who participated in the John Muir career day will report increased awareness of career opportunities. 6. Award a foster youth with a “Dare to Dream” Academic scholarship 7. 50% of the foster youth that participate in Get Set will have their identified goals met 	<ul style="list-style-type: none"> • 2,329 backpacks were donated to Foster A Dream; 966 of those backpacks came from JMH. • 12 youth participated in the Get Set Program; this was an increase from last year of 8 due to need and interest, there were 4 additional spots that were created to increase program participation. • Staff volunteers increased by 45% and mentorship participation increased by 64%. • Unable to reach an agreement with Contra Costa County on foster link. • 20 female foster youth participated in the JMH Young Women’s Empowerment Day; no data reported on increased knowledge. • Scholarship awarded. • 12 foster youth between the ages of 16 to 18 participated in the two week Get Set camps. All youth identified goals.

Coordination

Tactic 19: Support the Monument Community Partnership (MCP).
 FY 07 Baseline: Over 1,081 residents participated in education programs. 9,703 residents served in via health service network. 80 residents recruited to become community leaders. MCP partnered with 43 agencies

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Train 500 residents in economic development programs (day labor, technology and career development). 2. Provide free VITA income tax services for at least 300 local low-income residents. 3. Establish and implement a Board approved resident engagement strategy. 4. Rebuild Neighborhood Action Teams (NATs) with regular participation of at least 12 new Monument residents. 	<ul style="list-style-type: none"> • 525 residents were trained in economic development programs. (Technology – 254; Day Labor – 91, with 73 men and 18 women; Career Development – 180) • 381 families were served in 2012, by 25 volunteers at 2 sites • This objective was not met in 2012 due to the time-consuming merger process and integration of programs. • 2 new residents became leaders and certified Zumba instructors. • 3 new youth leaders have emerged from Go Get It, an afterschool mentoring and tutoring college bound program.

<ol style="list-style-type: none"> 5. Provide case management, referral and follow-up services to at least 100 residents. 6. Strategize product placement with at least 6 local grocery stores or minimarkets to promote healthier food choices. 7. Actively engage 350 local residents in learning about healthy lifestyles and relationships. 8. Implement training for 40 Monument First parents in ESL, technology, work readiness and related skills. 	<ul style="list-style-type: none"> • 25 parents volunteer to “drive” the Meadow Homes Walking School Bus. • 15 residents participated in a walkability audit addressing needs along Detroit Avenue near Meadow Homes school. • Served 476 participants looking for resources and specific services from housing to legal help. • This objective has not been met because of staffing changes and because we were not able to develop relationships with markets to the degree necessary. It was then decided - along with one of our partners (Wellness City Challenge) - that it would be better to focus first on training restaurants in becoming “healthy.” • 520 residents were engaged in learning about healthy lifestyles and relationships. • 30 residents will complete an ESL or asset building class.
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Tactic 20: Connect homeless patients discharged from hospital to Respite Care Center.

FY 10 Baseline: 69 homeless patients were identified as requiring transitional housing and 32 were placed in Respite Care Center

2012 Objectives	Outcomes
<ol style="list-style-type: none"> 1. 40% of patients referred will be admitted to respite 2. The Respite Center will decrease the hospital length of stay for eligible patients 	<ul style="list-style-type: none"> • 33% of JMH referred patients were admitted to respite. For all referring organizations, 26% of referred patients were admitted. • It is estimated that for every patient admitted to the Respite Center, 4 acute hospital days are saved. Therefore, the total admitted patients (132) avoided 528 hospital days.

The Community Health Fund

In addition to the programs listed, the Community Health Fund is integral in expanding and enhancing the health care services for those who need them most in Contra Costa County. The Community Health Fund distributes grants to community based, non-profit organizations who serve uninsured and under-served populations.

The Community Health Fund' distributes that money through a unique process that nurtures long-term partnerships with and among community-based nonprofits, and which results in sustainable health initiatives and systemic change. Many programs that receive their start from the Community Health Fund continue long past the grant periods and to this day deliver critical health care services. Consequently, many thousands of Contra Costa residents who might have slipped through the cracks in our health care system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support services for conditions that range from cancer and chronic disease through dental caries and mental illness. It is the Community Health Fund's mission to deliver the same kinds of results to the many in Central and East Contra Costa who still struggle to find adequate care.

Attachment F – 2013 Community Benefit Plan

1. 2013 John Muir Health Community Benefit Plan
2. 2013 John Muir Behavioral Health Community Benefit Plan

Attachment F – 2013 Community Benefit Plan
1.2013 John Muir Health Community
Benefit Plan

John Muir Health 2013 Community Benefit Plan

Healthy Community Vision: All residents achieve and maintain optimal physical and mental health. Children succeed in school and reach their full potential. Residents are economically independent and have access to adequate, affordable housing. Neighborhoods are safe. Violence, discrimination and in justice are eliminated. The air and water are clean. Residents are politically, socially and culturally active.

- Goal 1: To improve access to health care for low income residents**
Goal 2: To have measurable impact on the health of the community

Strategy 1: Increase direct care, charity care and subsidized care

Tactic 1: Provide low risk outpatient surgery through Operation Access.

FY 07 Baseline: 16 surgical services provided by JMH to predominately Latino patients (87%). 100% of patients reported improved health after surgical procedure

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Increase the number of surgical services provided by JMH by 10 percent in 2013. 2. JMH will add at least three physician volunteers to OA providers 3. Operation Access will provide surgical services to underrepresented minority patients in Contra Costa County. 4. Contra Costa patients will report high levels of satisfaction with the surgical services offered by Operation Access. 5. Contra Costa patients will report improved quality of life as reported by patient surveys 	<ul style="list-style-type: none"> • • • • •

Tactic 2: Provide specialty care to low-income, uninsured patients referred by community clinics.

FY 11 Baseline: 12 accepted referrals of patients in need of specialty care with 91% indicated Spanish as a preferred language. 38 specialists were recruited, in addition to hospital based physician groups.

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Recruit specialists to participate in the program as needed to meet the needs of the referred patients. 	<ul style="list-style-type: none"> •

2. Provide specialty charity care as budgeted.
3. Enroll patients in Medi-Cal that are diagnosed with condition requiring long-term care
4. Provide outcomes including # of cases, services provided, patient clinical outcomes, and satisfaction surveys

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Tactic 3: Provide primary care via the Mobile Health Clinic for the uninsured in Brentwood and Far East County on Saturdays.

FY 07 Baseline: Served 260 patients through the Saturday Clinic. 17% of patients presented with an urgent health need and 8% reported that they would have gone to the ED if the MHC was unavailable

2013 Objectives	Outcomes
1. The Mobile Health Clinic will serve at least 600 patients in the 2013 Saturday clinic.	•
2. The Mobile Health Clinic will provide patients with referrals for ongoing primary medical care.	•
3. The Mobile Health Clinic will maintain high levels of patient satisfaction.	•
4. The Mobile Health Clinic will reduce the number of avoidable Emergency Department visits.	•
5. The Mobile Health Clinic will serve at least 2700 patients thru partnerships.	•
6. The Mobile Health Clinic will participate in the JMH diabetes steering committee to develop diabetes education and care for the vulnerable populations.	•

Tactic 4: The Mobile Dental Clinic will provide preventative and restorative dental care for underserved children.

FY 07 Baseline: Provided oral health services to 466 children and enrollment assistance to 53 families. A total of 875 patient visits. 63% of the patients seen were connected to a dental home. 100% of patients reported high levels of quality and satisfaction with the services offered. 58% of the patients seen at the Mobile Dental Clinic previously had no access to dental care.

2013 Objectives	Outcomes
1. The Mobile Dental Clinic will provide oral health services to a minimum of 600 children.	•
2. The Mobile Dental Clinic will provide enrollment assistance to eligible patients.	•

- 3. The Mobile Dental Clinic will identify and establish a dental home for patients.
- 4. The Mobile Dental Clinic will maintain high levels of patient satisfaction.
- 5. The Mobile Dental Clinic will have increased access to dental care.

Tactic 6: Support Concord RotaCare Free Clinic.

FY 10 Baseline: 14 Clinics have been held and 258 patient served

2013 Objectives	Outcomes
1. Provide drivers for Rotocare Mobile Clinic to support evening clinics	•
2. Provide storage space for Rotocare Mobile Clinic	•
3. Provide lab and X-Ray services at discounted rates	•
4. Provide technical assistance as requested	•

Strategy 2: Increase access to care through enrollment programs

Tactic 1: Support East County efforts to increase access to primary care.

FY 10 Baseline: A Health Access Enrollment Manager was hired

2013 Objectives	Outcomes
1. Continue to work with East and Central County Access Action Team and East and Central County provider CEOs to develop collaborative programs to increase access to care	•

Tactic 2: Implement JMCC ED Referral Liaison Program to connect the uninsured to a medical home and other support services.

FY 09 Baseline: The ED Referral Liaison contacted 6,509 eligible patients and issued 6,793 referrals; a referral rate of 93%. 80% of patients referred reported a successful follow-up outcome and only 0.8% revisited the ED in less than 3 months for a non-urgent reason

2013 Objectives	Outcomes
1. Continue to identify and contact patients with no primary care physician or insurance who present at the ED for non-urgent	•

<p>reasons</p> <ol style="list-style-type: none"> 2. Provide contacted patients with appropriate health services, insurance assistance and community referral. 3. Maintain a referral rate of 70% 4. Revisit rates of patients who return to the ED for non urgent reasons in less than 3 months, 6 months and 12 months from the time of their last visit will remain below 1% 5. At least 70% of patients who were issued a referral will report successful follow-up outcomes 6. Collaborate and integrate where feasible with Complex Community Care Coordination program and case management departments in the ED to eliminate duplication. 	<ul style="list-style-type: none"> • • • • •
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Tactic 3: Reduce avoidable ED visits and hospitalizations for frequent users through the Complex Community Care Coordination program.
 FY 11 Baseline: Dedicated to program planning

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Identify 30-40 high risk frequent users to JMH. 2. The active New Directions clients will be transitioned to the CCCC program. 3. The frequent users will report better outcomes related to healthcare, housing, transportation, mental health, substance abuse, and employment. 4. Avoidable admissions and inpatient days will decrease for frequent users 5. ED visits for the identified frequent users will decrease within the first 6 months after they are enrolled and engaged in the program. 6. Develop the following metrics: # of potential patients, # ED visits, # successful referrals, and costs associated with each patient success. 	<ul style="list-style-type: none"> • • • • • •

Strategy 3: Support prevention, early diagnosis and early intervention

Screening

Tactic 1: Every Woman Counts Programs will provide free breast and cervical cancer screenings for low income women 25 years of age or older for cervical cancer and 40 years of age or older for breast cancer screening

FY 07 Baseline for Breast Cancer Screening: Served 350 women; 67% were Hispanic and 4% were African American. 92% returned for rescreening in 18 months. 89% of patients provided with “one stop” services

FY 11 Baseline for Cervical Cancer Screening: Served 19 women;

2013 Objectives	Outcomes
1. Every Woman Counts will continue to have breast and cervical cancer screening clinics.	•
2. Every Woman Counts will continue with a volume of over 450 patient screenings.	•
3. Every Woman Counts will continue to support efforts to diversify the demographics of the patient population through expanded service reach.	•
4. Every Woman Counts will continue to support screening African American women above the CDP’s statistics of 3% for breast and 2% for cervical through outreach efforts.	•
5. Within 18 months of their initial screening date, 80 percent of returning breast cancer screening patients will be re-screened.	•
6. Every Woman Counts will provide 90 percent of breast cancer patients with “one stop” services.	•
7. Every Woman Counts will provide cervical cancer screening patients with appropriate referrals for gynecological issues detected.	•
8. Every Woman Counts will enroll diagnosed patients in the Breast and Cervical Cancer Treatment Program (BCCTP) and refer to community partners for treatment.	•

Tactic 2: Support faith communities healthy ministries through the Faith and Health Partnership (FHP) Program.

FY 09 Baseline: 16 churches in relations with FHP, reached over 6,000 members. 225 newsletters distributed and 16 health campaigns conducted. 155 health events conducted among 16 churches. 533 screenings provided; 216 were abnormal and all referred appropriately.

2013 Objectives	Outcomes
1. Develop a mechanism for obtaining input from stakeholders in JMH, the community, and health agencies to assist in the development of	•

outreach plans to address the health issues Eastern Contra Costa County vulnerable populations by:

- a. Establish an advisory board comprised of John Muir Health clinicians, medical directors, and service line representatives to provide guidance with program plan and service delivery.
Completion date: June 1, 2013
- b. Convene the community health agency committee to establish a work plan for collaborative in 2013 to address the health disparities in Central and Eastern Contra Costa County.
Completion date: March 15, 2013
- c. Convene the community advisory board comprised of community-based organization, faith based, and service group leaders to provide guidance with program plan development.
Completion date: June 1, 2013

2. FHP will enlist JMH staff to provide education on health topics and conduct health screenings to detect adverse health conditions in the community in collaboration with community based organizations, faith community organization, and services groups in central and eastern Contra Costa County.
 - a. Community screening events
 - i. Unity for Community – Bay Point
 - ii. African American Health Expo Sept
 - iii. Monument Health Fair – Concord Oct 6, 2013
 - b. Co-sponsor health promotion events with health agencies and community partners to provide the community based organizations, faith community organization and services groups.
 - i. Shop, Stop, and Stroll
 - ii. Mental health conference
 - iii. Abundant Life “Gathering”
 - iv. Celebrity cooking event
 - c. Conduct seven outreach education campaigns on health topics such as obesity, diabetes, and heart disease for faith communities, community-based organizations.
 - d. Convene conferences addressing areas that negatively affect the health of East Contra Costa County residents in partnership with faith based, community based organization, and health agency as identified on the community needs assessment.
Example: Faith Community Nurse Foundations course, Emergency Preparedness, Domestic Violence, and Mental Illness
3. Pilot an intervention in partnership with the Concord Emergency referral program staff to reduce recidivism by establishing a relationship between the faith-based communities to serve as a referral and intervention source for the resident of their community.

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Tactic 3: Provide lung cancer CT screening services to people at high risk of developing lung cancer in an effort to decrease barriers to accessing appropriate and timely diagnosis and treatment of lung cancer.

FY 10 Baseline: Dedicated to program planning

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. The Lung Cancer Screening Program will perform at least 100 CT screening exams. 2. The Lung Cancer Screening Program will provide screenings to low income participants with incomes less than 200% of the Federal Poverty Level (FPL). 3. The Lung Cancer Screening Program will diversify the demographics of the population served through partnership development with community clinics, physicians and expanding the program reach to the low income, underinsured populations. 4. The Lung Cancer Screening Program will provide scan results and recommendations within 10 working days to 100% of the participants. 5. Participants will highly rate their overall experience as a subject in the research study. 6. 80% of the participants will report increased knowledge and engagement in their healthcare as a result of the services provided by the Lung Cancer Screening Program. 7. Participants will report positive lifestyle changes as a result of the education and services received. 8. Participants of the Lung Cancer Screening program will receive appropriate treatment and follow-up services, which are proxies for lives saved or extended. 	<ul style="list-style-type: none"> • • • • • • • •

Seniors

Tactic 4: The Medication Assistance Program will provide low-income patients with free or low-cost medications.
 FY 09 Baseline: 35 low-income Medicare patients were provided free or low-cost medications, saved patients a total of \$144,209 in medication costs

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Medication Assistance Program will track total number of prescriptions obtained and value of medications received. 2. Medication Assistance Program tracked the number of medications received per person and their value. 3. Medication Assistance Program identified monthly income of program participants in relation to percentage of federal poverty 	<ul style="list-style-type: none"> • • •

- guidelines.
4. Medication Assistance Program tracked referral sources for new program participants.

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Tactic 5: The Fall Prevention Program (FPP) will provide safety training and education for seniors.

FY 08 Baseline: Participated in 24 outreach events and conducted 8 presentations. 22 in-home assessments and modifications were conducted for 31 seniors

2013 Objectives	Outcomes
1. FPP will continue to participate in community outreach events every month to increase awareness of fall prevention to seniors, persons with disabilities and care providers.	•
2. FPP will maintain a county-wide Fall Prevention Coalition to provide information and resources that make a difference in fall prevention activities within agencies and for individuals.	•
3. FPP will continue to conduct home assessments and modifications for low income older adult residents of central and east Contra Costa County based on available funds.	•
4. Older adults who attended a FPP presentation will report that they have a greater awareness about why falls happen as reported by the post presentation survey.	•
5. Older adults who received a home assessment and modification will report that they are satisfied with the home improvements and recommendations.	•
6. Fall Prevention Coalition members will report that the meetings are useful and informative.	•
7. 85% of older adults who received a home assessment and modification will report that they have not fallen since the intervention.	•
8. Older adults who attended a FPP presentation will report increased knowledge about fall risk factors; knowledge obtained is a proxy for preventing falls and serious injuries.	•
9. Fall prevention materials will be provided to all MOW home delivered meals program participants with follow-up survey to determine their benefit from the information.	•

Tactic 7: Promote independence and enhance the quality of life of seniors through the Caring Hands Volunteer Caregivers

Program.

FY 07 Baseline: 267 seniors served, 13% were seniors of color. 81% reported satisfaction with services received and 84% perceived quality of life “good” and “excellent” after participating

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Caring Hands will serve 325 seniors. 2. Caring Hands will be stable with the number of Hispanic seniors served. They will not refused any new Spanish speaking seniors. 3. 85% of seniors will report increased convenience in getting to medical appoints and social interaction as a result of their involvement with Caring Hands service. 4. At least 80% of seniors who participated in Caring Hands will report their quality of life as “good” and “excellent” in the 2013 Quality of Life Survey. 5. Develop program plan for serving seniors in the East county. 	<ul style="list-style-type: none"> • • • • •

Tactic 8: The Senior Transportation Program (STP) will provide transportation to medical appointments for frail, isolated seniors.

FY 08 Baseline: Provided 264 on-way rides to 74 seniors

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Enable at least 130 frail, isolated, and disabled seniors get to medical appointments. 2. At least 18% of the seniors served will be Spanish speaking 3. STP will provide at least 950 one-way assisted rides. 4. Seniors will utilize STP’s transportation services on average of 8 times per year. 5. 90% of seniors will report increased accessibility to medical services and prescription pick-up as a result of STP rides. 6. A separate STP survey will be distributed and tabulated to better assess whether patient needs are being met. 	<ul style="list-style-type: none"> • • • • • •

Tactic 9: Provide chronic care management for low income, frail elderly.

FY 09 Baseline: 268 low income seniors served. 90% of participating seniors reported that they are more knowledgeable about condition. 30 day readmit rate

for Care Transitions Intervention (CTI) patients was 6.09% and for Tel-Assurance (TA) patients it was 0%

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Continue to contact 100% of patients referred by CCHP and all other referral sources. 2. Increase the number of engaged patients by 25% in one or more of the Case Management programs (e.g. increase from 140 patients in Tel-Assurance to 175 patients) 3. Maintain 85-90% patient satisfaction scores for the Tel-Assurance and Care Transitions programs. 4. Demonstrate low hospital re-admissions for patient who participate in the TA and CTI programs as compared to patients who do not participate in these programs. 5. Define and report level of participation: 1) Patients contacted, 2) Patients engaged 	<ul style="list-style-type: none"> • • • • •

Tactic 10: Connect seniors in the Monument community with programs and services to address their safety, health and social well-being.

FY 11 Baseline: 658 older adults were referred to the MCSSO. 65 older adults were provided with individual case management services. A total of 448 referrals were made to community resources.

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. MCSSO will accept program participants from Monument Community partners, faith based communities, Monument Community residents, and older adults who participate in Monument Community activities. 2. Individual case management services will be provided to 30 isolated older adults. 3. Ten health related presentations will be provided at St. Francis Church and other community locations. 4. MCSSO will provide appropriate referrals to participating older adults 5. 85% of the older adults who have completed case management services will have achieved 1 or more goals identified in their success plan. 6. At least 20 older adults will report involvement in neighborhood civic or community projects. 	<ul style="list-style-type: none"> • • • • • •

- 7. Participating older adults will report increased knowledge of community resources as a result of the presentations attended and education received
- 8. Older adults will report improved health outcomes as a result of the services received.
- 9. Older adults will report increased hope for the future as a result of the services received.

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Tactic 11: The Geriatric Care Coordination (GCC) program will enable older adults, families and caregivers to access all medical, health and community services that may assist in promoting best quality of life.

FY 07 Baseline: Received 1003 referrals, 787 referrals were from JMH providers. 90% of patients reported high satisfaction. 78% of patients reported more effectively managing activities of daily living

2013 Objectives	Outcomes
<ul style="list-style-type: none"> 1. Referrals to the GCC program will be 1,772 per year or greater. 2. GCC will increase the number of referrals from John Muir Health providers as measured the monthly GCC log, spreadsheet, and MIDAS reports. 3. 55% or more of patients receiving in-home assessments will have income of 200% of Federal Poverty Guidelines or less. 4. Participating patients will report a satisfaction rate of 95% or higher with the overall program as measured by the patient satisfaction survey. 5. Physicians with patients who have received services from the GCC program will report high satisfaction with the overall program as measured by the most recent physician satisfaction survey. 6. Participating patients in the GCC program will report that they are more effectively using the health care system as reported by the patient satisfaction survey. 7. GCC will demonstrate avoided emergency department visits, hospital admissions and readmissions for participating patients and will quantify each. 	<ul style="list-style-type: none"> • • • • • • •

Tactic 12: Partner with La Clinica and CCHP/CCHS to provide cardiac outpatient education for low-income patients unable to attend a traditional cardiac rehab program.

FY 10 Baseline: Program began June 2010, 26 patients referred, 18 enrolled. 60% reported increase in fitness levels and 50% reported increase in their

exercise abilities

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. Present three nutrition education modules to the patients at their 3rd, 5th, and 7th visit. This will include education, motivational techniques, and specific goals for each individual. 2. Implement patient satisfaction and outcome survey. 3. Provide secondary rehabilitation to low income patients with cardiovascular conditions. 4. Measure program adherence, percentage of patients who complete the program. 5. Participating patients will experience increased exercise frequency, duration and/or intensity, as measured through fitness testing in the first 3 months. 6. Participating patients will identify one change in eating behavior. 7. Participating patients will select a 3rd risk factor (smoking, blood sugars, stress) and create a plan to implement change, with the assistance of the trainer. 	<ul style="list-style-type: none"> • • • • • • •

Tactic 13: Provide an intensive/in-home exercise program targeting seniors who are most vulnerable to falling in their home

FY 12 Baseline: 22 enrolled, 18 unduplicated participants completed the program. 100% of participants reported that the program made a difference in their daily lives. 67% of participants had lowered FRAST Scores. 74% decreased times indicating decreased fall risk. 79% of participants showed positive results around self efficacy and daily activities. 72% of clients reported an increase in mood-a decrease of mood scale results

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. The FPP IHEP will serve approximately 32 participants from the Fall Prevention Program of Contra Costa County to participate in the In-Home Exercise program. 2. The FPP IHEP 32 people will receive in-home assessments by an Occupational Therapist and home modifications by a licensed contractor. 3. Participants will report that the program made a difference in their daily life. 4. Participants will lower their fall risk scores. 5. Participants will demonstrate increased balance and strength. 6. Participants will report an elevated level of self efficacy around fall 	<ul style="list-style-type: none"> • • • • • •

- prevention and daily activities.
- 7. Participants will report an increased lift in their mood.

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Youth

Tactic 14: Provide a Community Nurse in low-income schools in the Monument area of Concord and Pittsburg.

MDUSD 08-09 Baseline: Community nurse hired, 495 referrals made to community nurse resulting in 1,708 interventions. Interventions resulted in completed immunizations (49%), improved health status (46%) and positive behavior change (5%). 2 playground stencils purchased , 25 activity baskets disseminated, 7 food pyramids games given to kindergarten classrooms and 4 classrooms have incorporated nutrition education lessons once a month into their classrooms

PUSD FY 09-10 Baseline: Community nurse hired, working with 5 elementary schools. CATCH program implemented at 3 preschools, 120 students participating

2013 Objectives for MDUSD	Outcomes
1. The Community Nurse will track all referrals received and issued.	•
2. The Community Nurse will provide appropriate interventions for all referrals received.	•
3. 100% of K, 2 nd , and 5 th grades will receive mandated screenings.	•
4. Students contacted by the Community Nurse will report resulting outcomes from the interventions received.	•
5. 100% of the students with missing immunizations at the start of the school year will complete their immunizations by the end of the school year.	•
6. Healthy nutrition and exercise will be promoted through various programs, activities, classroom lessons and parent education.	•

2013 Objectives for PUSD	Outcomes
1. The Community Nurse will track all referrals received and issued.	•
2. The Community Nurse will identify and develop a plan of care for all diabetic students in assigned schools.	•
3. The Community Nurse will identify and develop a plan of care for identified asthmatic students in assigned schools.	•
4. The Community Nurse will track and report on all interventions and report resulting outcomes for diabetic and asthmatic students.	•
5. The Community Nurse will coordinate asthma management classes for selected students.	•

6. Healthy nutrition and exercise will be promoted through various programs, activities, classroom lessons and parent education.

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Tactic 15: Reduce recidivism and retaliation by connecting victims of intentional injuries to the Beyond Violence Program.

FY 10 Baseline: JMH social workers obtained consents from 93% of eligible patients. Interventionists obtained 100% of consents from referred patients. 90% of clients remained engaged after 3 months, 69% after 6 months. 100% of clients remained alive, avoided re-injury and were not involved in a criminal incident after 3 and 6 months of participating in the program.

2013 Objectives	Outcomes
1. JMH social workers will obtain signed consents from 85% of eligible patients	•
2. Interventionists will obtain signed consents from 75% of referred patients	•
3. 70% of clients will remain engaged in the program for at least 6 months	•
4. 90% of clients will still be alive in 6 and 12 months from the time they were enrolled in Beyond Violence.	•
5. 75% of clients will not have been involved in a criminal incident or re-injured in 6 and 12 months from the time they were enrolled in Beyond Violence.	•
6. 70% of clients will have received assistance preparing or completing documentation for legal or health services such as DMV related issues, Victim of Crime funds, or Medi-Cal.	•
7. 70% of clients will have pursued one or more of the following life enhancement activities: <ul style="list-style-type: none"> a. enrolled/re-enrolled in school (including traditional middle/high schools, alternative schools, college, and home school/independent study) b. participated in an educational support program (includes tutoring & GED preparation) c. received employment assistance d. got a job e. received legal advocacy f. received mental health counseling g. received assistance with health care services h. completed probation 	•

8. Implement tracking of community capacity building and other community engagement activities.

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Tactic 16: The Teen Pregnancy Resource Program will provide childbirth preparation for pregnant teens.

FY 08 Baseline: 9 participating sites and 26 teen participants. 2 out of 5 classes had 100% completion rates. 100% teens had full term birth without complications and 88% were still breastfeeding one month after delivery

2013 Objectives	Outcomes
1. Teen Pregnancy Resource Program will maintain relationships with current participating sites	•
2. Teen Pregnancy Resource Program will continue contacting and registering teen participants.	•
3. Teen Pregnancy Resource Program will provide comprehensive prenatal and parenting educational classes to participating teens from Central and East Contra Costa County.	•
4. The teen participants will report increased knowledge as a result of their participation in the classes offered.	•
5. The teen participants will report high levels of satisfaction with the services offered by the Teen Pregnancy Resource Program.	•
6. 80% of teen participants will deliver at full term without complications	•
7. 80% of teen participants will report that they are breastfeeding 1 week after delivery.	•

Tactic 17: Create healthy food and activity environments in neighborhoods and organizations that support children 0-5 and their families through the collaborative work of Healthy and Active Before Five (HAB45).

FY 10 Baseline: Dedicated to program planning

2013 Objectives	Outcomes
1. Inspire 10 Contra Costa agencies to adopt a new healthy food and/or beverage policy, practice and/or partnership that impacts rates of obesity for young children in Contra Costa.	•
2. Convene at least 2 collaborative membership meetings to inspire progress among local organizations serving young children in Contra Costa in implementing the action plan and policy agenda.	•
3. Provide technical assistance to 10 community partners in efforts to	•

promote healthy changes in organizational practices. Offer technical assistance to John Muir Nutritional Services in encouraging healthy foods offered at standing meetings within the organization.

4. Build collaboration among HAB45, John Muir and community partners that results in 3 local agencies or businesses adopting practices, policies and/or creating lactation spaces consistent with HAB45's breastfeeding-friendly standards.
5. Build collaboration among HAB45 and community partners to develop educational strategies and materials which support healthy beverages in agency "food environments." To promote the consumption of water as an alternative to sugary drinks, disseminate to community partners.

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Tactic 18: Support Foster A Dream which provides bridge services and mentoring opportunities for foster youth who are transitioning to emancipation.

FY 08 Baseline: 400 backpacks filled and distributed. 3 career related workshops conducted and 62 youth participated. 5 mentors and 2 board members recruited. 1 foster youth awarded "Dare to Dream" academic scholarship

2013 Objectives	Outcomes
1. Fill and distribute 500 backpacks.	•
2. Foster youth will be supported in their transition to emancipation by participating in Get Set programs.	•
3. 50% of the foster youth that participate in Get Started will have their identified goals met.	•
4. Foster A Dream will expand mentor and volunteer capacity by recruiting new volunteers.	•
5. Foster a dream will expand the overall mentoring program.	•
6. Award a foster youth with a "Dare to Dream" Academic scholarship.	•
7. Explore and provide, where feasible, health related services to youth such as screenings, educational seminars and job shadowing opportunities.	•

Coordination

Tactic 19: Support the Monument Community Partnership (MCP).

FY 07 Baseline: Over 1,081 residents participated in education programs. 9,703 residents served in via health service network. 80 residents recruited to become community leaders. MCP partnered with 43 agencies

2013 Objectives	Outcomes
1. Carry out a comprehensive process to implement a new brand, key messages, name and visual identity for the merged organization.	•
2. Develop and implement a thorough communication strategy for the organization that takes into account both internal and external communications with all key stakeholders.	•
3. Develop integrated organizational, programmatic and staff performance plans that ensure accountability, alignment and efficiency.	•
4. Develop metrics and data tracking in line with performance plans for regular, ongoing evaluation.	•
5. Train 500 residents in economic development programs (day labor, technology and career development). a. 100 residents will secure permanent employment. b. 250 residents will utilize at least 2 services of MCP or one of our partners. c. At least 50 residents will receive occupational health and safety training.	•
6. Provide free VITA income tax services for at least 350 local low-income residents. a. At least 5 new volunteers will be trained to provide income tax support for residents. b. VITA tax services will impact the local economy by returning at least \$350,000 to clients.	•
8. Provide job related case management services to at least 60 residents a. At least 30 clients will also receive ESL instruction b. At least 10 job seekers will be placed in a local business internship/work experience opportunity.	•

9. Establish and implement a Board approved resident engagement strategy.
 - a. At least 20 resident representatives and 2 partner organization representatives will provide valuable input.
 - b. Implementation activities and evaluation methods will be developed.
10. Provide leadership training and/or coaching to at least 30 resident leaders.
 - a. 10 new residents will emerge as leaders.
 - b. Identify and support 30 or more additional residents as active leaders (using their skills to benefit the community) working in collaboration with others
 - c. The development of community leaders and promotores will be celebrated and measured.
11. Provide resource, referral and follow-up services to at least 75 drop in residents.
 - a. At least 50 residents will access local resources and report a positive impact on their lives.
 - b. Resources will be kept current through partnerships and participation in the area Service Network.
12. Provide health information, resources and support to at least 1,200 community residents
 - a. Serve as the lead agency for organizing and publicizing the Monument Community Health Fair
 - b. Work closely with health promoters in providing health education to at least 90 residents
 - c. Put forth direct efforts that result in 40 or more residents registering or renewing at La Clinica
13. Serve as lead agency to promote healthy eating in the Monument HEAL Zone.
 - a. Educate parents, coaches and schools about healthy beverage choices
 - b. Lead a promotional campaign to encourage water consumption

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- and decrease sugar sweetened beverage consumption.
- c. Encourage and facilitate the development of a Healthy Restaurant Association with at least 4 member restaurants
- d. Provide training and guidance to at least 6 resident community promoters in offering and promoting healthy cooking classes.
- 14. Serve as lead agency to promote active living and safe exercise.
 - a. Implement identified physical activity at 4 or more apartment complexes or other institutions, engaging at least 200 unduplicated residents in identifiable physical activity.
 - b. Complete a walk audit and follow up report of an area surrounding an elementary school in the Monument.
 - c. Review and help initiate implementation of a Safe Routes to School plan for one of the community elementary schools.
 - d. Plan and facilitate at least 2 annual walking and/or bicycling events to educate at least 40 adults and children regarding walking and cycling as a safe commuting alternative.

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Tactic 20: Connect homeless patients discharged from hospital to Respite Care Center.

FY 10 Baseline: 69 homeless patients were identified as requiring transitional housing and 32 were placed in Respite Care Center

2013 Objectives	Outcomes
1. JMH Case Managers/Social Workers will identify patients that meet criteria for respite.	•
2. JMH will refer qualifying patients to the Respite Center.	•
3. 40% of patients referred will be admitted to respite.	•
4. The interdisciplinary respite team to will provide services to all eligible patients.	•
5. The Respite Center will decrease the hospital length of stay for eligible patients.	•

In addition to the programs listed, the Community Health Fund is integral in expanding and enhancing the health care services for those who need them most in Contra Costa County. The Community Health Fund distributes grants to community based, non-profit organizations who serve uninsured and under-served populations.

The Community Health Fund' distributes that money through a unique process that nurtures long-term partnerships with and among community-based nonprofits, and which results in sustainable health initiatives and systemic change. Many programs that receive their start from us continue long past the grant periods and to this day deliver critical health care services. Consequently, many thousands of Contra Costa residents who might have slipped through the cracks in our health care system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support services for conditions that range from cancer and chronic disease through dental caries and mental illness. It is the Community Health Fund's mission to deliver the same kinds of results to the many in Central and East Contra Costa who still struggle to find adequate care.

Attachment F – 2013 Community Benefit Plan
2. 2013 John Muir Behavioral Health Community
Benefit Plan

John Muir Behavioral Health Center 2013 Community Benefit Plan

Healthy Community Vision: All residents achieve and maintain optimal physical and mental health. Children succeed in school and reach their full potential. Residents are economically independent and have access to adequate, affordable housing. Neighborhoods are safe. Violence, discrimination and in justice are eliminated. The air and water are clean. Residents are politically, socially and culturally active.

Goal 1: To improve access to health care for low income residents

Goal 2: To have measurable impact on the health of the community

Strategy 1: Increase direct care, charity care and subsidized care

Tactic 1: Explore medication management and expanded substance abuse services for behavioral health patients, which results in more effective outpatient management and, when appropriate, connection to needed support services.

FY 11 Baseline: Dedicated to program planning

1. Develop business plan for outpatient center including expanded chemical dependency outpatient services with a full exercise and nutrition component and medication management clinic.

Strategy 3: Support prevention, early diagnosis and early intervention

Tactic 1: Support the Putnam Clubhouse in Concord.

FY 09 Baseline: 226 members spent 16,000 hours participating in Clubhouse activities. 12 members secured unsubsidized employment, 14 returned to school, and 1 received high school diploma. 90% reported increased in mental and personal well-being, 89% reported increase in emotional well-being.

1. By December 2013, the Clubhouse will have an average daily attendance of 30, and members will spend 40,000 hours participating in Clubhouse activities. Measured by program logs and member sign-in sheets,
2. By December 2013, the number of members ages 18 to 25 will increase by at least 10 people.
3. By December 2013, at least 80% of respondents in the annual member satisfaction survey will report an increase in their independence.
4. By December 2013, at least 80% of respondents in the annual member satisfaction survey will self-report improved quality of life from participation in the Clubhouse program.
5. By December 2013, at least 15 additional members will be placed in unsubsidized employment, at an average (unsubsidized) wage of \$8.50 per hour. Measured by program logs.

6. By December 2013, the overall membership will show a statistically significant decrease in hospitalizations and out-of-home placements following Clubhouse membership as measured by self-reported data.

Attachment G – Economic Valuation Tables
1. Programs for the Vulnerable Community

John Muir Health
Programs Targeted For...Vulnerable
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Behavioral Health Center: Free Discharge Medications Behavioral Health Center (87201)	3,532	0	3,532	25	25
Behavioral Health Center: NAMI: In Our Own Voice Behavioral Health Center (87201)	9,405	0	9,405	1	1
Behavioral Health Center: Putnam Club House Board Participation Behavioral Health Center (87201)	2,413	0	2,413	1	9
Birth Center: High Risk Infant Follow Up Program High Risk Infant (7406)	164,501	0	164,501	87	163
Cancer Institute: Breast and Cervical Cancer Treatment Program Cancer Institute (8702)	12,060	0	12,060	17	17
Cancer Institute: Every Woman Counts Program and Clinics Cancer Institute (8702)	324,419	0	324,419	446	630
Cancer Institute: Specialty Care Program Pro Fees Cancer Institute (8702)	284,731	0	284,731	183	307
Cardiology: Cardiac Outpatient Education Program Cardiac Conditioning (7597)	5,780	0	5,780	15	1
Caring Hands Program: Health Care Support Services Caring Hands (8672)	618,729	0	618,729	230	1
Caring Hands Program: Senior Transportation Program Caring Hands (8672)	102,537	0	102,537	119	1
Community Health Alliance: Community Contributions Community Health Alliance (8773)	38,700	0	38,700	12	12
Community Health Alliance: Community Health Nurse Community Health Nurse (8767)	266,915	0	266,915	558	1
Community Health Alliance: Faith and Health Partnership Faith and Health Partnership (8760)	177,780	0	177,780	8	8
Community Health Alliance: Faith Community Capacity Building Faith and Health Partnership (8760)	21,000	0	21,000	28	2
Community Health Alliance: FHP Campaign Outreach Faith and Health Partnership (8760)	123,931	0	123,931	11,201	9
Community Health Alliance: FHP Community Outreach & Education Faith and Health Partnership (8760)	61,358	0	61,358	1,248	22
Community Health Alliance: FHP Health Fairs Faith and Health Partnership (8760)	32,651	0	32,651	1,204	6
Community Health Alliance: FHP Nursing Education Faith and Health Partnership (8760)	9,022	0	9,022	45	2
Community Health Alliance: Foster A Dream Community Health Alliance (8773)	29,469	0	29,469	32	1
Community Health Alliance: Health Career Support Community Health Alliance (8773)	8,151	0	8,151	1	1
Community Health Alliance: In-kind Donations Community Health Alliance (8773)	14,540	0	14,540	1	1
Community Health Alliance: La Clinica Oakley Site Community Health Alliance (8773)	150,000	0	150,000	1	1

John Muir Health
Programs Targeted For...Vulnerable
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Community Health Alliance: Mobile Dental Clinic Mobile Dental Clinic (8776)	402,223	0	402,223	824	187
Community Health Alliance: Mobile Health Clinic Mobile Health Clinic (8777)	348,841	0	348,841	3,554	275
Community Health Alliance: Monument Community Parntership Community Health Alliance (8773)	85,000	0	85,000	2,000	1
Community Health Alliance: Other Resources Community Health Alliance (8773)	137,119	0	137,119	1	1
Community Health Alliance: Staffing Community Health Alliance (8773)	630,924	0	630,924	1	1
Community Health Alliance: Triennial Assessment Community Health Alliance (8773)	22,572	0	22,572	7	1
Community Health Alliance: Vulnerable Population Program Grants Community Health Alliance (8773)	115,000	0	115,000	258	2
Community Health Fund - Grants Community Health Fund (8619)	2,002,002	0	2,002,002	1	1
Community Health Fund - Other Resources Community Health Fund (8619)	81,649	0	81,649	1	1
Community Health Fund - Staffing Community Health Fund (8619)	396,870	0	396,870	1	1
Emergency Department: ED Referral Liaison Program Emergency Department (8768)	173,827	0	173,827	8,923	260
Emergency Services: Physician Pro Fees Emergency Services (7011)	430,257	0	430,257	209	1
Health System: Donations - Vulnerable Health System Facilities (8340)	41,000	0	41,000	6	6
Nursing Administration: Foster A Dream BackPack Challenge Nursing Administration (8721)	6,432	0	6,432	919	1
Nursing Administration: Foster A Dream Career Day Nursing Administration (8721)	161	0	161	20	0
Pharmacy: Medical Relief Donations Pharmacy - JMWC (8391)	382	0	382	1	1
Pharmacy: Patient Assistance Program Pharmacy - JMCC (8390)	6,485	0	6,485	1	1
Physicians Network: Chronic Care Case Management John Muir Physician Network (8966)	405,940	0	405,940	506	1
Pulmonary Rehabilitation: Equipment Loans Pulmonary Rehabilitaton (7088)	6,580	0	6,580	66	42
Pulmonary Rehabilitation: Maintenance Excerise Pulmonary Rehabilitaton (7088)	13,344	0	13,344	25	1
Pulmonary Rehabilitation: Senior Care Pulmonary Rehabilitaton (7088)	2,009	0	2,009	25	1
Rossmoor: Equipment Donations Rossmoor Outpatient Center (8972)	67,118	4,427	62,691	1,143	1

John Muir Health
Programs Targeted For...Vulnerable
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs			
	Expenses	Offsets	Benefit	Persons	Encounters		
Senior Services: Fall Prevention (Vulnerable) Senior Services (8792)	24,745	0	24,745	1	1		
Senior Services: Geriatric Care Coordination Senior Services (8792)	614,750	0	614,750	1,646	1,646		
Senior Services: Monument Community Senior Service Outreach Senior Services (8792)	95,663	0	95,663	686	1		
Senior Services: Monument Fall Prevention Senior Services (8792)	11,297	0	11,297	149	21		
Senior Services: Prescription Medication Assistance Program Senior Services (8792)	145,564	0	145,564	57	402		
Social Services: Complex Community Care Coordination Social Services (8361)	113,127	0	113,127	30	1		
Social Services: Continuing Care Services Social Services (8361)	126,295	0	126,295	35	4		
Social Services: Homeless Respite Social Services (8361)	53,217	0	53,217	120	2		
Social Services: Medication Assistance (JMWC/JMCC) Social Services (8361)	63,158	0	63,158	221	2		
Social Services: Skilled Nursing, Board & Care, DME (JMCC) Social Services (8361)	85,235	0	85,235	15	2		
Social Services: Skilled Nursing, Board & Care, DME (JMWC) Social Services (8361)	188,792	0	188,792	142	3		
Social Services: Transportation Social Services (8361)	114,540	0	114,540	1,617	3		
Trauma: Beyond Violence Trauma (7016)	167,670	0	167,670	25	2,237		
Women's Health Center: Teen Pregnancy Resource Program Women's Health Center (7405)	31,561	0	31,561	41	462		
Number of Programs	58	Grand Totals	9,672,973	4,427	9,668,546	38,740	6,795

Attachment G – Economic Valuation Tables

2. Programs for the Broader Community

John Muir Health
Programs Targeted For...Broader Community
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Behavioral Health Center: Donations Behavioral Health Center (87201)	2,500	0	2,500	1	1
Behavioral Health Center: Expressive Art Therapy Internships Expressive Arts Therapy (7802)	140,854	0	140,854	4	1
Behavioral Health Center: Nursing Student Clinical Practicum Behavioral Health Center (87201)	482,214	0	482,214	204	1
Behavioral Health Center: Suicide Prevention Conference Social Services (8361)	2,413	0	2,413	1	1
Brentwood Campus: Brentwood Corn Fest Brentwood Medical Center (8793)	20,226	0	20,226	1	1
Brentwood Campus: Clinician Education Brentwood Medical Center (8793)	2,148	0	2,148	23	2
Brentwood Campus: Community Donations Brentwood Medical Center (8793)	6,000	0	6,000	7	7
Brentwood Campus: Community Education Brentwood Medical Center (8793)	5,941	0	5,941	409	11
Brentwood Campus: Community Events Brentwood Medical Center (8793)	7,787	0	7,787	3	3
Brentwood Campus: Conference Room Donation - Community Buidling Brentwood Medical Center (8793)	335	0	335	1	5
Brentwood Campus: Conference Room Donation - In Kind Brentwood Medical Center (8793)	777	0	777	1	13
Brentwood Campus: Health Career Support Brentwood Medical Center (8793)	796	0	796	27	1
Brentwood Campus: Health Fairs Brentwood Medical Center (8793)	4,471	0	4,471	1	1
Brentwood Campus: In-Kind Donations Brentwood Medical Center (8793)	195	0	195	2	2
Cancer Institute: Community Health Fairs Cancer Institute (8702)	10,401	0	10,401	81	3
Cancer Institute: Community Outreach Events Cancer Institute (8702)	33,458	0	33,458	821	6
Cancer Institute: Community Presentations Cancer Institute (8702)	9,209	0	9,209	276	8
Cancer Institute: Community Support Activities Cancer Institute (8702)	3,456	0	3,456	571	10
Cancer Institute: Conferences Cancer Institute (8702)	643	0	643	500	1
Cancer Institute: Nursing Education Cancer Institute (8702)	6,270	0	6,270	136	4
Cancer Institute: Physician Education Cancer Institute (8702)	16,623	0	16,623	202	7
Cancer Institute: Screenings Cancer Institute (8702)	10,526	0	10,526	157	1

John Muir Health
Programs Targeted For...Broader Community
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Cancer Institute: Support Groups Cancer Institute (8702)	2,677	0	2,677	30	12
Cardiology: Cardiac Conditioning Education Classes Cardiac Conditioning (7597)	321	0	321	24	1
Clinical Research: Generalizable Research Clinical Research (8026)	1,368,601	0	1,368,601	118	2
Community Health Alliance: Interns Community Health Alliance (8773)	5,870	0	5,870	3	1
Community Health Alliance: Wellness Project Research Study Community Health Alliance (8773)	3,980	0	3,980	30	2
Diabetes: Community Education Diabetes Center (7771)	13,264	1,750	11,514	189	7
Diabetes: Community Health Fairs Diabetes Center (7771)	643	0	643	1	1
Diabetes: Diabetes Support Groups Diabetes Center (7771)	643	0	643	40	8
Emergency Services: EMS Base Station Coordination Emergency Services (7011)	829,668	0	829,668	3,432	365
Health System: Conference Room Donations - Community Building Health System Facilities (8340)	2,558	0	2,558	1	7
Health System: Conference Room Donations - In Kind Health System Facilities (8340)	26,495	0	26,495	2	56
Health System: Donations - Broader Health System Facilities (8340)	42,550	0	42,550	15	11
Laboratory: Donations Laboratory (7500)	6,744	0	6,744	5	14
Laboratory: Health Career Support Lab Services Education (8744)	33,625	0	33,625	1,943	94
Medical Library:Virtual Community & Family Centered Health Library Medical Library (8691)	33,413	0	33,413	1	1
Neurosciences: Board Participation Neurosciences (8759)	2,443	0	2,443	2	14
Neurosciences: Community Presentations & Outreach Neurosciences (8759)	4,502	0	4,502	271	3
Neurosciences: Information and Referral Assistance Neurosciences (8759)	2,556	0	2,556	1	1
Neurosciences: National Brain Tumor Foundation - Angel Walk Neurosciences (8759)	4,202	0	4,202	1	1
Neurosciences: Support Groups Neurosciences (8759)	7,993	0	7,993	16	19
Nursing Education: Nursing Students Education & Training - CC Nursing Education - JMCC (8741)	780,403	0	780,403	237	1
Nursing Education: Nursing Students Education & Training - WC Nursing Education - JMWC (8742)	1,110,107	0	1,110,107	436	1

John Muir Health
Programs Targeted For...Broader Community
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Nutrition Services: Community Presentations Nutrition Services (8341)	558	0	558	60	6
Nutrition Services: Health Professions Education Nutrition Services (8341)	643	0	643	200	1
Osteoporosis Center: Osteoporosis Lectures Osteoporosis Center (6009)	384	0	384	50	1
Pharmacy: Clinical Education Pharmacy - JMCC (8390)	198	0	198	110	2
Pharmacy: Medication Presentations (JMCC) Pharmacy - JMCC (8390)	241	0	241	28	2
Pharmacy: Student Rotations (JMCC) Pharmacy - JMCC (8390)	56,438	0	56,438	9	1
Pharmacy: Student Rotations (JMWC) Pharmacy - JMWC (8391)	80,557	0	80,557	13	1
Physicians Network: Community Education and Seminars John Muir Physician Network (8966)	12,515	0	12,515	240	24
Pulmonary Rehabilitation: Clinical Rotations Pulmonary Rehabilitaton (7088)	2,413	0	2,413	38	114
Pulmonary Rehabilitation: Community Health Fairs Pulmonary Rehabilitaton (7088)	4,985	0	4,985	1	1
Pulmonary Rehabilitation: Health Education Pulmonary Rehabilitaton (7088)	401	0	401	23	1
Pulmonary Rehabilitation: Support Groups Pulmonary Rehabilitaton (7088)	6,028	0	6,028	87	12
Pulmonary Rehabilitation: Workforce Development Pulmonary Rehabilitaton (7088)	1,608	0	1,608	50	8
Rehab-Inpatient: Clinical Internships (CC) Inpatient Rehabilitation (7770)	193,591	0	193,591	8	2
Rehab-Inpatient: High School Presentations and Job Shadowing Inpatient Rehabilitation (7770)	4,262	0	4,262	53	2
Rehab-Outpatient: Clinical Internships Outpatient Rehab (7772)	52,579	0	52,579	10	2
Rehab-Outpatient: Community Outreach Outpatient Rehab (7772)	26,451	1,260	25,191	287	150
Rehab-Outpatient: Lecturers & Faculty Outpatient Rehab (7772)	1,205	0	1,205	75	1
Rossmoor: Conference Room Donations - In Kind Rossmoor Outpatient Center (8972)	674	0	674	1	12
Senior Services: AARP Driving Safety Training Senior Services (8792)	10,356	0	10,356	264	18
Senior Services: Blood Pressure Screening Senior Services (8792)	33,027	0	33,027	2,406	166
Senior Services: Community Education Seminars Senior Services (8792)	22,479	0	22,479	1,524	69

John Muir Health
Programs Targeted For...Broader Community
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Senior Services: Fall Prevention (Broader)					
Senior Services (8792)	17,333	0	17,333	212	11
Senior Services: Health Fairs					
Senior Services (8792)	10,356	0	10,356	3,797	15
Senior Services: Health Insurance Counseling and Advocacy Program					
Senior Services (8792)	10,356	0	10,356	146	27
Senior Services: Information and Referral Assistance					
Senior Services (8792)	233,560	0	233,560	7,733	7,733
Senior Services: Memory Screening					
Senior Services (8792)	20,469	0	20,469	265	72
Senior Services: Newsletter					
Senior Services (8792)	78,948	0	78,948	50,338	3
Senior Services: Outreach/Public Speaking					
Senior Services (8792)	10,356	0	10,356	155	7
Senior Services: Patient Navigator Program					
Senior Services (8792)	121,075	0	121,075	1,193	1,974
Social Services: ACMA Board Member					
Social Services (8361)	1,929	0	1,929	1	12
Social Services: Interns					
Social Services (8361)	79,832	0	79,832	6	4
Spiritual Care: Bereavement Correspondence					
Spiritual Care (8680)	7,878	0	7,878	4,068	1
Spiritual Care: Clinical Pastoral Education					
Spiritual Care (8680)	274,955	0	274,955	21	1
Spiritual Care: Grief Support Groups					
Spiritual Care (8680)	6,019	0	6,019	142	24
Trauma: Car Seat Fitting Station					
Trauma (7016)	121,513	0	121,513	2,190	1,169
Trauma: Car Seat Safety Coalition					
Trauma (7016)	6,469	0	6,469	22	2
Trauma: Car Seat Safety Technician Certification Training					
Trauma (7016)	20,725	0	20,725	16	1
Trauma: Every 15 Minutes					
Trauma (7016)	35,921	0	35,921	7,500	5
Volunteer Services: School Tours for Students					
Volunteer Services (8671)	2,410	0	2,410	423	22
Women's Health Center: Cash Donations					
Women's Health Center (7405)	2,940	0	2,940	1	1
Women's Health Center: Community Based Clinical Services					
Women's Health Center (7405)	16,664	1,921	14,743	100	50
Women's Health Center: Community Health Education					
Women's Health Center (7405)	2,615,621	327,247	2,288,374	34,300	1
Women's Health Center: Conference Room Donations - In Kind					
Women's Health Center (7405)	286	0	286	1	7

John Muir Health
Programs Targeted For...Broader Community
For period from 1/1/2012 through 12/31/2012

<u>Title / Department</u>	Monetary Inputs			Outputs			
	Expenses	Offsets	Benefit	Persons	Encounters		
Women's Health Center: Health Care Support Services Women's Health Center (7405)	80,011	11,170	68,841	1,420	1		
Workforce Development: Coalition Building Workforce Development (8654)	4,421	0	4,421	26	21		
Workforce Development: Donations for Health Career Promotion Workforce Development (8654)	77,521	0	77,521	1,587	12		
Workforce Development: Health Career Student Support Workforce Development (8654)	60,374	0	60,374	6,676	206		
Workforce Development: Health Professional Education Workforce Development (8654)	232,326	0	232,326	8	1		
Workforce Development: In-Kind Donations Workforce Development (8654)	66,620	0	66,620	1,491	101		
Workforce Development: Leadership Development and Training Workforce Development (8654)	11,042	0	11,042	80	4		
Workforce Development: Mentorships and Internships Workforce Development (8654)	414,797	0	414,797	145	145		
Workforce Development: Nursing Education Workforce Development (8654)	720,517	0	720,517	112	5		
Workforce Development: Scholarships Workforce Development (8654)	5,500	0	5,500	20	5		
Number of Programs	98	Grand Totals	10,930,838	343,348	10,587,490	139,959	12,951

Attachment G – Economic Valuation Tables
3. Community Partner Organizations

John Muir Health collaborates with the following organizations:

- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Medical Response (AMR)
- American Red Cross
- Antioch High School
- Association Hispana del Cancer
- Bay Imaging Consultants
- Bay Point African American Health Initiative
- Bay Point Partnership
- Lifelong Community Health Center
- California Transplant Donor Network
- CalStar Air Ambulance
- Catholic Charities of the East Bay
- Center for Human Development
- Central County Senior Coalition
- Child Abuse Prevention Council
- City of Concord
- City of Richmond Office of Neighborhood Safety
- Clayton Valley High School
- Community Clinic Consortium of Contra Costa and Solano Counties
- Community Youth Center, Concord
- Concord Chamber of Commerce
- Concord High School
- Concord Rotary Club
- Contra Costa County Health Services
- Contra Costa County Health Services affiliated OB/GYN Physicians
- Contra Costa County Office of Education
- Contra Costa District Attorney's Office
- Contra Costa Employment and Human Services Department
- Contra Costa Fall Prevention Program
- Contra Costa Health Ministries Network
- Contra Costa Health Plan
- Contra Costa Mental Health Services Department
- Crestwood Health Center
- Crossroads High School, Concord
- East County Senior Coalition
- Families First
- First Five of Contra Costa County
- Food and Nutrition Policy Consortium
- Health Ministries Association
- Healthy Start
- Independence High School, Brentwood
- Independent Learning High School, Pittsburg
- Independent Living Center
- International Center for Clubhouse Development
- Jewish Children's Services
- Kaiser Permanente
- La Clinica de la Raza
- Liberty Union High School, Brentwood
- Local Contra Costa County police and fire departments
- Medical Anesthesia Consultants Group
- Michael Chavez Center for Economic Development
- Monument Community Partnership
- Mt. Diablo Unified School District
- Muir OB/GYN
- National Alliance on Mental Illness (NAMI) of Contra Costa County
- National Association for Mental Illness Contra Costa County
- National Association for the Advancement of Colored People (NAACP)
- Network for a Healthy California
- New Connections
- Northern California Comprehensive Cancer Center
- One Day at a Time

- Operation Access
- Pittsburg Unified School District
- Planned Parenthood
- Resources for Community Development
- Ronald McDonald House Charities of the Bay Area
- RotaCare Free Clinic, Concord
- RYSE
- Saint Matthew Lutheran Church
- San Ramon Valley High School
- Senior Alternatives
- St. Francis of Assisi Catholic Church, Concord
- St. John Vianney Catholic Church, Walnut Creek
- STAND! for Families Free of Violence
- Sycamore Place (HUD housing)
- The Williams Group
- Tice Valley Oaks (HUD housing)
- Trader Joe's
- Walnut Creek Senior Club
- We Care Services
- Welcome Home Baby
- Women, Infants and Children (WIC) Pittsburg
- Women's Initiative, Concord
- Ygnancio Pathology Medical Group
- Youth Alive!
- Youth Intervention Network, Antioch

Attachment H – John Muir Health Patient Assistance/Charity Care Program Policy



Subject: AD - Patient Financial Assistance Program				
Applies To:	<input checked="" type="checkbox"/>	John Muir Medical Center – Concord	<input checked="" type="checkbox"/>	John Muir Medical Center – Walnut Creek
	<input type="checkbox"/>	John Muir Physician Network	<input type="checkbox"/>	John Muir Behavioral Health Center

Purpose:

The purpose of this Policy is to set forth a fair and equitable process for providing patient financial assistance for medically necessary care provided at **John Muir Health (JMH)** to patients who have limited or no means to pay the full billed charges for their care. **This Policy is not a substitute for personal responsibility.** Patients are expected to cooperate with John Muir Health, and are required to cooperate in determining their **eligibility** for various programs in order to qualify for **patient** assistance under this Policy, and to pay for their care to the extent of the ability to pay.

Definitions

Allowable Medical Expenses: The total of family medical bills that if paid, would qualify as deductible medical expenses for Federal income tax purposes without regard to whether the expenses exceed the IRS-required threshold for taking the deduction. Paid and unpaid bills may be included.

Billed Charges: Charges for services by **John Muir Health** as published in the Charge Description Master (CDM).

Business Office: Department which is part of John Muir Health and is responsible for billing, collection and payment processing.

Discounted Care: Medical bills which are sent by **John Muir Health**, and which receive a discount from the full, billed charges.

Payment Plan: Plan which sets a series of equal payments over an extended period of time to satisfy the patient-owed amounts of bills sent by **John Muir Health**.

Federal Income Tax Return: The form which is submitted to the IRS for purposes of reporting taxable income. The form must be a copy of the actual, signed and dated form submitted to the IRS

Federal Poverty Guideline (FPG): Guidelines set by the Federal Government which establishes income levels for households living above or below defined poverty or subsistence annual incomes

Household Income: Income of all family members who reside in the same household as the patient, or in the household which the patient claims on their tax returns or other government documents as their home address

Medically Necessary: Services or supplies that the treating physician determines are needed for the diagnosis or treatment of a medical condition and meet the standards of good medical practice.

Out-of-Pocket Costs: Costs which the patient pays for out of personal funds and/or income.

Patient Financial Assistance: Commonly known as ‘Charity Care,’ a program which will prospectively or retroactively reduce the amount owed by the patient for the bills sent by John Muir Health.

Qualifying Assets: Monetary assets which are counted toward the patient’s income in determining if the patient will meet the income eligibility for the program. For purposes of this Policy, “Qualifying Assets” shall mean 50% of the patient’s monetary assets in excess of \$10,000, including cash, stocks, bonds, savings accounts or other bank accounts, but excluding IRS qualified retirement plans **and** deferred-compensation plans. **Certain** real property or tangible assets (primary residences, automobiles, etc.) **shall not be included in “Qualifying Assets;” however, additional residences in excess of a single primary residence will be included, as will recreational vehicles.** “Qualifying Assets” will not include the principal amounts of funds contained within an IRS recognized retirement account, such as an IRA, 401K or 403B retirement accounts.

Qualifying Patient: Patient who meets the financial qualifications for the **Patient Financial Assistance** program as defined in Section III.C.1

Third Party Insurance: An entity (corporation, company health plan trust, automobile med pay benefit, etc.) other than the patient which will pay all or a portion of the patient’s medical bills.

Policy:

John Muir Health is committed to providing financial assistance to patients who have sought medically necessary care at John Muir Health System but have limited or no means to pay for that care. Patient Financial Assistance refers to what is commonly known as ‘Charity Care.’ John Muir Health follows the Generally Accepted Accounting Principles for charity care. John Muir Health will provide emergency medical care to all individuals, regardless of their ability to pay or eligibility under this policy.

Procedures

Scope of Policy

Services Eligible Under This Policy

This Policy shall apply to any **medically necessary service provided at John Muir Health owned and operated facilities with the exclusion of Behavioral Health, and Physician Network services.** Patient Financial Assistance eligibility may also be extended to other medical services rendered by and at **John Muir Health** on a case-by-case **basis** after the appropriate approval process.

John Muir Health does not **provide patient assistance for the professional fees charged** by physicians **and other providers for their services**, even if those services were rendered at a **John Muir Health facility.** In accordance with **California Health and Safety Code**, emergency physicians who provide

emergency medical care at John Muir Health are required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the Federal Poverty Guideline (FPG). Detailed policies for emergency physician discounts shall be maintained by the individual physicians or their representative networks.

Community Benefit

The John Muir Health Patient Financial Assistance Program is intended to assist members of the local community in paying for necessary healthcare services. This policy shall not apply to patients outside of the community except on a case-by-case basis to be determined by JMH Business Office management.

Communication of Patient Financial Assistance Options

1. John Muir Health provides notice of the availability of patient financial assistance via:
 - a. Signage
 - b. Patient brochure
 - c. Billing statement
 - d. Collection action letter
 - e. Online at www.johnmuirhealth.com/patients-and-visitors/payment-and-insurance/patient-financial-assistance-program
2. All notices are translated into the following language(s): Spanish
3. John Muir Health provides individual notice of patient financial assistance availability to a patient that may be at risk of meeting their financial responsibility.

Patient Financial Assistance - Patient Application

Financially Qualified Patients

A patient may qualify for financial assistance under this Policy if **they meet one of the following guidelines based on income or expenses and they are not eligible for other private or public health coverage:**

- a. **Income. A patient is eligible to receive free care based on income under this policy if both of the following qualifications apply:**

Household Income (as defined in policy) is at or below 400% of the FPG

Qualifying Assets do not exceed an amount equal to 200% of his or her billed charges for services rendered. For purposes of this Policy, "Qualifying Assets" shall:

Include 50% of the patient's monetary assets in excess of \$10,000, including cash, stocks, bonds, savings accounts or other bank accounts

Exclude IRS qualified retirement plans, such as IRAs, 401K or 403B retirement accounts, or deferred-compensation plans

Exclude certain real property or tangible assets (primary residences, automobiles, etc.); however, additional residences in excess of a single primary residence and recreational vehicles may be included

Expenses. Patients not eligible based on income may be eligible for Patient Financial Assistance through an exception-based review if their allowable medical expenses have depleted the family's income and resources so that they are unable to pay for eligible services. Exception-based discounts may be issued on a sliding scale from 0-100% at the discretion of JMH Business Office Management. The following two qualifications must both apply:

Expenses - The patient's allowable medical expenses must be greater than 20% of the household income. (Allowable medical expenses are the total of family medical bills that if paid, would qualify as deductible medical expenses for Federal income tax purposes without regard to whether the expenses exceed the IRS-required threshold for taking the deduction. Paid and unpaid bills may be included.)

Resources - The patient's excess medical expenses (the amount by which allowable medical expenses exceed 20% of the household income) must be greater than available Qualifying Assets.

Patient Responsibility for **Patient Financial Assistance**

In order to qualify for financial assistance under this Policy, a patient (or his or her guardian or family member) must:

Cooperate with John Muir Health in identifying and determining alternative sources of payment or coverage from public and private payment programs;

Submit a true, accurate and complete application for financial assistance;

Provide a copy of his or her most recent pay stubs (or certify that he or she is currently unemployed);

Provide a copy of his or her most recent federal income tax return (including all schedules); and

Provide such documents and information regarding his or her monetary assets as may be reasonably requested by John Muir Health.

If the patient has third party insurance which would have covered the qualifying services, the patient is responsible for complying with the conditions of coverage for their health insurance. Failure to do so, when the patient could have reasonably complied, may result in a denial of eligibility under the **Patient Financial Assistance** program.

John Muir Health shall not use any information submitted by a patient regarding the patient's monetary assets in connection with his or her application for any collection activities of John Muir Health. Information provided by the patient regarding the patient's monetary assets will only be used for the determination of whether or not such patient qualifies for financial assistance under this Policy.

Under-insured Patients

For patients with high deductibles or non-covered services, John Muir Health will investigate the patient's health plan to determine if Patient Financial Assistance discounts are allowed. The patient may be required to submit a financial assistance application in order to receive a discount. Per California Health and Safety Code, a patient is eligible to apply for a discount if his or her income is at or below 350% of the FPG and his or her annual out-of-pocket costs for medical

expenses exceed 10% of his or her household income in the prior 12 months. Exception-based discounts may be issued on a sliding scale from 0-100% at the discretion of JMH Business Office staff and management.

1. **Eligibility Period**

If a patient qualifies for free care for a specific service or hospital stay, a retroactive Patient Financial Assistance write-off will be applied to all patient balances for any services up to six (6) months prior to the application submission date. Other balances may be considered at the discretion of Business Office staff/management. For any services that occur after the application submission date, the patient must submit a new application to be considered for Patient Financial Assistance.

2. **Refund of Amounts Previously Paid**

In the event a patient or any member of the patient's immediate family pays all or part of his or her bill for services rendered, and is subsequently determined to qualify for free or discounted care under this Policy, John Muir Health shall promptly refund to such patient or his or her immediate family member, as applicable, the amount of any such overpayment to John Muir Health.

3. **Appeal Regarding Application of this Policy**

In the event any patient believes his or her application for **Patient Financial Assistance** was not properly considered in accordance with this Policy, or he or she otherwise disagrees with the application of this Policy in his or her case, a patient may submit a written request for reconsideration to the Vice-President, Revenue Cycle, and then to the Chief Financial Officer of John Muir Health, who shall be the final level of appeal.

4. **Non-Discriminatory Application of this Policy**

Any decisions made under this Policy, including the decision to grant or deny financial assistance under this Policy, shall be based on an individualized determination of financial need, and shall not take into account race, **color, national origin, citizenship, religion, creed**, gender, sexual preference, age, or **disability**.

5. **Application by the Patient**

- a. Financial Counselors, upon discovery of the patient's financial circumstances during the patient interview, will advise the patient of the Patient **Financial Assistance** Program and the availability of financial assistance under this Policy
- b. Patients will be informed of available assistance through a standard message placed on the patient's bill, as well as through a handout available at the Medical Centers, **through the Business Office and/or through the John Muir Health Internet site**.
- c. The Patient **Financial Assistance** Program's availability and referral numbers will be placed within any notification on John Muir Health's internet site, the patient's bill, or the available handout.
- d. Notice of availability of financial assistance and instructions for patient screening will be posted in the Emergency Room, and the main Admitting Department lobby of the Medical Centers, as well as in the offsite business office and other outpatient sites, as appropriate.

- e. Other venues may be **used** to educate and inform the patient and/or physician population of the availability of the Patient **Financial** Assistance Program as deemed appropriate
- f. Patient, or a patient's guardian or legal conservator, may apply to the Patient **Financial** Assistance Program by calling the **JMH Business Office** and requesting an application from a program representative, or by requesting an application from a financial counselor on site at the Medical Centers
- g. A patient may apply for multiple outstanding balances on the same application.
- h. **Applications may not be submitted more than six (6) months following the first patient statement date.**
- i. **John Muir Health will review Patient Financial Assistance applications monthly for approval.** Balances approved will be submitted for write-off to a transaction code assigned to Patient **Financial** Assistance, and will follow the signature authority of the John Muir Health Write-Off Guidelines.
- j. Any recoveries to an account which has qualified and was absorbed under the Health System's Patient Assistance Program will have the amount of the recovery reversed from the Patient **Financial** Assistance adjustment code to ensure the diminished Charity Care is reflected appropriately in the general ledger.

Patient Financial Assistance - For Applications by the Staff/Management of the JMH Business Office for Presumptive Eligibility:

1. On an individual patient basis, the staff or management member of the **Business Office** will complete an internal Patient **Financial** Assistance Application to include a full explanation of:
 - a. The reason the patient or patient's parent/guardian cannot apply on his/her own behalf, and the patient's documented extenuating medical or socio-economic circumstances which preclude the patient from completing the application him/herself.
2. Patient notification of the committee's decision is not required.
3. John Muir Health may also assign accounts to presumptive eligibility, without a Patient **Financial** Assistance application submitted by the patient, based on predetermined criteria collected from approved sources. These criteria include:
 - a. The patient having documented in his/her medical record as being homeless or verification received through **John Muir Health** or a family member that the patient is currently incarcerated;

OR

 - b. The patient qualifies for a government program with eligibility requirements that reasonably meet the qualifications for the John Muir Health **Patient Financial Assistance** program within six (6) months of the date the patient received services at **John Muir Health**;

OR

- c. After normal collection efforts have not produced any payment, and John Muir Health has identified with reasonable effort and assurance that the patient's estimated income is at 250% or less of the FPG.

Patient/Family Education: Provided through publication of this policy on the JMHS website, direct education from Financial Counselors and Patient Concern Liaisons, and posted information as outlined in this policy (Section III, B.)

Documentation: Patient Financial Assistance Application

Reference/Regulations: AB-774; Negotiated Class Action Settlement dtd 04/25/2008			
Sponsor(s) Name & Title:		Origination Date:	Supersedes:
Mike Moody Chief Financial Officer		December 2006	Previous title: AD - Patient Assistance / Charity Care Program / Uninsured Patient Discount Program (SA-11.04)
Record of Review Dates			
Review Only Dates:	Revision Dates:	List Committee, Medical Staff, etc. Reviews:	
	10/2009; 12/2011		
Record of Approval Dates			
PPRC: --	Admin: --	MEC-WC: --	MEC-CC: --
ELT: 1/31/12	Board: 12/06, 11/09, 2/12		

Attachment I- Community Assessment

2010 Community Assessment Summary

How Do We Define Our Community?

John Muir Health's primary and secondary service area extends from southern Solano County into eastern Contra Costa County and south to San Ramon in southern Contra Costa County. The service area includes 85 percent of our inpatient catchment area. The communities that comprise the primary service area include Concord, Walnut Creek, Pleasant Hill, Martinez, Lafayette, Danville, Alamo, Orinda, Moraga and Clayton. The communities that comprise the secondary service area include Brentwood, Oakley, Discovery Bay, Byron, Knightsen, Bethel Island, Benicia, Pittsburg, Bay Point, Antioch and San Ramon. John Muir Health's Trauma Center serves all of Contra Costa County, as well as southern Solano County and is the backup Trauma Center for Alameda County.

The primary focus of our community benefit programs is on the needs of vulnerable populations. We define vulnerable populations as those with evidenced-based disparities in health outcomes, significant barriers to care and the economically disadvantaged. These criteria result in a primary Community Benefit Service Area that includes the communities of the Monument area in Concord and the Eastern Contra Costa County cities of Bay Point, Pittsburg, Antioch, Oakley, Brentwood and farther east parts of unincorporated Contra Costa County.

How is the Triennial Assessment Conducted?

As part of the California SB697 triennial cycle, a comprehensive community assessment was completed in 2010. The 2010 community assessment was completed through a collaborative process initiated by the Hospital Council of Northern and Central California and community hospitals in Contra Costa County. Participants included John Muir Health, Kaiser Permanente and Sutter Delta Medical Center. Conducted by the Community Health Assessment, Planning and Evaluation Group of Contra Costa Health Services (CHAPE), the 2010 quantitative assessment compiled existing data based on collaborative objectives.

The Community Indicator Report can be found at www.johnmuirhealth.com and www.cchealth.org. Upon request from the public or media, John Muir Health will also assist the requestor in finding the County health information they need. A summary of the Community Indicator Report focusing on Central and East Contra Costa demographic changes and health disparities is attached. The summary was used to develop the 2012 Community Benefit Plan.

How does JMH obtain the input of those with special expertise in public health and those who serve and represent vulnerable populations?

In addition to the quantitative portion of the community assessment described above, John Muir Health and Kaiser Permanente jointly conducted a survey of low income residents through the following community organizations which serve vulnerable population

- CHD Promotoras and Health Conductors
- Familias Unidas
- First 5 Regional
- La Clinica de la Raza
- Monument Community Partnership
- Monument Crisis Center
- Planned Parenthood- Shasta/Diablo
- Senior Outreach Services/Meals on Wheels
- WIC- Concord

John Muir Health used various other mechanisms to incorporate community input into the annual Community Benefit Plan. During 2010, John Muir Health kept abreast of current health issues of importance to the community by active participation within the Monument Community Partnership, East County Access Action Team, Primary Care Access Stakeholders Group, Bay Point Family Partnership, Contra Costa Health Ministries Network, Clinic Consortium Specialty Care Initiative, Families CAN and other ongoing collaborations with community-based organizations. These sources of information provide current information regarding community health status and also help identify emerging needs in the service area population.

John Muir Health develops partnerships to address health issues identified through its internal emergency department data. The John Muir Medical Center – Concord Campus Emergency Department Referral Liaison and John Muir Medical Center – Walnut Creek Beyond Violence programs were both developed in this way.

Community organizations also seek out John Muir Health as a partner. In 2008, John Muir Health implemented the Community Nurse program based on the 2007 community assessment which identified childhood overweight and diabetes prevention as areas of focus. Subsequently, a second school district asked John Muir Health to expand its community nursing program into their district during 2010.

John Muir Health is fortunate to benefit from the input and expertise of the County Health Services Department in a number of ways. In addition to the triennial Community Health Indicator Report completed on behalf of the community hospitals by the Public Health Division of the County Health Services Department (CCHS), CCHS is a participant in many of our partnerships: Mobile Health Clinic, Mobile Dental Clinic, Beyond Violence, Tel-Assurance remote monitoring for low income seniors with chronic illnesses, Fall Prevention Program of Contra Costa, JMCC ED Referral Liaison and the Monument Community Partnership. CCHS is also a partner in almost all of the collaborative groups mentioned above.

What are the needs in the service area?

Attached is a summary of the Community Indicator Report highlighting the health issues impacting the JMH Community Benefit service area. The Community Indicator Report highlights the disparities in health outcomes throughout the County including primary and chronic disease needs and other health issues of uninsured and low income persons as well as minority groups.

Where are the needs greatest?

The 2010 Community Health Assessment identified several health disparities in Central and Eastern Contra Costa County including:

- Cancer deaths in Antioch, Concord, Oakley, Pittsburg and Brentwood
- Heart disease deaths in Antioch, Oakley, Pittsburg, Concord and Martinez
- Stroke deaths in Antioch, Pittsburg, Concord and Oakley
- Breast Cancer deaths in Brentwood, Antioch, Pittsburg and Concord
- Lung Cancer deaths in Oakley, Antioch, Pittsburg and Concord
- Teen birth rates in Antioch, Concord, Bay Point and Brentwood
- Overweight 5th graders in Antioch and Pittsburg
- Diabetes death in Antioch and Pittsburg
- Non-fatal assault hospitalizations in Antioch, Pittsburg, Richmond and Concord
- Homicide deaths in Antioch and Pittsburg
- Hospitalization due to fall age 65+ in Antioch, Pleasant Hill, Martinez, Concord and Walnut Creek

- African Americans are most significantly impacted by health disparities and have a shorter life expectancy

Implementation Strategy/Community Benefit Plan

Since 1995 JMH has done an annual Community Benefit (CB) Plan which includes goals and objectives. The CB plan is updated and approved by the JMH Board of Directors each year. It is shared with the California Office of Statewide Health Planning and Development (OSHPD) by May 31 of each year in compliance with CA SB 697. The JMH CB plan is the implementation strategy to address the health needs of the communities we serve. The annual report to OSHPD also reflects the execution of the CB plan in the previous year.

Where Is John Muir Focusing Its Efforts?

John Muir Health selects its focus areas based on the community assessment, internal data and community partner input. Since 2007 new programs have specifically focused on programs which address the needs of **vulnerable populations** using three funding criteria.

The first funding criterion is that the program serves vulnerable populations defined as populations with one or more of the following characteristics:

- Evidenced-based disparities in health outcomes, e.g. African Americans with heart disease, African American women with breast cancer and African Americans and Latinos with diabetes.
- Significant barriers to care, e.g. the isolated or frail elderly, those with language or cultural barriers to effective care, those with barriers to appropriate and timely health care due to lack of health insurance, those with transportation or mobility barriers, those with limitations on their capacity to voice their needs in the health care system such as children.
- Economically disadvantaged, e.g. uninsured, underinsured and/or working poor residents.

Our second funding criterion requires that programs are delivered through **partnerships** with community based organizations, other providers, public agencies or business organizations. John Muir Health believes that it can maximize the impact of its investment by partnering with organizations whose expertise complements that of John Muir Health. No one organization has the financial resources and expertise to address all the unmet health needs of the vulnerable residents in our communities; it is only through meaningful collaboration that change is possible. Our community partnerships are managed by internal department champions and take advantage of the clinical and technical expertise of John Muir Health.

Our third funding criterion calls for selecting programs we believe will positively **impact the health of the community** in a measurable way.

An internal, multi-disciplinary Community Benefits Advisory Committee (CBAC) representing the various parts of John Muir Health reviews the community assessment data, program evaluations and requests for new programs using our funding criteria. The Committee makes recommendations for program funding in the annual budget process.

How do we select the specific community benefit programs we offer?

Since 2007 John Muir Health has focused its community benefit efforts in programs for vulnerable populations defined as those with one or more of the following characteristics: Evidenced-based disparities in health outcomes, significant barriers to care, economically disadvantaged.

Because the unmet health care needs are always greater than any one or any combination of providers can address, JMH prioritizes its focus areas using the following selection criteria:

1. Incidence/Prevalence (How many people are affected?)
 - a. Growing need
 - b. Worsening trend
 - c. Affects vulnerable populations
 - d. There are health disparities
 - e. The problem adversely impacts the individual, his/her family and community
2. There are few resources targeting this issue
 - a. There are gaps in service
 - b. This issue has experienced reduced funding
3. JMH is well-positioned to address this issue
4. If we were to address this issue, we will have a visible impact
5. Leveraging partnerships and community resources

The CBAC further recommends programs for the annual budget using the following selection criteria:

1. Address a community need
2. Serve a vulnerable population (low income, significant barriers to care, disparities in health outcomes)
3. Does not duplicate existing community services and JMH is well positioned to provide the service
4. Measurable participant impact
5. Build on the capacity and strengths of community based organizations and JMH, e.g. technical assistance, convening, support services, funds, grass roots networks, service feedback, etc.
6. Likelihood of success
7. Sustainable
8. Doesn't duplicate Community Health Fund activities

Our Community Benefit goals for 2012-14² are as follows:

1. To improve access to health care for low income residents
2. To have measurable impact on health of the community

Strategies for 2012-2014²:

- a. Increase direct care, charity care and subsidized care
- b. Increase access to care through enrollment programs
- c. Support prevention, early diagnosis, early intervention and maximize participant impact

² In 2011, we developed multiyear goals, strategies and focus areas for 2012-2014. This plan will now only inform community benefit investments through 2013 because we are currently undergoing the Community Health Needs Assessment (CHNA) process in response to the new federal requirements outlined by the Affordable Care Act. The new CHNA will identify the community's prioritized health needs. An implementation plan will be adopted in 2013 in response to the CHNA results and will outline of multiyear goals and strategies for 2014 to 2016.

How are John Muir Health community benefit programs delivered?

Programs are delivered through two organizations:

Community Health Alliance (CHA), a department of John Muir Health, which:

- Provides community health education, screening and early detection services through partnerships
- Initiates and participates in partnerships with community based organizations
- Coordinates system-wide community benefit planning, assessment and evaluation

Community Health Fund, a separate, public benefit corporation governed by 10-member appointed Board including 5 members appointed by the John Muir Association and 5 members appointed by the Mt. Diablo Health Care District. The Community Health Fund:

- Awards grants for community-based health programs and initiatives to address un-met health needs.
- Convenes community based organizations and public sector organizations to focus on pervasive health issues.

Community Needs Not Addressed

John Muir Health acknowledges that the health needs of vulnerable residents in Central and East Contra Costa County cannot be met by any one public or private organization. John Muir Health selects focus areas based on its clinical and organizational strengths, the availability and willingness of appropriate community organization partners, the incidence and prevalence of the need, the potential for making a positive impact and available financial and staff resources.

John Muir Health is also committed to supporting and complementing effective community programs with staff expertise, technical assistance or financial resources in order to avoid duplication or undertaking programs for which other organizations are better suited to succeed and make a difference.

In selecting community benefit programs, John Muir Health matches the community needs with its internal skills, resources, and community partnership expertise.

John Muir Health selected focus areas where the investment of its expertise and limited resources would be maximized. Through its partnerships, John Muir Health supported existing organizations and avoided duplicating programs on expenditures.

There are a number of reasons John Muir Health is not able to address all of the needs identified in its most recently conducted needs assessment. Slow recovery of the economy, changes in the delivery system in Contra Costa County under health care reform and reductions in Medicare reimbursement require all hospital systems to make strategic choices to focus community benefit contributions on the greatest needs in the community and to maximize the positive impact of those contributions.

While the county does not have a community-wide community benefit plan, the providers work together closely in many areas to address specific needs which may be focused in a particular part of the county where the need is most acute. Consistent with our partnership philosophy, we believe organizations can have a greater collective impact on the health of the community by working together.

Central and East Contra Costa County health care providers include:

- John Muir Health with medical centers in Concord and Walnut Creek and outpatient centers in Brentwood, Concord and Walnut Creek
- Kaiser Permanente with medical centers in Antioch, Walnut Creek and Richmond
- Sutter Delta Medical Center, Antioch
- Contra Costa Regional Medical Center with outpatient clinics in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg and Richmond
- La Clinica de la Raza, Inc., a federally qualified health center (FQHC) with clinics in the Monument area of Concord, Pittsburg and Oakley.
- Brookside Community Health Center, a FQHC, with clinics in San Pablo and Richmond (all in West County and out of the John Muir Health primary service area)
- RotaCare Free Clinics, Concord and Pittsburg
- Planned Parenthood offering with sites in Concord, Antioch
- San Ramon Regional Medical Center, San Ramon

John Muir Health engages with all the available health care providers through County-wide and regional coalitions, partnerships to deliver specific services and programs or through grants for specific programs that address unmet health needs for vulnerable populations. John Muir Health also works with appropriate community-based social service providers in addition to various departments and programs of the County Health Services Department.

John Muir Health is also committed to supporting and complementing effective community programs with staff expertise, technical assistance or financial resources in order to avoid duplication or undertaking programs for which other organizations are better suited to succeed and make a difference.

Approved by John Muir Health
Board of Directors
December 14, 2011



Community Assessment Report

Contra Costa County Demographic Summary



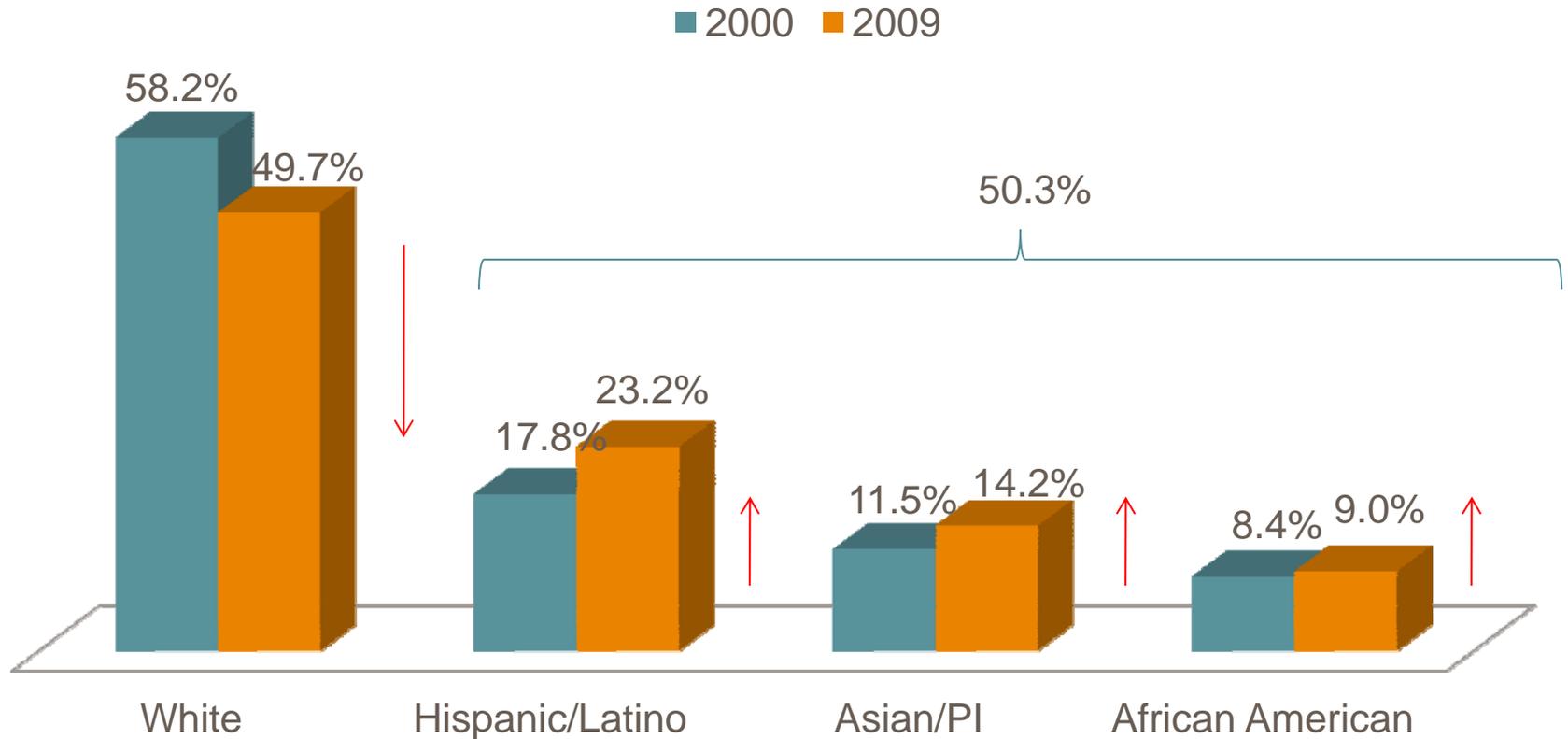
	Oakley	Brentwood	Antioch	Pittsburg	Bay Point	Pleasant Hill	Martinez	Richmond	Concord	Walnut Creek	CCC
Population	32,035	49,480	100,219	64,148	20,374	32,862	35,145	102,285	121,160	63,486	1,029,703
Trend	↑	↑	↑	↑	↓	N/A	↓	↑	↓	↓	↑
Gender (% of population)	Male (51.9%)	Female (51.6%)	Female (50.1%)	Female (51.7%)	Female (51.1%)	Female (51.5%)	Female (51.3%)	Female (51.3%)	Male (50.1%)	Female (53.9%)	Female (50.1%)
Age Group w/ Largest Growth	50 to 64	5 to 19	50-64	50-64	5 to 19	N/A	50 to 64	50 to 64	50 to 64	50 to 64	50 to 64
65 & Older (% of population)	6.5%	10.3%	7.8%	8.2%	8.3%	13.3%	11.7%	9.6%	11.6%	25.1%	12.0%
Trend	↑	↑	↑	→	↑	N/A	↑	↓	↑	↓	↑
Race/Ethnicity: % White	53.50%	58.80%	40.80%	23.30%	29.40%	69.70%	72.10%	19.40%	54.90%	77.00%	49.70%
Trend	↓	↓	↓	↓	↓	N/A	↓	↓	↓	↓	↓
Race/Ethnicity: % Non-White	43.30%	37.30%	55.60%	72.60%	65.60%	25.10%	24.10%	78.00%	41.70%	21.20%	50.30%
Trend	↑	↑	↑	↑	↑	N/A	↑	↑	↑	↑	↑
Largest Non-white Group (% of population)	Hispanic or Latino (33.8%)	Hispanic or Latino (27.2%)	Hispanic or Latino (29.2%)	Hispanic or Latino (38.8%)	Hispanic or Latino (45.2%)	Asian (13.9%)	Hispanic or Latino (13.4%)	Hispanic or Latino (33.5%)	Hispanic or Latino (28.5%)	Asian (11.9%)	Hispanic or Latino (22.9%)
Foreign Born (% of population)	15.5%	17.4%	21.9%	31.8%	32.4%	22.2%	11.7%	31.1%	28.6%	19.9%	24.1%
Language Spoken Other than English (% of population)	26.7%	26.0%	30.4%	45.9%	48.7%	24.0%	15.3%	44.2%	38.4%	22.6%	32.6%
Language Most Spoken (% of non-English speakers)	Spanish (22.4%)	Spanish (18.8%)	Spanish (19.8%)	Spanish (30.9%)	Spanish (40.1%)	Asian/PI (10.0%)	Spanish (7.3%)	Spanish (21.1%)	Spanish (23.6%)	Asian/PI (7.5%)	Spanish (52.6%)
No High School Diploma (% of population)	16.6%	13.5%	15.9%	24.8%	26.3%	6.3%	7.0%	21.1%	14.5%	4.0%	12.0%
Trend	↑	↓	↑	↑	↓	N/A	↓	↓	↓	↓	↓
Poverty: 200% below FPL (% of population)	21.0%	13.8%	24.0%	33.0%	41.7%	14.1%	14.2%	36.6%	25.6%	12.8%	23.3%
Trend	↑	↓	↑	↑	↑	N/A	↑	↑	↑	↑	↑
Highlighted red box = % higher than CCC				↑ = increase from 2007			↓ = decrease from 2007			N/A = data not available	

Demographic Trends: Age of Residents

- Within the cities, the largest population growth is among 50-64 year old residents
- The 65 and older population has increased county-wide from 8.3% in 2000 to 12.0% in 2008
- The 65 and older population is projected to increase by 17.25% in the next 5 years



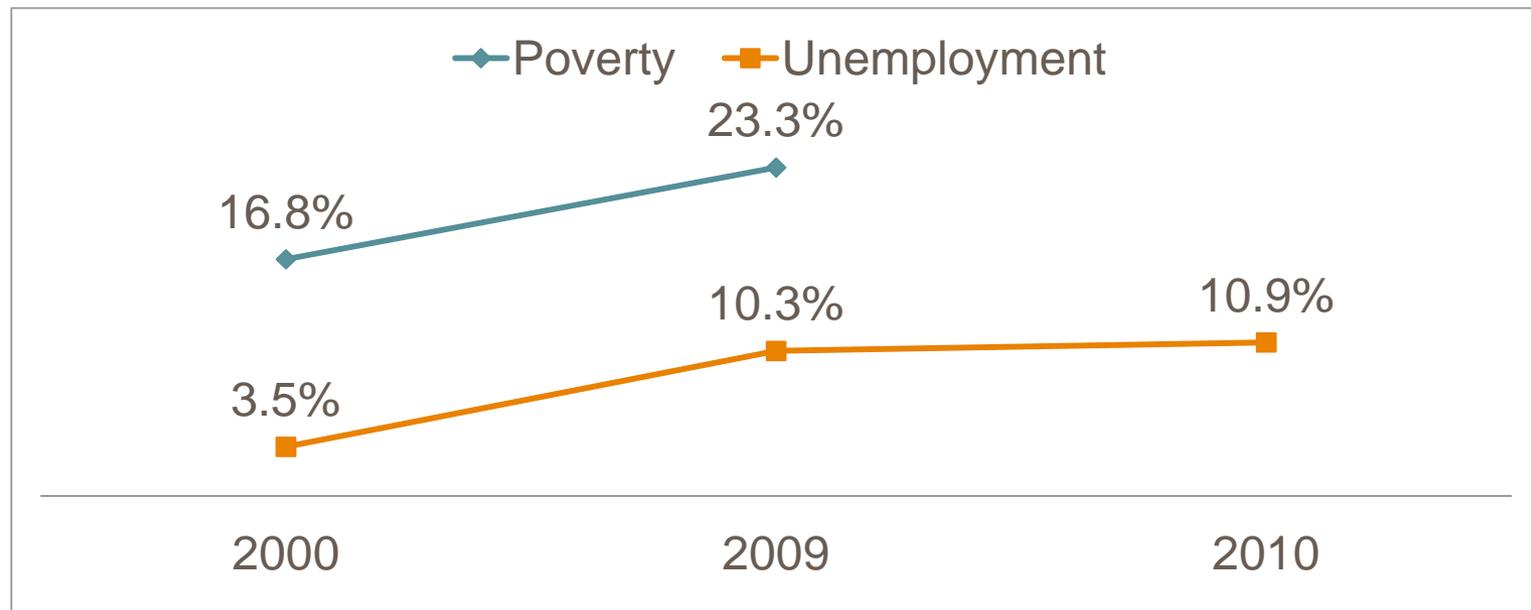
Demographic Trend: Race and Ethnicity



Note: Red arrows indicate trend

Demographic Trend: Poverty & Employment

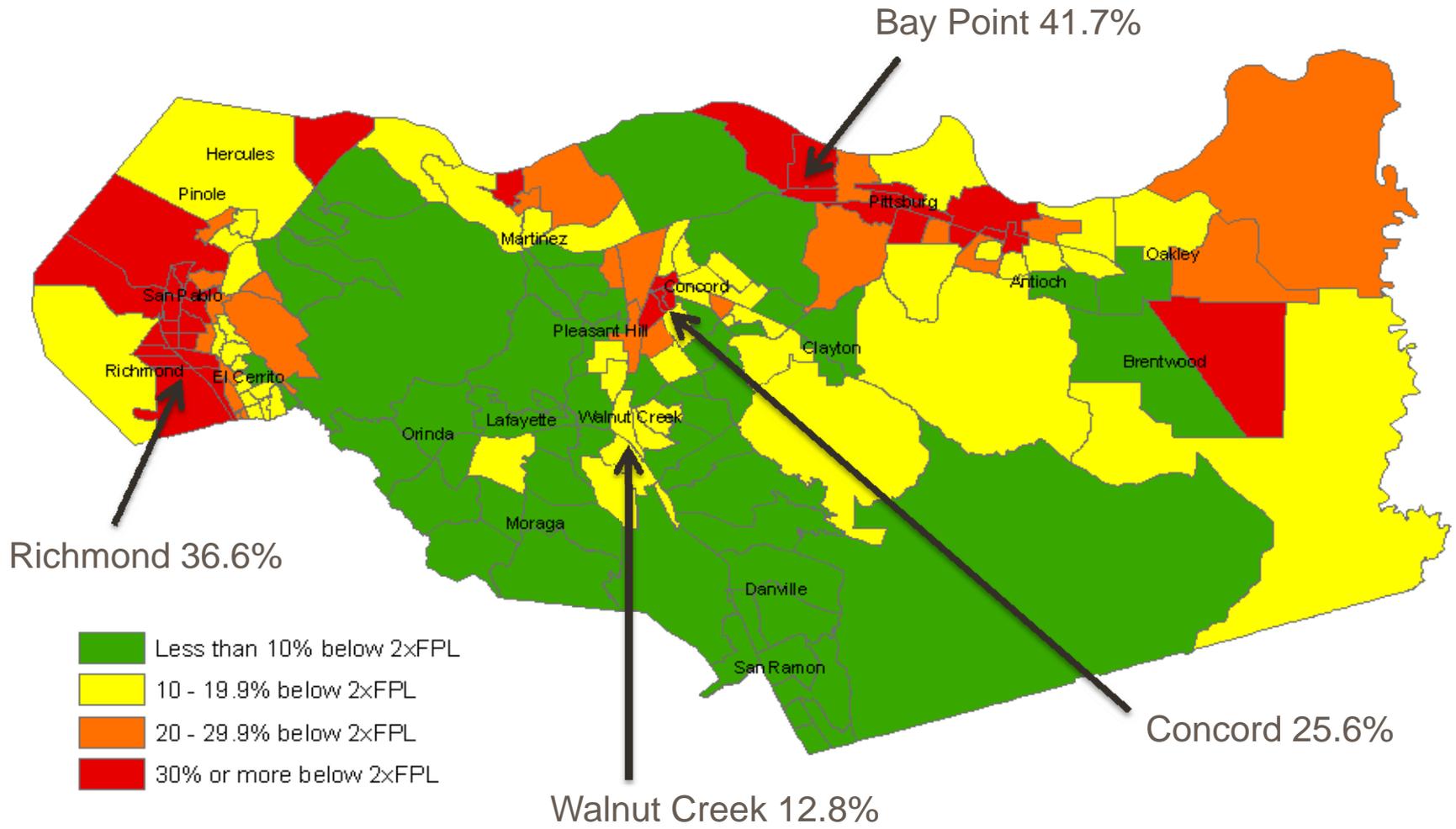
- The county's unemployment rate and residents living below 200% of the federal poverty level has increased since 2000.



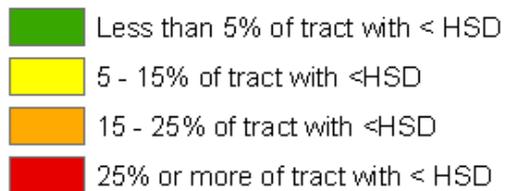
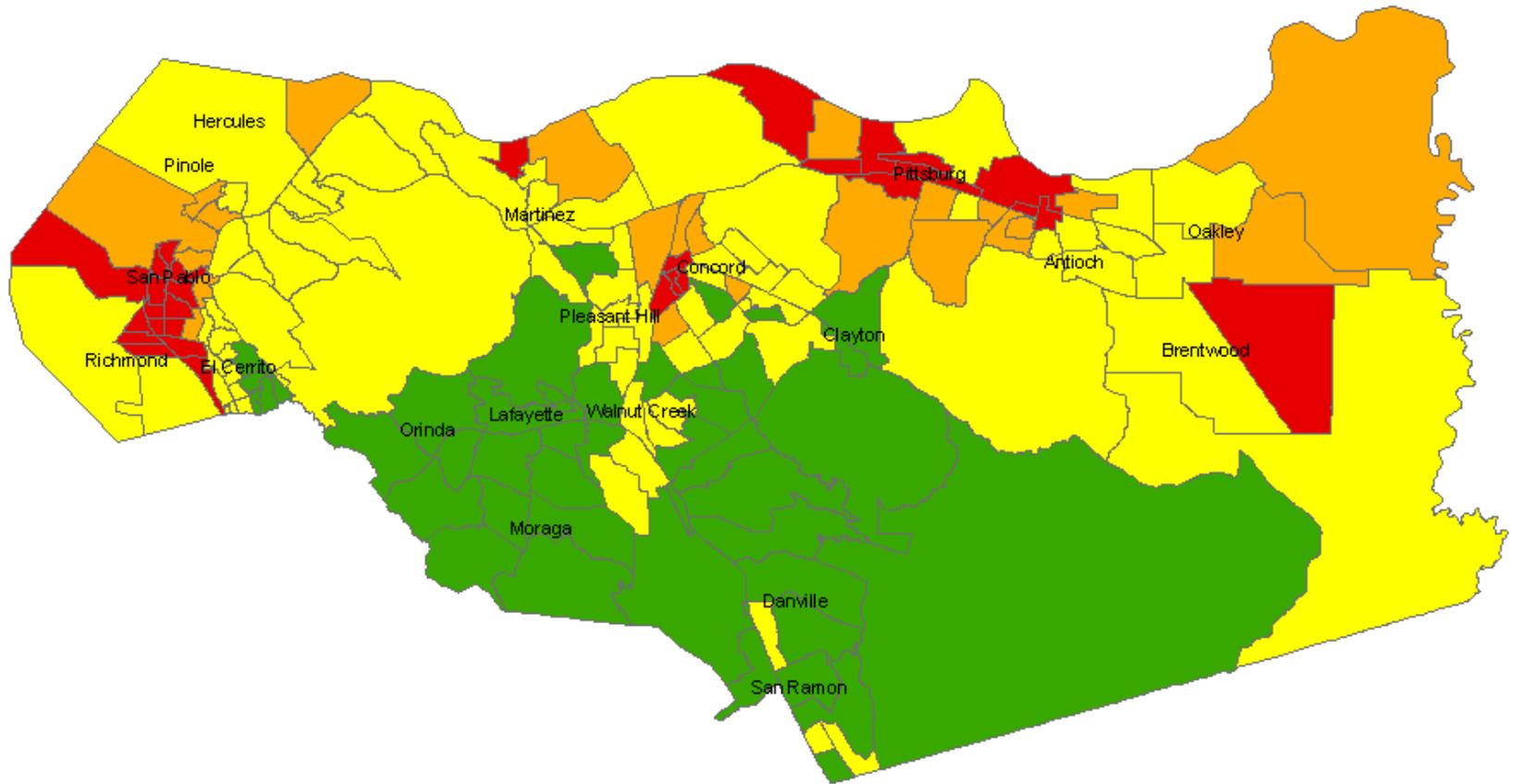
Note: poverty data not available for 2010

Contra Costa County Poverty by Census Tract 2000

Contra Costa County 23.3%



Contra Costa County Educational Attainment by Census Tract 2000



Summary of Trends

- Shift in older adults residents
- Non-whites are the majority
- Poverty and unemployment rates have increased throughout the County
- Distribution of racial and ethnic groups, poverty, unemployment and educational attainment is not equal

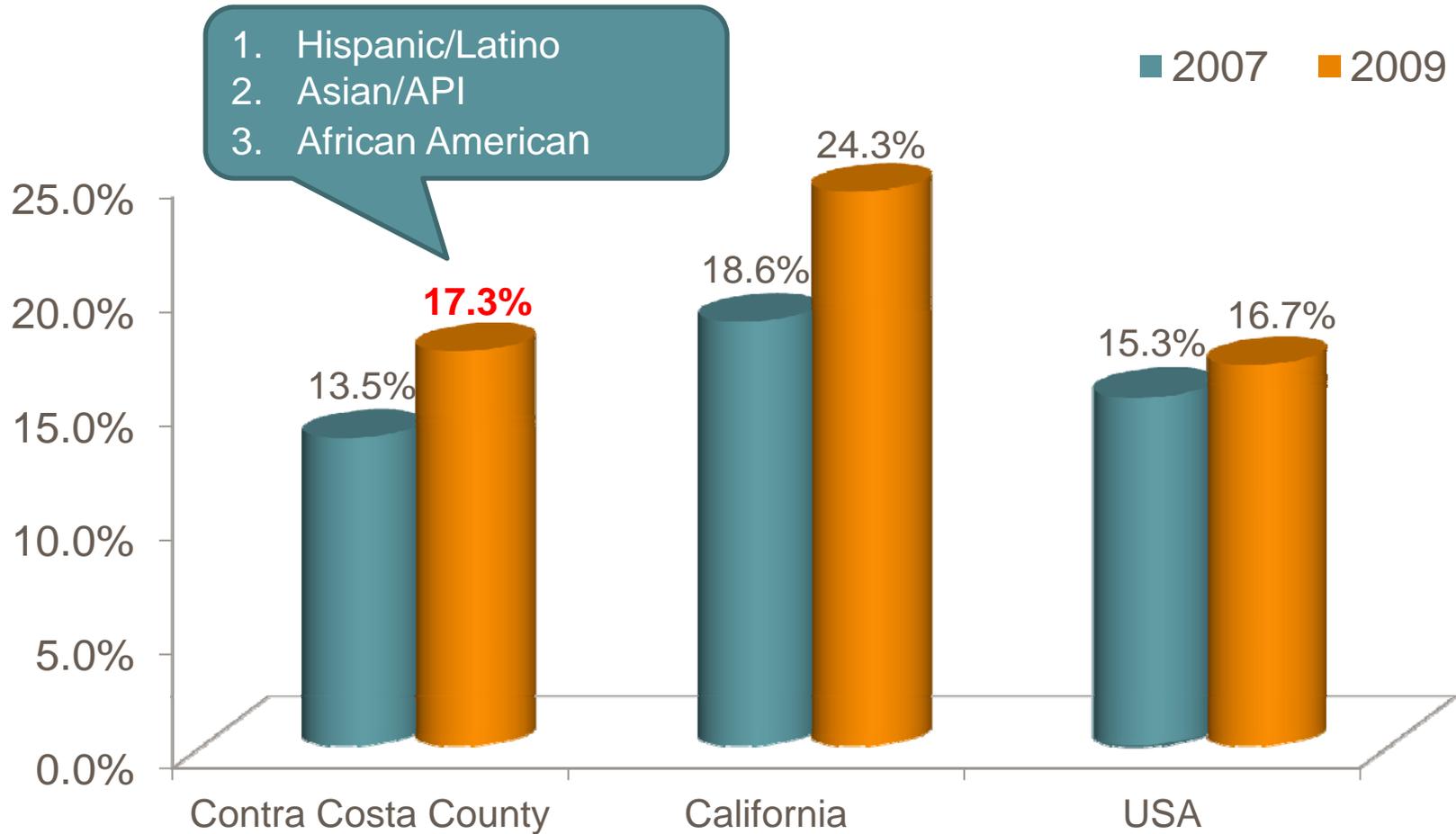
Impact of Demographic and Economic Indicators



1. Access to Health Care
2. Health Status
3. Health Outcomes

1. Access to Health Care

Access to Health Care: Uninsured Rate

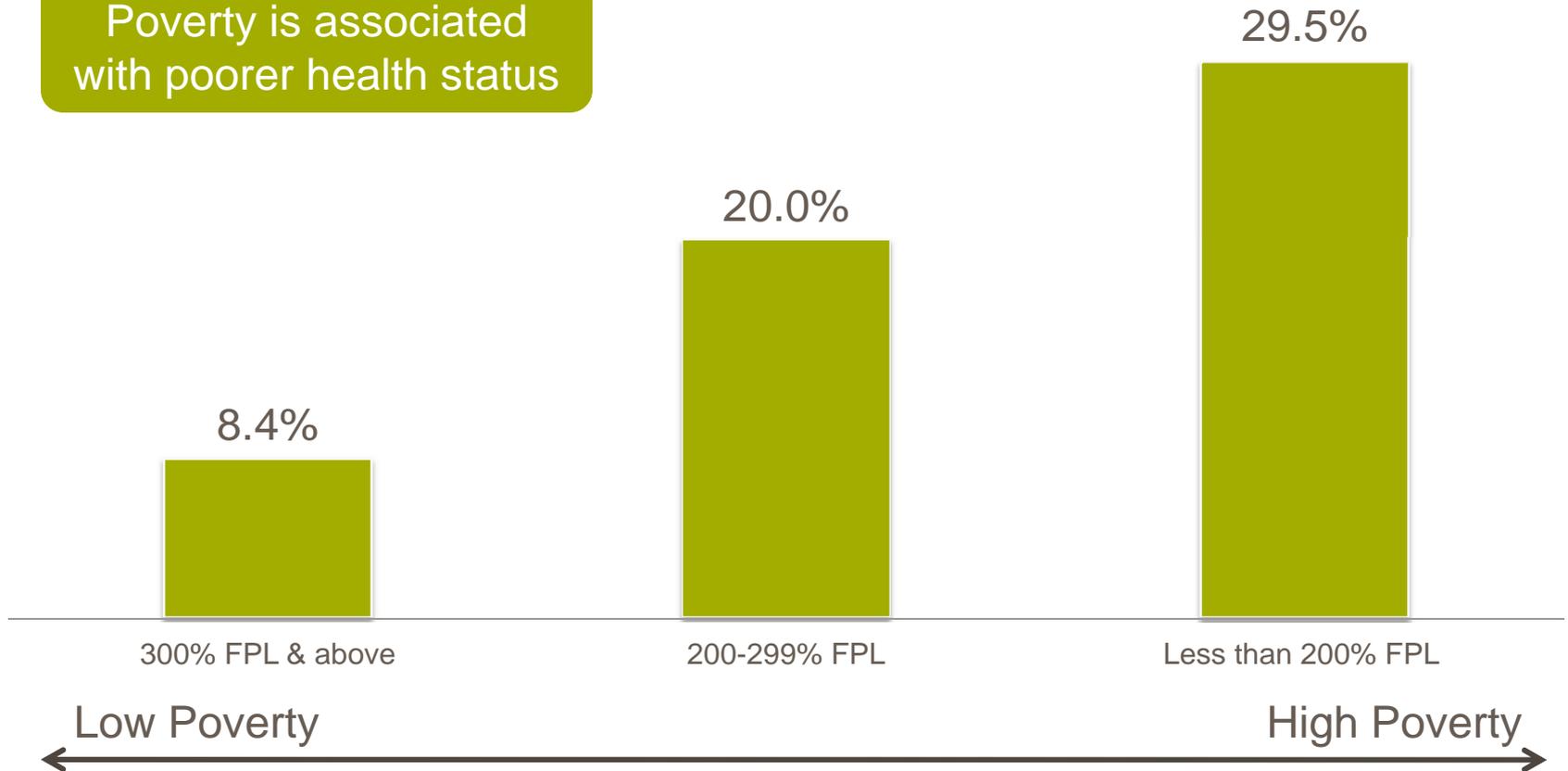


2. Health Status

Self Reported Health Status by Poverty

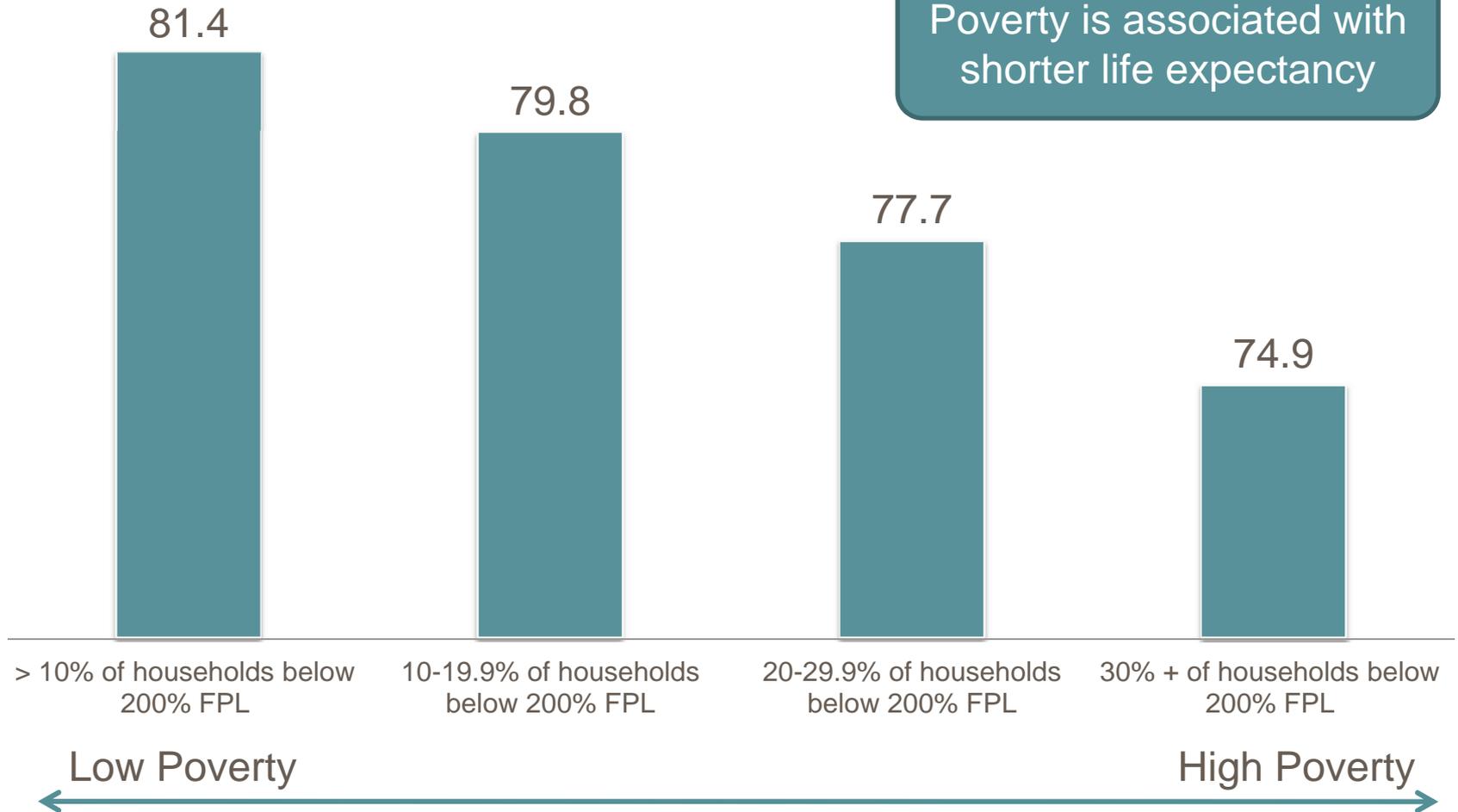
Percent Reported Poor/Fair Health Status by FPL

Poverty is associated with poorer health status

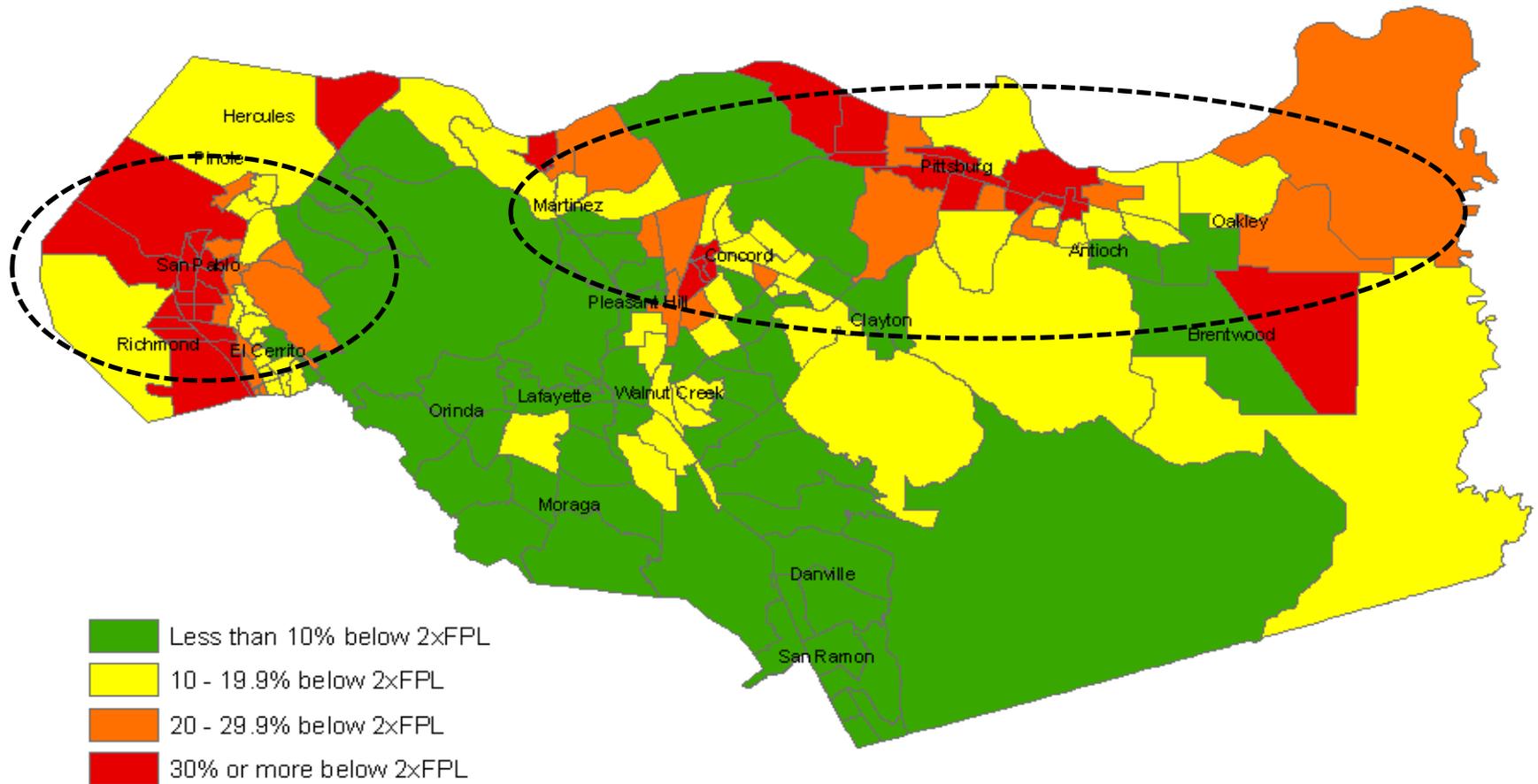


Life Expectancy by Poverty

Poverty is associated with shorter life expectancy



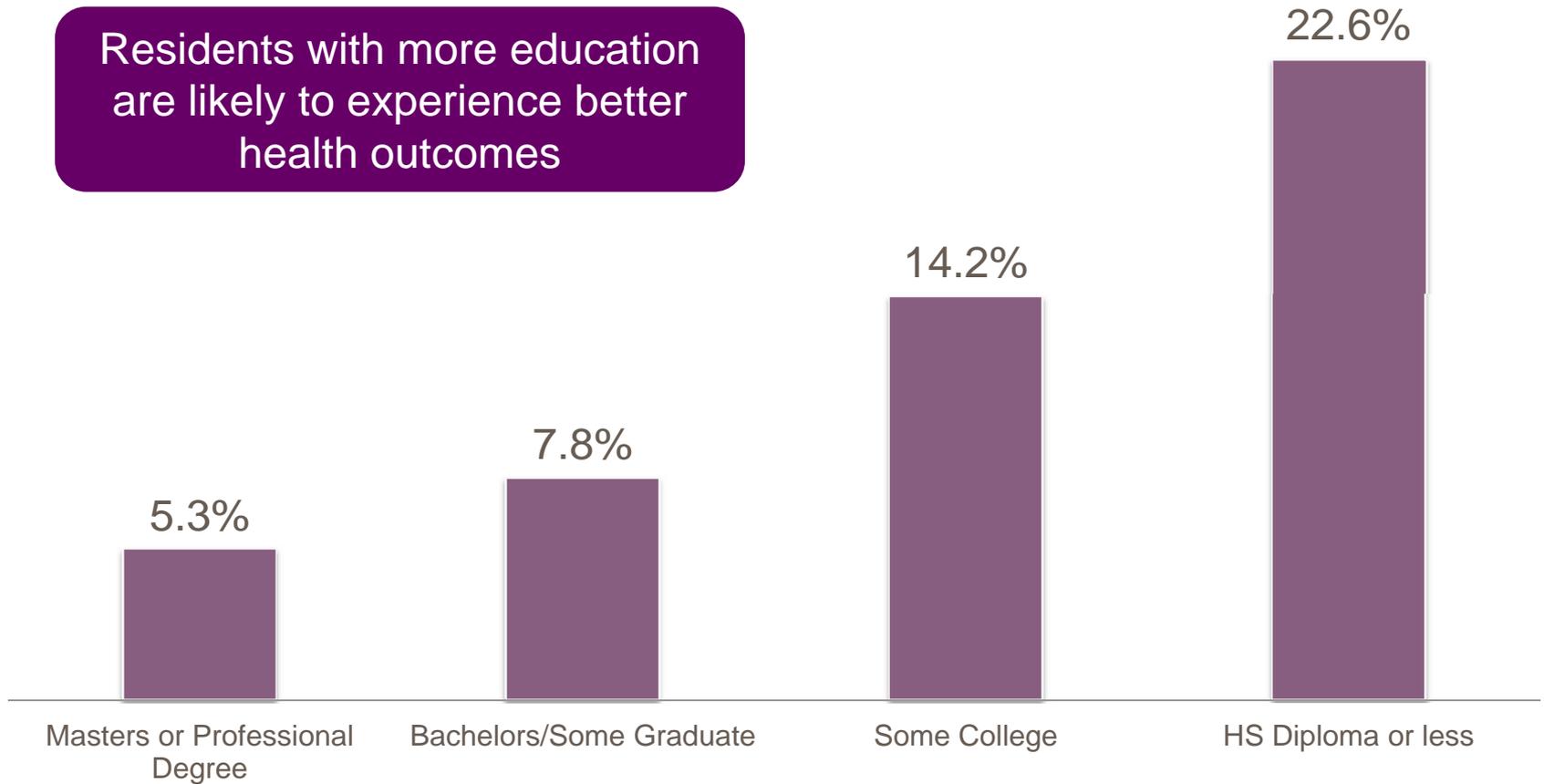
Contra Costa County Poverty by Census Tract 2000



Self Reported Health Status by Education

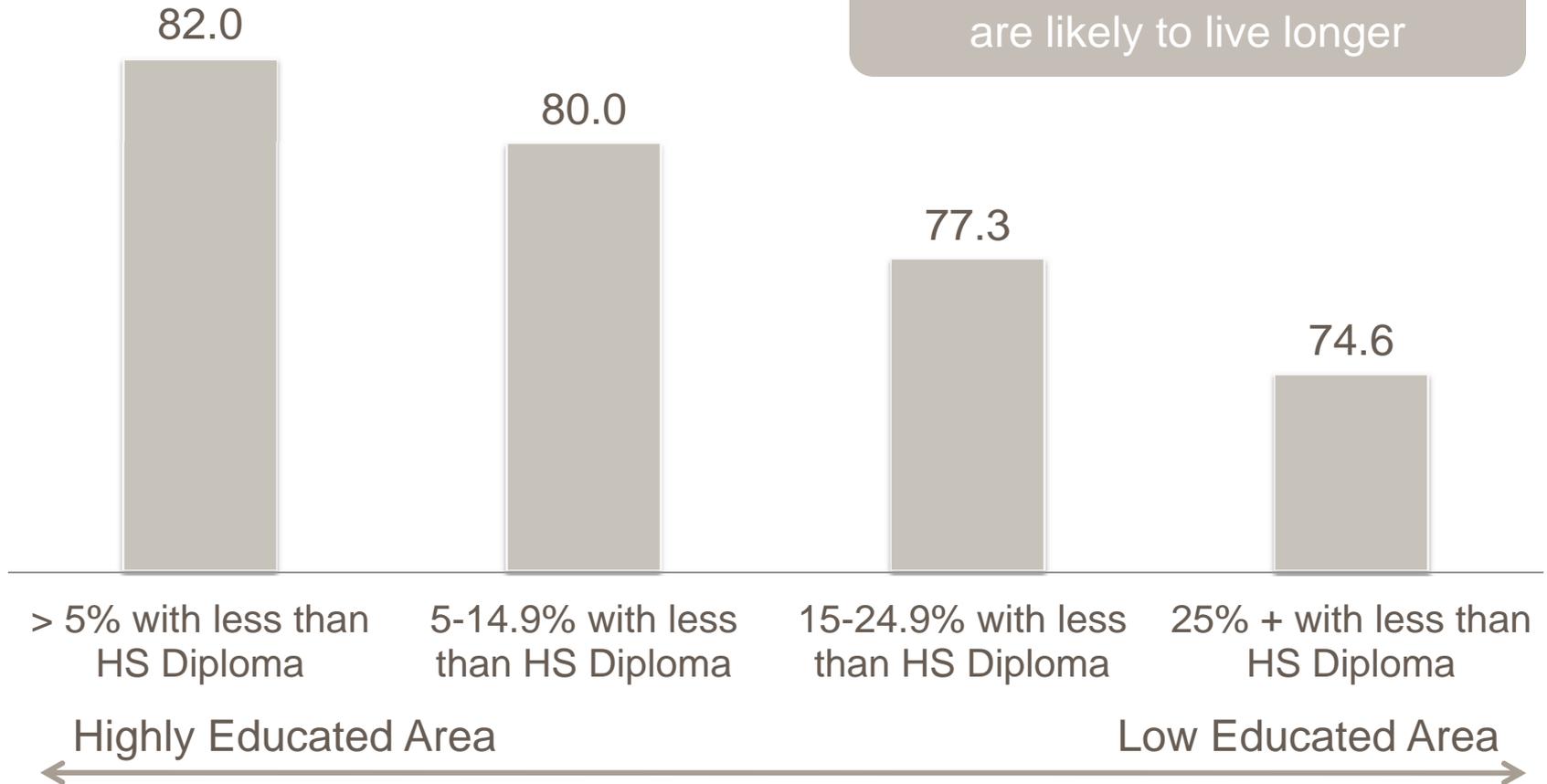
Percent Reported Poor/Fair Health by Education

Residents with more education are likely to experience better health outcomes

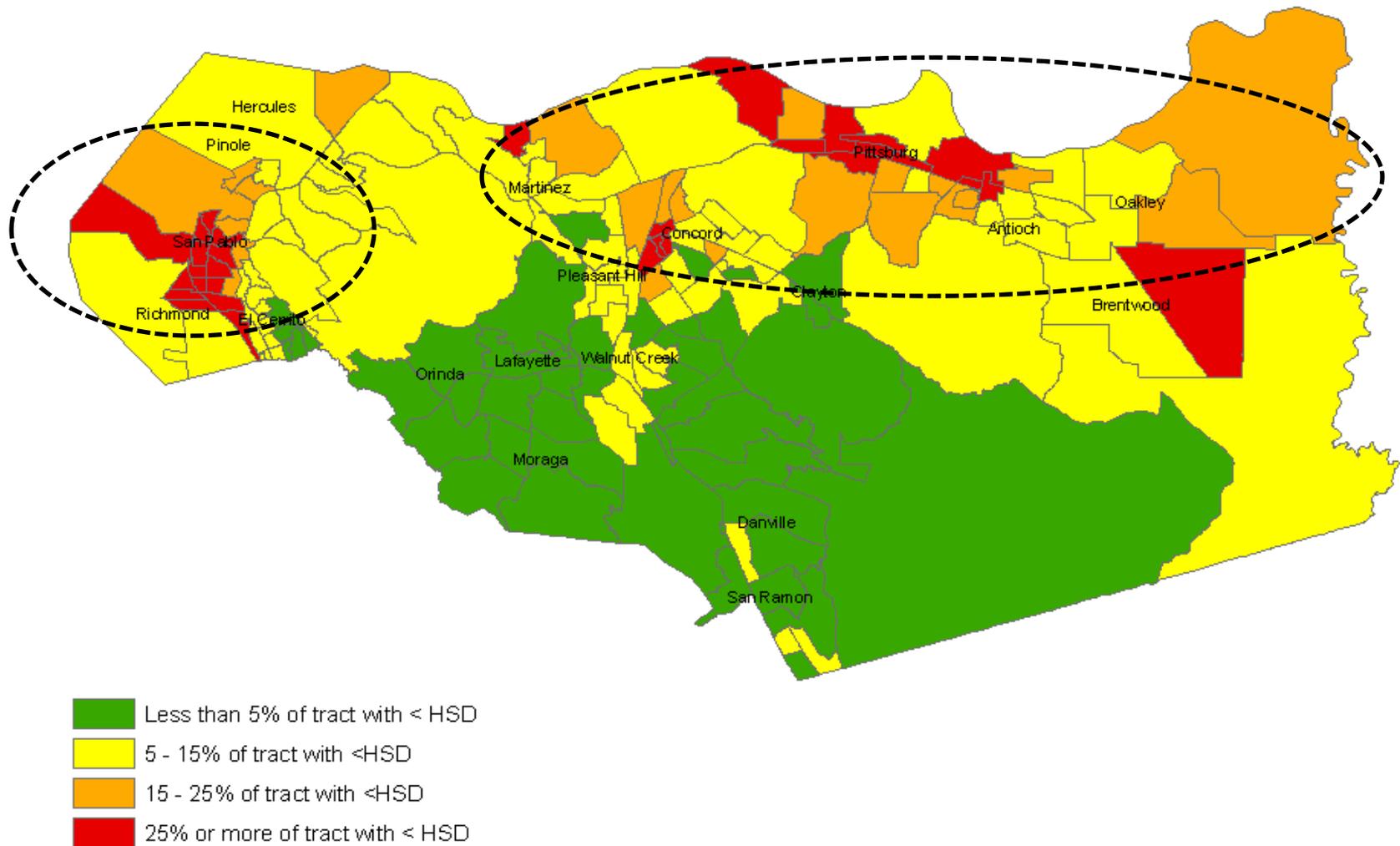


Life Expectancy by Education

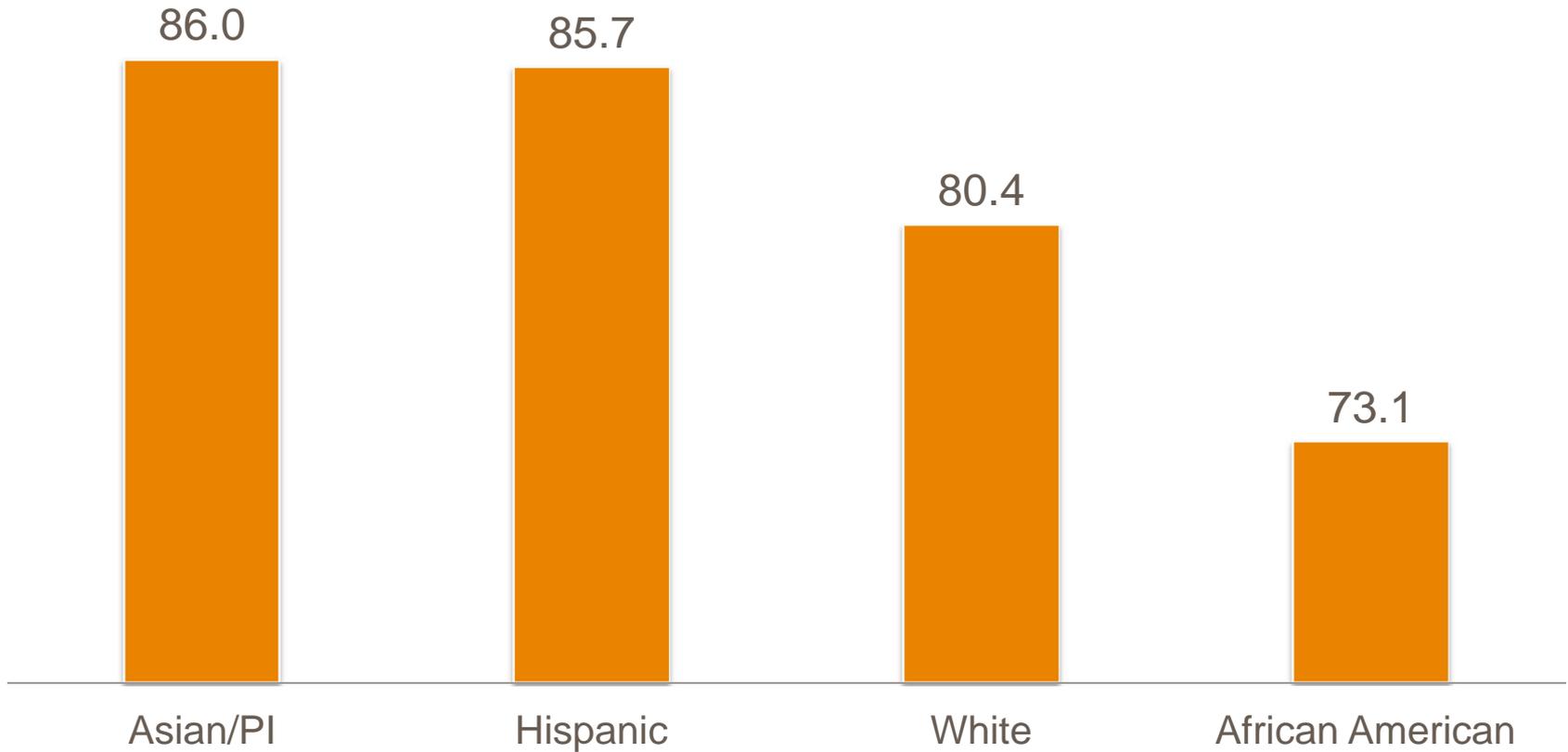
Residents with more education are likely to live longer



Contra Costa County Educational Attainment by Census Tract 2000



Life Expectancy by Race & Ethnicity



3. Health Outcomes

Health Indicators	Oakley	Brentwood	Antioch	Pittsburg	Bay Point	Pleasant Hill	Martinez	Richmond	Concord	Walnut Creek	CCC	Disparity (Race, ethnicity, gender)
Birth to teens (rate per 1,000)	29.2 😊	24.9 😞	39.0 😞	47.2 😊	60.2 😞	NA	14.0 😊	54.0 😊	28.8 😞	6.3 😊	23.5 😞	Latina AA
All Cancer Deaths (rate per 100,000)	219.2 😞	169.2 😊	200.8 😊	180.0 😊	130.2 😊	160.7	207.0 😊	177.7 😊	172.4 😊	180.3 😊	162.0 😊	AA, Men, ages 35-64
Breast Cancer Deaths (rate per 100,000)	NA	31.2	29.8 😞	24.8	NA	NA	NA	21.4	23.9 😊	24.6 😊	23.0 😊	AA Women
Colorectal Cancer Deaths (rate per 100,000)	NA	18.8	25.5 😞	21.1 😞	NA	NA	22.6 😊	15.9 😊	18.0 😊	15.8 😊	16.5 😞	AA
Lung Cancer Deaths (rate per 100,000)	60.4 😊	33.6 😊	57.1 😊	49.1 😊	NA	40.6	43.7 😊	46.2 😊	44.5 😊	42.6 😊	38.8 😊	AA
Prostate Cancer Deaths (rate per 100,000)	NA	NA	NA	NA	NA	NA	NA	35.0 😊	23.0 😊	27.9 😊	22.7 😊	AA Men
Diabetes Deaths (rate per 100,000)	NA	22.0	35.1 😞	37.0 😞	NA	20.2	25.5 😊	32.4 😊	22.2 😊	10.1 😊	18.9 😊	AA Men
Heart Disease Deaths (rate per 100,000)	226.5 😊	132.1 😊	211.1 😊	181.5 😊	121.7 😊	156.7	188.5 😊	210.2 😊	153.8 😊	114.0 😊	147.5 😊	AA Men
Stroke Deaths (rate per 100,000)	51.5 😊	44.9 😊	56.1 😊	71.9 😊	NA	40.0	48.6 😊	61.5 😊	51.9 😊	43.1 😊	46.7 😊	AA
Overweight 5th Graders (% by School District)	25.0% 😊	27.3%	36.6% 😞	36.2% 😊	NA	26.2%	25.0% 😞	36.5% 😞	26.2% 😞	19.1% 😞	26.5% 😊	Latino AA, Boys
Unintentional Injury Deaths (rate per 100,000)	26.0 😊	24.9 😊	31.5 😞	33.0 😞	32.4	25.2	40.6 😞	30.8 😊	29.2 😞	37.2 😞	26.7 😞	AA, White age 65+
Unintentional Injury Hospitalizations (rate per 100,000)	448.3 😊	471.0 😊	640.4 😞	493.3 😊	493.3 😊	632.7	562.9 😊	468.2 😞	597.9 😞	1913.7 😞	537.1 😞	age 65+, 75% due to falls
Homicides (rate per 100,000)	NA	NA	11.7	11.7	NA	NA	NA	38.6	NA	NA	9.3 😞	AA, Men, ages 21-44
Non-Fatal Assault Hospitalizations (rate per 100,000)	25.6 😊	NA	54.8 😞	61.6 😞	NA	NA	32.5 😊	135.9 😊	64.4 😞	NA	37.0 😞	AA, Men, ages 15-24
AIDS (rate per 100,000)	NA	NA	8.0 😊	10.7	NA	NA	NA	13.3 😊	7.8 😊	11.2	6.9 😊	AA Men
Childhood Asthma Hospitalization (rate per 10,000)	10.9 😊	11.4 😞	20.0 😞	15.7 😊	13.9 😊	11.2	10.7 😊	29.9 😊	13.9 😞	NA	16.1 😊	AA Boys
Highlighted red box = rate higher than CCC				😞= worse than 2007			😊= better than 2007			NA = The rate was not available		

How to Review the Chart

1. Health Outcome Rates that have worsened county-wide
2. Cities where health outcome rates are higher than the county
3. Cities where health outcome rates have worsened since 2000
4. Populations that are disproportionately affected by the health outcomes

Avoidable Health Disparities

- Rates for most health indicators have decreased in Contra Costa County, but disparities related to city of residence, race/ethnicity, gender and age still persist.
 - African Americans die more from the county's leading causes of death than any other racial group
 - Men are more likely to die from cancer than females
 - The greatest number of unintentional injury hospitalizations occurred among residents 65 years and older
 - Residents 21-44 and African American males are more likely to be hospitalized from non-fatal assaults and die from homicide

Non-fatal Assault Hospitalization Rates by Zip Code

