



2013 Community Benefit Report

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



Prepared May 2014

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Executive Summary

John Muir Health is a not-for-profit, community-based organization that is governed locally. Our focus is on improving the health of the people of Contra Costa County. 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, which provides 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 follows the guidelines developed by the Catholic Healthcare Association and VHA Inc. for reporting the economic value of its Community Benefit contributions.

During Fiscal Year 2013, John Muir Health made over \$105 million in Community Benefit contributions.

2013 John Muir Health Community Benefit Contributions	
Charity Care	\$25,143,000
Medi-Cal Shortfall	\$60,713,000
Subsidized Health Services	\$1,637,000
Health Improvement	\$7,949,000
Community Building	\$644,000
Financial and In-Kind Contributions, Grants	\$2,606,000
Health Professions Education	\$3,953,000
Research	\$1,479,000
Community Benefits Operations	\$916,000
Total	\$105,040,000

These categories are consistent with IRS Form 990 Schedule H for Hospitals definitions. 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 \$215 million. This is not included in the total above.

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

2013 John Muir Health Community Benefit Contributions	
Charity Care	\$25,143,000
Medi-Cal Shortfall	\$60,713,000
Vulnerable Populations	\$9,520,000
Broader Population	\$4,232,000
Health Professions Education and Research	\$5,432,000
Total	\$105,040,000

Community Benefit contributions include activities at John Muir Medical Center, Walnut Creek, John Muir Medical Center, Concord, John Muir Health Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network.

Our local commitment is expressed in the many initiatives we deliver to the community at large. 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, the Faith and Health Partnership and the Community Nursing Program.

In 2013, our Community Benefit activities further focused on those with disparities in health outcomes. We continued our partnerships with La Clínica 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, Operation Access and the La Clínica-John Muir Health Specialty Care Program. We continued our hospital-based violence intervention program to provide individual and family support to victims of intentional violence at the John Muir Medical Center, Walnut Creek Trauma Center. 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.

For additional information on our community programs for vulnerable populations, refer to attachment E, the 2013 Community Health Improvement Plan which includes 2013 program year-end results and 2014 program objectives.

All of us within John Muir Health are proud of the benefits we provide to the community. 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.

"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.

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. See attachment A for a complete description of John Muir Health facilities.

For more information, you can find the John Muir Health Organizational Chart in attachment B and the John Muir Health entity's Board of Directors lists in attachment C.

John Muir Health's Community Benefit services are delivered throughout the health system in a variety of ways. John Muir Health Community Health Improvement oversees Community Benefit activities.

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

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?

2013 Community Health Needs Assessment

John Muir Health has long valued a systematic approach for identifying community health needs in order to guide thoughtful and effective Community Benefit investment for years to come. In 2013, John Muir Health conducted another triennial Community Health Needs Assessment (CHNA) in response to the federal requirements described in section 501(r)(3) of the Internal Revenue Code and the requirements of California Senate Bill 697, enacted in 1994. This 2013 CHNA continues the John Muir Health's long-standing commitment to the communities we serve by understanding their needs and assets in order to define where and how John Muir Health community investments can have the greatest impact.

All John Muir Health entities collaborated with Kaiser Foundation Hospital Walnut Creek and Kaiser Foundation Hospital Antioch in the 2013 CHNA process. The process included comprehensive review of secondary data on health outcomes, drivers, conditions and behaviors in addition to the collection and analysis of primary data through community conversations with members of vulnerable populations in our service area. We gathered input on the identified community health needs and the relative priority among them, through a convening of public and community health leaders, advocates and experts. The resulting prioritized list represents a community understanding informed by both data and experience with particular relevance for vulnerable populations in the John Muir Health service area (listed in priority order).

1. Increased exercise and activity
2. Healthy eating
3. Primary care services and information (health literacy) including adequate Spanish capacity
4. Economic security
5. Asthma prevention and management
6. Specialty care
7. Affordable, local mental health services
8. Peri-natal care
9. Affordable, local substance abuse treatment services
10. Parenting skills and support

The CHNA report was approved by the Board of Directors in October 2013.

The 2013 CHNA report is available to the public as a Community Benefit. The 2013 full CHNA report and the previous 2010 report are available on John Muir Health's website: <http://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html>

Ongoing Community Input

John Muir Health used various mechanisms to incorporate community input into our annual plan in addition the triennial CHNA. During 2013, John Muir Health kept abreast of current health issues of importance to the community by active participation within the Dental Collaborative of Contra Costa, East County Access Action Team, Contra Costa County Safety Net Innovation Network, Health and Livable Pittsburg, Healthy and Active Before Five, 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 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 and the Monument Community Partnership. CCHS is also a partner in most of the collaborative groups mentioned above.

Where Is John Muir Health Focusing Its Efforts?

Community Health Improvement Plan

In 2013, John Muir Health adopted a triennial Community Health Improvement Plan in response the health needs identified in the 2013 CHNA report. The Community Health Improvement Plan serves as the triennial implementation strategy for John Muir Health hospitals: John Muir Health Medical Center, Walnut Creek, John Muir Health Medical Center, Concord and John Muir Health Behavioral Health Center.

In 2013, John Muir Health convened the CHNA Advisory Committee, comprised of John Muir Health leadership and community health experts. The CHNA Advisory Committee reviewed the CHNA report and utilized three criteria to select the community health needs that John Muir Health would address as an organization from 2013 to 2016.

The John Muir Health Community Health Improvement plan identified the following community health needs to address and including these specific strategies:

3. Primary care services and information (health literacy) including adequate Spanish capacity
 - Support activities in schools that address the need for health information, services and referrals for children and their families
 - Provide and/or support medical care services to uninsured adults who are unable to access care quickly and affordably

- Provide care coordination services to connect patients with health care (medical home) and other support services so they can access care quickly and affordably
 - Support and/or provide chronic condition management education and support services
 - Support community-based organizations that provide health evidence based education and support services
6. Specialty care
- Support and/or provide specialty care services to uninsured residents through John Muir Health affiliated physicians
 - Support and/or provide screening programs and referral services in order to detect and treat conditions early
7. Affordable, local mental health services
- Provide intervention and referrals to violence-related trauma victims in order to prevent recidivism and retaliation
 - Support and/or provide behavioral health intervention services to uninsured and vulnerable populations

The Community Health Improvement Plan includes long and short term goals, strategies, anticipated impacts and metrics associated with each John Muir Health selected community health need. It also describes the reasons why John Muir Health did not select the other identified community health needs.

The Board of Directors approved the Community Health Improvement Plan in October 2013.

The Community Health Improvement Plan is available on John Muir Health's website: <http://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html>

The Community Health Improvement Plan also serves as the foundation for annually evaluating the impact of our Community Benefit investments through measurable annual objectives and timeframes. Please see the 2013 Community Health Improvement Plan annual update that includes 2013 program year-end results and 2014 program objectives in attachment E.

Program Funding Criteria

The community health need focus areas outlined in the Community Health Improvement Plan outline the high level plan for addressing community health. Additionally, John Muir Health uses the following program funding criteria to select the specific programs that will achieve the Community Health Improvement Plan's goals:

1. 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.

2. 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.
3. Programs will positively **impact the health of the community** in a measurable way.

An internal, Community Benefit Oversight Committee annually reviews community assessment data and program evaluations. The Committee makes recommendations for program funding in the annual budget process. 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.

Economic Valuation of Community Benefit

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 2013, John Muir Health contributed more than \$105 million in Community Benefit. 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.

2013 John Muir Health Community Benefit Contributions

The economic valuation of Community Benefit contributions includes Community Benefit activities provided by all John Muir Health entities: John Muir Medical Center, Concord, John Muir Health Center, Walnut Creek, Behavioral Health Center, John Muir Physician Network and John Muir/Mt. Diablo Community Health Fund. Contributions are shown for Fiscal Year 2013 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 2013, John Muir Health contributed over \$105 million in community benefit. These contributions include:

Purpose	Description	Contribution Amount
Charity Care	John Muir Health provides 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. The amount listed are costs not charges and do not include bad debts.	\$25,143,000
Government Sponsored Health Care (Medi-Cal shortfall)	John Muir Health provides 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 the cost (not charges) 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.	\$60,713,000
Subsidized Health Services	These services are underwritten by John Muir Health. In some cases John Muir Health provides services at a loss because the service is the only available resource in the community. We consider these losses a community benefit. Subsidized services include the Emergency Medical Services ambulance base station for the county at John Muir Medical Center, Walnut Creek.	\$1,637,000
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. John Muir Health provides the community an array of resources including health care professionals, mobile health services information and education services. The Community Health Improvement department 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.	\$7,949,000
Community Building	Community Building includes workforce development activities and community collaborative development. It includes John Muir Health’s support for the Monument Community Partnership.	\$644,000
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. John Muir Health contributes over \$1 million annually to the John Muir/Mt. Diablo Community Health Fund to focus on ways to achieve fundamental improvements in the health status of uninsured, underserved and overlooked families, children and	\$2,606,000

	seniors. Also included in Financial and In-Kind Contributions 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.	
Health Professions Education	Community Benefit also includes health professions education programs in the areas of nursing, physical therapy, ultrasound technology, radiologic technology, rehabilitation, clinical pastoral care and other health professions.	\$3,953,000
Research	Clinical research funded by government agency or tax-exempt organizations where findings are available to the public.	\$1,479,000
Community Benefit Operations	In order to coordinate our Community Benefit planning and execution of programs to maximize their impact, John Muir Health also supports a small dedicated staff and their office operations.	\$916,000
Total		\$105,040,000

In addition, John Muir Health provided care to Medicare inpatients and outpatients whose estimated costs exceeded payments made by the government-sponsored Medicare program. The Medicare shortfall, the difference between the cost of care for Medicare beneficiaries and the payments for those services, was over \$215 million. This is not included in the above total.

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

2013 John Muir Health Community Benefit Contributions	
Charity Care	\$25,143,000
Medi-Cal Shortfall	\$60,713,000
Vulnerable Populations	\$9,520,000
Broader Population	\$4,232,000
Health Professions Education and Research	\$5,432,000
Total Benefits Reported	\$105,040,000

Community Benefit contributions include programs at John Muir Medical Center, Walnut Creek, John Muir Medical Center, Concord, John Muir Health Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network. A separate 2013 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Health Behavioral Health Center.

Non-Quantifiable Benefits

John Muir Health contributes to the community in many non-quantifiable ways that are not outlined in this report. The health system continually provides leadership in the community, assists with local capacity building and participates in community-wide health planning. John Muir Health staff are actively involved in community organizations

as volunteers. Their leadership in the community helps to develop partnerships to address the needs of the vulnerable and underserved. The following are examples of non-quantifiable benefits provided to the community in 2013:

- The American Heart Association Heart (AHA) Walk was held on September 22, 2013. More than 300 John Muir Health physicians, clinical staff, administrators, employees and volunteers participated. Together they raised \$100,160 to fight heart disease and stroke. John Muir Health placed in the top five for money raised from companies and organizations throughout the Bay Area, achieving recognition in the AHA's Circle of Excellence.
- John Muir Health's commitment to environmental sustainability is evident through many initiatives, including the work of the Green Team. In 2013, the Green Team eliminated Styrofoam cups for the John Muir Health inventory and waste stream.
- John Muir Health nurses are deeply involved in their community through volunteering. John Muir Health encourages nursing volunteerism and community involvement through Magnet[®] recognition status where nurses support health by building partnerships with the community. For example, nurses at John Muir Medical Center, Concord provide health education monthly at the local farmer's market.
- John Muir Health employees are dedicated to engaging the next generation of health career professionals in a variety of ways. One such way is the e-mentoring program, which connects students interested in a healthcare career with information and support from a mentor. In 2013, 52 John Muir Health employees volunteered to mentor local high school students.

Attachments

Attachment A – John Muir Health Structure

Facility	Location	Description
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. John Muir Medical Center, Walnut Creek is accredited by The Joint Commission, a national surveyor of quality patient care.
John Muir Medical Center, Concord	2540 East Street, Concord, CA	John Muir Medical Center, Concord is a 267-bed acute care facility that serves Contra Costa County and southern Solano County. John Muir Medical Center, Concord is accredited by The Joint Commission.
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.
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.
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. Outpatient services offered include laboratory, medical imaging and physical and occupational therapy.

John Muir Health Outpatient Center, Walnut Creek	1450 Treat Blvd. Walnut Creek, CA	John Muir Health Outpatient Center, Walnut Creek is a comprehensive outpatient medical facility offering a wide range of physician and clinical services. Outpatient services offered include internal and family medicine, pediatric medicine, endocrinology and metabolism, urgent care, medical imaging, lab services, bone health services and weight management program.
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.
John Muir Health Urgent Care Centers		Other important components within the John Muir Health organization include four urgent care centers in Walnut Creek, Concord, Brentwood and San Ramon.

Attachment B – Board Lists

John Muir Health 2014 Board of Directors

JOHN MUIR HEALTH
JOHN MUIR PHYSICIAN NETWORK
JOHN MUIR BEHAVIORAL HEALTH

COMMUNITY MEMBERS - VOTING

David L. Goldsmith, Chair
Thomas G. Rundall, Ph.D., Vice Chair
Philip J. Batchelor, Treasurer
William F. (Rick) Cronk, Secretary
Linda Best
Robert E. Edmondson
Marilyn M. Gardner
Mike Robinson
Calvin (Cal) Knight (CEO)

PHYSICIAN MEMBERS - VOTING

Ravi Hundal, M.D.
Taejoon Ahn, M.D.
Mark Musco, M.D.
Bimal Patel, M.D.
Deborah Kerlin, M.D.
David Birdsall, M.D.

EX-OFFICIO – NON-VOTING

Deborah Arce, M.D.
Steven M. Kaplan, M.D.
Johannes Peters, M.D., JMMC, Walnut Creek Chief of Staff
John (Tim) Ganey, M.D., JMMC, Concord Chief of Staff
Lee Huskins, President & CAO, John Muir Physician Network)

John Muir/Mt. Diablo Community Health Fund 2014 Board of Directors

The Community Health Fund is governed by an independent, ten-member, appointed Board of Directors, with five members appointed by the Concord/Pleasant Hill 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
Ken Carlson
Bill Gram-Reefer
Laura Hoffmeister
Rina Shah, M.D.
Jack Weir

Attachment C – Map of Service Area

**Attachment D – John Muir Health Community
Health Improvement Plan:
2013 Year End Results and 2014 Objectives**

John Muir Health 2013 Community Health Improvement Plan

The Community Health Improvement Plan includes initiatives and community based programs operated or substantially supported by John Muir Medical Center Walnut Creek, John Muir Medical Center Concord and John Muir Health Behavioral Health Center. Programs were developed in response to the Community Health Needs Assessment, internal data and community partner input.

Community Health Need: Primary care services and information (health literacy) including adequate Spanish Capacity

Long Term Goal: Increase access to quality, evidenced based health information, prevention and health care services to vulnerable residents of Central and East Contra Costa County

- Intermediate Goals:**
1. Increase prevention, health care services and referrals to youth in vulnerable communities
 2. Increase prevention, health care services and referrals to adults in vulnerable communities
 3. Increase patient's ability to manage their health problems
 4. Increase knowledge of healthy living behaviors for vulnerable populations

Strategy: Support activities in schools that address the needs for health information, services and referrals for children and their families

Tactic 1: Provide a Community Nurse in low-income schools in the Monument area of Concord and Pittsburg to promote health and safety, intervene in health problems, provide care management services and actively connect students and their families to community resources.

FY 10 Baseline: During the 2009-2010 school year, the Community Nurse received 309 referrals and then referred 220 to external community resources, such as the county health department, community clinics, family and child agencies and physician appointments. 100% of students received mandated screenings.

2013 Objectives

1. During the 2013-2014 school year, the Community Nurse will track all referrals received and issued and will provide appropriate

Outcomes

- From August 2012 to June 2013, a total of 1,390 referrals were

interventions for all referrals received.

2. The Community Nurse will provide appropriate interventions for all referrals received.
3. During the 2013-2014 school year, 100% of K, 2nd, and 5th grades will receive mandated screenings.
4. During the 2013-2014 school year, 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.

received by the Community Nurse and 500 referrals were then made to external community resources.

- Referrals resulted in a total of 7,046 interventions including medical, family consultations and screenings.
- In 2012-2013, 100% of K, 2nd and 5th graders received the mandated screenings.
- 100% of the students with missing immunizations completed their requirements by year end.

2014 Objectives

- In addition to the 2012-2013 school year objectives, during the 2013-2014 school year, the Community Nurse will extend activities to coordinate diabetic and asthmatic services for selected students in Pittsburg Unified School District.
- For both Mount Diablo Unified and Pittsburg Unified, the Community Nurse will promote healthy nutrition and exercise through various programs, activities, classroom lessons and parent education.

Tactic 2: 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 for a total of 875 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 previously had no access to dental care.

2013 Objectives

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.

Outcomes

- In 2013, the Mobile Dental Clinic provided oral health services to 304 children for a total of 1,165 visits.
- A total of 215 families were provided with insurance enrollment assistance.
- 98% of Mobile Dental Clinic patients were connected to a dental home through referral partnerships with Lifelong Brookside, La Clínica de la Raza or Contra Costa Health Services Clinics.
- According to the Patient Satisfaction Survey, 94% of patients report that they would recommend the Mobile Dental Clinic and experienced high levels of quality and satisfaction with the oral health services.
- 41% of patients had never been to a dentist prior to their visit to Mobile Dental Clinic.

2014 Objectives

- In 2014, the Mobile Dental Clinic aims to provide oral health services to a minimum of 500 children.
- All other objectives remain the same for 2014.

Strategy: Provide and/or support medical care services to uninsured adults who are unable to access care quickly and affordably

Tactic 1: 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 Emergency Department if the Mobile Health Clinic was unavailable.

2013 Objectives

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 2,700 patients through partnerships.

Outcomes

- The Mobile Health Clinic served 517 patients during the Saturday clinic, among which 39% were new patients.
- The Mobile Health Clinic made 108 referrals, the majority (79%) concentrated in health agencies, particularly La Clínica Oakley and Brentwood Health Center.
- 100% of patients reported satisfaction with the services offered and received.
- If the Mobile Health Clinic was not available, 11% of patients reported that they would not have sought care and another 28% of patients reported that they would have sought care at the Emergency Department.
- The Mobile Clinic served 2,439 through partnerships.

2014 Objectives

- In 2014, the Mobile Health Clinic aims to serve 550 patients in the 2014 Saturday clinic.
- In 2014, the Mobile Health Clinic aims to serve at least 2,500 patients through partnerships.
- All other objectives remain the same for 2014.

Tactic 2: Support Concord RotaCare Free Clinic.

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

2013 Objectives	Outcomes
<ol style="list-style-type: none">1. Provide drivers for Rotocare Mobile Clinic to support evening clinics2. Provide storage space for Rotocare Mobile Clinic3. Provide lab and X-Ray services at discounted rates4. Provide technical assistance as requested	<ul style="list-style-type: none">• JOHN MUIR HEALTH provided drivers for 58 clinics in 2013.• Objective completed.• Lab and X-Ray services were provided to 180 patients at discounted rates.• Advised on planning of new mobile clinic, which launched May 1, 2013.

Tactic 3: Partner with La Clínica and CCHP/CCHS to provide cardiac outpatient education for low-income patients unable to attend a traditional cardiac rehabilitation program.

FY 10 Baseline: Cardiac Outpatient Education Program (COPE) began in June 2010. 26 patients were referred and 18 enrolled. 60% reported increases in fitness levels and 50% reported increases in exercise abilities.

2013 Objectives	Outcomes
<ol style="list-style-type: none">1. Provide secondary rehabilitation to low income patients with cardiovascular conditions and measure program adherence.2. Participating patients will experience increased exercise frequency, duration and/or intensity, as measured through fitness testing in the first 3 months.3. Participating patients will identify one change in eating behavior.4. 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">• In 2013, 57 patients were referred, 34 signed-up and 17 completed the 8 session program (50% engagement).• The 17 individuals who completed the full 8 sessions experienced 100% of increased exercise frequency and/or duration.• 90% of participants set one nutritional goal.• 90% selected one additional risk factor and created a plan to engage in reduction of risk factor.

Funding for the program ended in 2013

Strategy: Provide care coordination services to connect patients with health care and other support services so they can access care quickly and affordably

Tactic 1: Reduce avoidable ED visits and hospitalizations for frequent users through the Complex Community Care

Coordination (CCCC) program.

FY 11 Baseline: 14 patients who were identified as frequent Emergency Department (ED) users enrolled in the program. For the 14 patients, inpatient days decreased on average from 161 to 28 days post-enrollment in the program. ED visits decreased on average from 320 to 67 visits post-enrollment.

2013 Objectives	Outcomes
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<ol style="list-style-type: none"> 1. In 2013, the CCCC program will identify 30-40 high risk frequent users to John Muir Health. 2. In 2013, the frequent users will report improvement in access to benefits including Medi-Cal and county programs. 3. In 2013, the frequent users will report better outcomes related to healthcare, housing, transportation, mental health, substance abuse, and employment. 4. In 2013, 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. 	<ul style="list-style-type: none"> • The program has served 73 clients, 38 who are active and 35 that have graduated from the program. • 68 patients are enrolled in Medi-Cal, Medicare or Basic Adult Care while 5 patients lack coverage. • Of the total clients: <ul style="list-style-type: none"> ○ 10 experienced a change in medical diagnosis ○ 10 received medical interventions ○ 13 obtained new or changed primary care physicians ○ 6 experienced changes in their mobility ○ 8 obtained medical equipment ○ 10 experienced changed in their medication access or management ○ 3 experienced either new or changes in their mental health diagnosis ○ 5 obtained new or changed mental health providers ○ 10 experienced changes in their mental health treatment • ED visits decreased 35% after enrollment in the program. • ED inpatient cases decreased 40% after enrollment in the program. • Inpatient days decreased 54% after enrollment in the program
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2014 Objectives

- All objectives remain the same for 2014.

Tactic 2: Connect homeless patients discharged from hospital to Respite Care Center to provide recuperative care to medically fragile homeless adults.

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

2013 Objectives	Outcomes
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<ol style="list-style-type: none"> 1. John Muir Health Case Managers/Social Workers will identify patients that meet criteria for respite and refer qualifying patients to the Respite Center. 	<ul style="list-style-type: none"> • In 2013, 112 patients were referred to the Respite Center.
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| <ul style="list-style-type: none"> 2. 40% of patients referred will be admitted to respite. 3. The interdisciplinary respite team to will provide services to all eligible patients. 4. The Respite Center will decrease the hospital length of stay for eligible patients. | <ul style="list-style-type: none"> • In 2013, 63% of the patients referred were accepted and among them, 38 patients were admitted to respite. • In 2013, on average, admitted patients were provided with nearly 9 medical linkages and stayed in the program for an average of 61.74 days. • In 2013, patients who were admitted to respite from John Muir Health saved 152 hospital days. |
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2014 Objectives

- All objectives remain the same for 2014.

Tactic 3: The JMCC ED Referral Liaison Program will 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

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| <ul style="list-style-type: none"> 1. The ED Referral Liaison will continue to identify and contact patients with no primary care physician or insurance who present at the ED for non-urgent reasons. 2. The ED Referral Liaison will maintain a referral rate of 70% in 2012. 3. The ED Referral Liaison will provide contacted patients with appropriate health service, insurance assistance and community referrals. 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% in 2012. 5. At least 70% of patients who were issued a referral in 2012 will report successful follow-up outcomes (e.g. making an appointment with a PCP/Clinic, going to an appointment with a PCP/Clinic, enrolling in Medi-Cal or following through with community resource referral). | <ul style="list-style-type: none"> • The program contacted 5,865 patients in 2013. • The program provided at least 898 referrals (data incomplete). • The program provided at least 898 referrals (data incomplete). • Data are unavailable. • Data are unavailable. |
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Funding for the program ended in 2013

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

FY 09 Baseline: 35 low-income Medicare patients were provided 374 free or low-cost medications, which 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 guidelines. 4. Medication Assistance Program tracked referral sources for new program participants. 	<ul style="list-style-type: none"> • In 2013, 56 Medicare patients who have medication costs that exceed their ability to pay were served from Central and East Contra Costa County. The 56 patients were provided with 391 prescriptions. • In 2013, the Medication Assistance program provided \$269,769.93 worth of prescription medications. • In 2013, 89% of people assisted (n=50) in this program had incomes of 200% or less of the Federal Poverty Level. • In total, the Medication Assistance program completed 94 referrals, primarily to senior services and case management.
2014 Objectives	
<ul style="list-style-type: none"> • All objectives remain the same for 2014. 	

Tactic 5: Connect seniors in the Monument community with programs and services to address their health including social barriers to health (Monument Community Senior Services Outreach).

FY 11 Baseline: 658 older adults were referred to the MCSSO and 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 one or more goals identified in their 	<ul style="list-style-type: none"> • In 2013, MCSSO received 589 referrals, primarily from agency and church/faith community resources. • In 2013, MCSSO provided case management services, where a success plan was developed, for a total of 90 older adults. • In 2013, MCSSO organized a total of 20 health-related presentations in the community, where a total of 1,339 older adults were in attendance. • In 2013, MCSSO initiated a total of 674 referrals for social well-being, health and safety issues. • In 2013, among those seniors who identified as “closed cases” (n=28), 19 seniors (68%) were able to achieve one or more goals

<p>success plan.</p> <ol style="list-style-type: none"> At least 20 older adults will report involvement in neighborhood civic or community projects. Participating older adults will report increased knowledge of community resources as a result of the presentations attended and education received. Older adults will report improved health outcomes as a result of the services received. <i>Older adults will report increased hope for the future as a result of the services received.</i> 	<p>identified in their success plan and 6 seniors were unable to be contacted</p> <ul style="list-style-type: none"> In 2013, 44 older adults were involved in neighborhood civic or community projects. In 2013, 30% of participating seniors are aware and know how to access and share resources. After participating in the program, 45% still report having an untreated illness and 40% report that they are receiving the care they need or have no urgent health needs. While not all seniors reported increased hope for their future, half of respondents were “pretty hopeful” that their lives would improve in the upcoming year.
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2014 Objectives

- All objectives remain the same for 2014.

Tactic 6: The Senior Transportation Program (STP) will provide transportation to medical appointments for frail, isolated seniors.
 FY 08 Baseline: Provided 264 one-way rides to 74 seniors.

2013 Objectives	Outcomes
<ol style="list-style-type: none"> Enable at least 130 frail, isolated, and disabled seniors get to medical appointments and provide at least 950 one-way assisted rides. At least 18% of the seniors served will be Spanish-speaking Seniors will utilize STP’s transportation services on average of 8 times per year. 90% of seniors will report increased accessibility to medical services and prescription pick-up as a result of STP rides. 	<ul style="list-style-type: none"> In 2013, STP provided 878 one-way assisted rides, serving 119 seniors in total. In 2013, 17% of all seniors assisted use Spanish as their predominant language. On average, seniors utilized STP’s transportation services 7 times during the year. 96% of seniors reported increased accessibility to secure doctor appointments and 97% reported increased convenience to pick up medications.

2014 Objectives

- All objectives remain the same for 2014.

Tactic 7: The Teen Pregnancy Resource Program will provide pregnant teens with support services in order to avoid pregnancy complications.

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
<ol style="list-style-type: none"> 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 one week after delivery. 	<ul style="list-style-type: none"> • In 2013, a total of 59 community organizations and physicians offices were identified as participating sites. • 37 teens participated in the program, ranging in age from 15-19 with an average age of 17.72 years old. • 100% of 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. • Classes contributed to an increase in knowledge across all topics taught. • 100% of participants reported the program to be “very valuable.” • 100% of delivered babies were full term and without complication. • 100% of mothers were breastfeeding one week after delivery.

Funding for the program ended in 2013

Tactic 8: The Patient Navigator will provide individualized health education, referrals to community resources and additional support services to seniors who are likely to experience adverse health consequences.

FY 08 Baseline: 133 cases were referred to the Patient Navigator. 70 Advanced Healthcare Directives were mailed and 15 patients completed the document. Healthy at Heart program was offered to 128 patients and completed by 25 patients. 95% of patients would refer the Healthy at Heart program to others.

2013 Objectives	Outcomes
<ol style="list-style-type: none"> 1. In 2013, the Patient Navigator Program will assist patients and their families in effectively obtaining health care by providing information about services and health education and appropriate referrals. 2. In 2013, 95% of the referred cases will be resolved. 	<ul style="list-style-type: none"> • In 2013, information was provided to 896 seniors by either by mail or phone to patient, family or caregiver. A total of 1270 resources were provided to these seniors. • In 2013, 97% of the cases referred were resolved. Resolved cases are those that end in an outcome, such as information requested

3. In 2013, physicians will report high satisfaction with the services provided by the Patient Navigator Program as reported by the Physician Satisfaction Survey.
4. In 2013, patients will report high satisfaction with the services provided by the Patient Navigator Program as reported by the Patient Satisfaction Survey.
5. In 2013, patients will report quality of life improvements as reported by the Patient Satisfaction Survey.
6. In 2013, 50% of the patients participating in the Health at Heart program will report that their health habits have changed or improved as a result of the information receive.

by the patient is provided and billing issues.

- In 2013, physician surveys were not performed.
- In 2013, 100% of patients reported high levels of satisfaction with the services received by the Patient Navigator Program.
- In 2013, 43% of respondents reported that their quality of life is better as a result of the Patient Navigator Program.
- In 2013, 95% of patients reported that their health habits changed or improved based on the information they received.

2014 Objectives

- All objectives remain the same for 2014.

Strategy: Support and/or provide chronic condition management education and support services

Tactic 1: The Transforming Chronic Care (TCC) program provides chronic care management for low income, frail elderly.

FY 09 Baseline: TCC served 268 low income seniors. 90% of participating seniors reported that they are more knowledgeable about condition. 30 day readmit rate for Care Transitions Intervention (CTI) patients was 6% and for Tel-Assurance (TA) patients it was 0%.

2013 Objectives

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.
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

Outcomes

- In 2013, the Tel-Assurance program received a total of 254 referrals from these sources; a 50% reduction in the number of referrals received in 2012. The majority of referrals (92%) came from “other sources” while the remainder (8%) came from CCHP.
- A total of 204 low income patients were engaged in all programs in 2013, a 59% decrease from 2012.
- 82% of patients strongly agree that the Care Transitions Nurse clearly explained the Personal Health Record and 79% strongly agree that their nurse helped them to understand what questions to ask my physician.
- In 2013, the programs were able to demonstrate reduced inpatient readmissions for participating patients. Care Transitions

<p>participate in these programs.</p> <p>5. In 2013, define and report level of participation: 1.) Patients contacted, 2.) Patients engaged.</p>	<p>Intervention Readmission Rate in 2013 was reduced from 12.5% to 8.8%. The readmission rate for CHF patients in Tel-Assurance decreased from 12.5% to 5.9%.</p> <ul style="list-style-type: none"> • Average length of participation varies per patient and ranges from 21 days to 5+ years. In 2013, patient participation was the shortest for the Tel-Assurance program ranging from 21-30 days.
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2014 Objectives

- All objectives remain the same for 2014.

Tactic 2: 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 and 787 referrals were from John Muir Health providers. 90% of patients reported high satisfaction. 78% of patients reported more effectively managing activities of daily living.

2013 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 of 350% 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 	<ul style="list-style-type: none"> • Referrals in 2013 to the GCC Program totaled 1701, an increase of 3.4%. • Referrals from John Muir Health providers for 2013 were 1362, an increase of 1.7%. • In 2013, 70% of patients receiving in home assessment, who were agreeable to disclosing their incomes, had incomes less than 350% of the Federal Poverty Guidelines. • In 2013, 97% of all patients surveyed reported being very satisfied or satisfied with the GCC program. The patient satisfaction survey is sent to those who have face to face contact with GCC staff either at a home assessment or an office consultation. • Physician satisfaction surveys were not conducted in 2013. • In 2013, 75% of participating patients reported that they are more effectively managing daily activities. • As a result of the services provided by the GCC program, 35 hospitalizations, 7 readmissions, and 62 emergency department

will quantify each.

visits were avoided in 2013.

2014 Objectives

- All objectives remain the same for 2014.

Strategy: Support community based organizations that provide evidenced based health education and support services

Tactic 1: The Fall Prevention Program (FPP) will provide safety training, home modifications and education for seniors.

FY 08 Baseline: FPP participated in 24 outreach events and conducted 8 community presentations. 22 in-home assessments and modifications were conducted for a total of 31 seniors.

2013 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.
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.

Outcomes

- In 2013, 850 people were served through community outreach events and 610 were served through educational presentations.
- In 2013, 4 coalition meetings were held and on average 43 individuals representing 39 agencies attended.
- In 2013, FPP received 162 referrals and conducted home safety assessments and modifications in 130 homes for 229 low income older adult residents of Central and East Contra Costa County.
- 93% 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.
- Results from the 2013 Home Assessment and Modification Satisfaction Survey indicate that older adults who received a home assessment and modification are very satisfied with the services.
- Coalition members acknowledge the positive results from their joint efforts to reduce falls.
- Older adults who received in home assessment and modifications in 2013 report high quality of life improvements. Of these older adults, 74% 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 Meals on Wheels home delivered meals program participants with follow-up survey to determine their benefit from the information.

- A six class series of four sessions each was offered at senior centers and low income senior residential communities. Participating seniors reported increased knowledge about fall risk factors and learned how to get up after a fall.
- Fall prevention materials were provided to all Meals on Wheels home deliveries.

2014 Objectives

- All objectives remain the same for 2014.
- One objective will be added: 85% of seniors report that they would not have access to fall prevention services had they not participated in the program.

Tactic 2: Promote independence and enhance the quality of life of seniors through the Caring Hands Volunteer Caregivers Program.

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

2013 Objectives

1. Caring Hands will serve 325 seniors.
2. Caring Hands will be stable with the number of Hispanic seniors served. They will not refuse any new Spanish speaking seniors.
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 80% of seniors who participated in Caring Hands will report their quality of life as “good” or “excellent” in the 2013 Quality of Life Survey.

Outcomes

- In 2013, Caring Hands served 205 seniors with 188 volunteers.
- Caring Hands maintained a group of 14 Spanish-speaking volunteers who served 6 Spanish-speaking seniors.
- 96% of seniors reported increased convenience to get to medical appointments and 89% reported improved social interaction.
- As a result of the program in 2013, 74% of seniors reported their quality of life as “good” or “excellent.”

2014 Objectives

- All objectives remain the same for 2014.

Tactic 3: Support faith community health ministries through the Faith and Health Partnership (FHP) program.

FY 09 Baseline: 16 churches in relations with FHP, reached over 6000 members. 225 newsletters distributed and 16 health campaigns conducted. 155 health events conducted among 16 churches. Among the 533 screenings provided, 216 were abnormal and all individuals were referred appropriately.

2013 Objectives

Outcomes

<ul style="list-style-type: none"> • Develop a mechanism for obtaining input from stakeholders in John Muir Health, the community, and health agencies to assist in the development of outreach plans to address the health issues East Contra Costa County vulnerable populations. • FHP will enlist John Muir Health staff to provide health education and conduct screenings in collaboration with community-based organizations, faith organizations, and service groups in Central and East Contra Costa County. • 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. 	<ul style="list-style-type: none"> • In 2013, established an advisory board (John Muir Health clinicians, medical directors, and service line representatives), convened a community health agency committee and a community advisory board (faith-based and service group leaders) to provide guidance on program plan development. • Community screening events <ul style="list-style-type: none"> ○ Unity for Community – Bay Point – June ○ African American Health Expo – September ○ Monument Health Fair – Concord – October • Co-sponsored health promotion events: <ul style="list-style-type: none"> ○ Disaster Preparedness Conference – January ○ Shop, Stop, and Stroll – February ○ Food Day – October • Conducted six outreach education campaigns on health topics such as childhood obesity, women’s health, men’s health, heart disease and walking for faith communities, reaching 8,650 individuals. • Pilot did not occur due to a reduction in Emergency Department staff.
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2014 Objectives

<ul style="list-style-type: none"> • FHP will continue to collaborate with advisory committees and organize community screenings and health education events. • In addition, FHP will explore John Muir Health faith based programs (i.e., Pastoral Services, volunteer programs, Caring Hands, Senior Rides) and develop synergies and collaboration to benefit John Muir Health patients, community members and vulnerable populations.

Tactic 4: Support Foster A Dream to provide 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
<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. 	<ul style="list-style-type: none"> • In 2013, 937 backpacks with school supplies were donated by John Muir Health staff, volunteers, and physicians. • In 2013, 10 youth participated in the Get Set Program, which included a two week intensive camp.

3. In 2013, 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.

- In 2013, all of the youth who participated in the camp have all set the goal to graduate high school in June 2013. Monthly meetings were held with the youth to ensure their personal milestones were achieved.
- In 2013, two new staff volunteers were added to the program.
- Foster A Dream did not increase mentorship in 2013, however all current mentors maintained participation.
- The 2013 scholarship was awarded to a student at Cal State East Bay.
- John Muir Health nursing leaders organized a Hand Washing Booth to increase knowledge of infection prevention methods at Foster A Dream’s Winter Wonderland event, where over 1,000 foster youth attended.

Funding for the program ended 2013

Tactic 5: 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

1. Carry out a comprehensive process to implement a new brand, key messages, name and visual identity for the merged organization.
2. Train residents in economic development programs (day labor, technology and career development).
3. Provide free income tax services for local low-income residents.
4. Provide job related case management services to at least 60 residents.

Outcomes

- In 2013, Monument Community Partnership and Michael Chavez Center merged and rebranded to form Monument Impact.
- In 2013, 11 workers secured permanent employment through the Day Labor Program. A total of 299 students graduated from a technology class (beginner, intermediate or advanced). In 2013, 102 clients were provided services at Career Development Department.
- 23 volunteers were trained to provide income tax support. The estimated impact of refunds in Concord in 2013 was over \$740,000.
- 24 students graduated from the 6 month advanced session, where they received ESL instruction and skills for an administrative job.

5. Establish and implement a Board-approved resident engagement strategy.
6. Provide leadership training and/or coaching to at least 30 resident leaders.
7. Provide resource, referral and follow-up services to drop in residents.
8. Provide health information, resources and support to at least 1,200 community residents at the Carnival of Health (Monument Community Health Fair).
9. Serve as lead agency to promote healthy eating in the Monument HEAL Zone.
10. Serve as lead agency to promote active living and safe exercise.

- Completed a comprehensive draft of a resident engagement strategy in collaboration with 6 residents and 1 partner organization.
- 22 residents from the Day Labor Program emerged as leaders. Overall, there were 18 active male Health Promotores.
- Over 200 community members were referred to services such as healthcare, legal assistance, worker rights, housing support, domestic violence, mental health, immigration services and others.
- Carnival of Health took place on October 5, 2013, serving in total 550 families and 1,134 individuals. In total, 652 individuals participated in either dental, vision, blood sugar or childhood development screenings and 275 were referred to services.
- Worked with Healthy and Active Before 5 to assist six Monument Community service agencies to pass healthy food policies. Launched the "Sugar Bites" Campaign. 25 Promotores were trained to teach the Cooking Matters curriculum and taught 17 sessions, with over 300 community members in attendance.
- Five residents were certified as Zumba instructors and taught classes at 8 apartment complexes, parks and schools for an average of 32 classes a month, serving 180 residents per week for one hour of exercise. A walk audit was conducted on Detroit Ave, from Clayton Rd. to Monument Blvd. Safe Routes to School plans were developed for Cambridge and Meadow Homes Elementary Schools. In total, 7 community events were held on bicycle safety.

2014 Objectives

1. Provide community health education and support services in the Monument Community by training and working with at least 30 key community leaders in schools and other settings.
 - a. Train the Trainers - Support, strengthen and facilitate leadership development of community Promotores, working with at least 24 active Promotores who receive intensive coaching and training to conduct health education, outreach and peer support.
 - b. Work with schools and apartment complexes to increase the number of low-income individuals (infants, children and adults) who consistently consume healthy food and beverages and who engage in a healthy lifestyle.
2. Provide health information, and other resources and support to at least 1,200 community residents
 - a. Provide resources and referrals to at least 150 drop-in low-income residents.
 - b. Serve as the lead agency for organizing and publicizing the annual Monument Community Health Fair.

Tactic 6: 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 11 Baseline: “Pledge the Practice” campaign received 138 pledges from local organizations committing to make healthy changes. HAB45’s advocacy and technical assistance work has resulted in the formal adoption of 14 new local policies by local agencies. 82% reported that HAB45’s work has helped make their agency a healthier place.

2013 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. 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. 3. Provide technical assistance to 10 community partners in efforts to 	<ul style="list-style-type: none"> • HAB45 convened two Leadership Council meetings in January and September of 2013. 50 Leadership Council members attended the January meeting and 46 members attended the September meeting. • In 2013, HAB45 has fostered 4 partnerships and approved 7 new healthy policies passed at organizations within Contra Costa County: <ol style="list-style-type: none"> a. The Pacific Coast Farmers Market, Fresh Approach Program passed a Movement & Play Policy. This policy is estimated to reach 1,176 children and 1,000 adults. b. The Food Bank of Contra Costa and Solano passed a Healthy Food & Beverage Policy. This policy is estimated to reach 700 children and 500 adults. c. East Bay Center for Performing Arts passed a Healthy Beverage Policy. This policy is estimated to reach 2,500 children and 2,500 adults. d. Junior Giants (coordinated by Michael Chavez Center) passed a Healthy Beverage Policy. This policy is estimate to reach 200 children and 100 adults. e. The Cambridge Walking Club (coordinated by Michael Chavez Center) passed a Healthy Beverage Policy. This policy is estimated to reach 50 children and 75 adults. f. West County Regional Group passed a Healthy Food and Beverage policy. This policy is estimated to reach 50 children and 70 adults. g. Pogo Park passed a Tap Water Promotion policy. This policy is estimated to reach 500 children and 500 adults • In 2013, HAB45 provided technical assistance to over 10

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 result 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.

community partners in order to promote healthy changes in organizational practices, some of which include the Families CAN Collaborative, Sugar Savvy Train-the-Trainer, Health Promoter Conference, Water Promotion Convening, Ambrose Community Center, and Pittsburg Parks and Recreation.

- In 2013, HAB45 approved three new breastfeeding accommodation policies passed at organizations within Contra Costa County:
 - a. Pacific Coast Farmer's Market Fresh Approach Program: This policy is estimated to reach 350 babies and 350 breastfeeding mothers.
 - b. Pittsburg Health Center: This policy is estimated to reach 3,000 babies and 2,500 breastfeeding mothers
 - c. Solomon Temple Baptist Church: This policy is estimated to reach 350 babies and 350 breastfeeding mother.
- At the September Leadership Council meeting, debuted two new sample healthy policies: the Tap Water Promotion Policy and the Reducing Marketing of Unhealthy Foods & Beverages to Children Policy.

2014 Objectives

1. By December 2014, convene at least 2 Leadership Council meetings to inspire progress among local organizations serving young children in Contra Costa County in implementing HAB45's action plan and policy agenda.
2. By December 2014, in collaboration with the Executive Committee, select and champion 1-3 new policy or advocacy ideas.
3. By December 2014, provide technical assistance to 10 community partners in efforts to promote healthy changes in organizational practices and policy adoption. Specifically for John Muir Health, provide technical assistance around the assessment of John Muir Health breastfeeding and lactation policies and make recommendations for improvement.
4. By December 2014, in collaboration with community partners, pass 10 policies that aim to promote healthy eating and active living among young children in Contra Costa County.
5. By December 2014, in collaboration with community partners, develop and implement an action plan to improve parks and promote healthy behaviors in parks, specifically by implementing park assessments, park and play maps and developing an advocacy plan around improving access to clean drinking water in parks.

Community Health Need: Specialty Care

Long Term Goal: Increase access to quality specialty care services to vulnerable residents of Central and East Contra Costa County

Intermediate Goal: 1. Link uninsured residents to specialty care providers

Strategy: Support and/or provide specialty care services to uninsured residents through John Muir Health affiliated physicians

Tactic 1: 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. 2. Provide specialty charity care as budgeted. 3. Coordinate referrals to specialty care services and at minimum, accept 50% of all referrals to complete specialty care at John Muir Health. 4. Monitor diagnoses of all procedures and interventions and provide necessary follow-up support for diagnosed patients. 5. Enroll patients in Medi-Cal that are diagnosed with condition requiring long-term care. 	<ul style="list-style-type: none"> • Consistent to the previous year, 172 physicians participated in the program. • 88% of patients referred identified as Hispanic/Latino. • In total, 319 patients were referred from La Clínica and among them, 200 were accepted into the Specialty Care Program. The top referring health conditions include: gastrointestinal, gynecological, and breast. 222 referrals were made to specialists for the 200 patients, which is an average 1.1 referrals per patient. • In 2013, a total of 3 cancer diagnoses were made. In addition, 577 procedures and interventions were provided throughout the year. The majority of interventions were consultations and diagnostics. • Implemented process to transition eligible patients to Medi-Cal.

2014 Objectives

- All objectives remain the same for 2014.

Tactic 2: Provide low risk outpatient surgery to uninsured patients through Operation Access.

FY 07 Baseline: 16 surgical services provided by John Muir Health 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 John Muir Health by 10 percent in 2013. 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"> • In 2013, 39% of Operation Access surgical services in Contra Costa County were provided by John Muir Health. This amounted to a total of 55 surgical procedures provided by John Muir Health surgeons, all of which were provided in a John Muir Health operating room. In 2013, there were an additional 38 minor and radiology procedures and 26 specialist evaluations. • The number of Latino patients receiving surgical services in Contra Costa County decreased slightly to 87% but remained a majority of the population served. 31% of patients reported that they had visited an ER for their condition, prior to being referred to the program. • Over 90% patients reported that they were highly satisfied with the helpfulness of the OA staff, their overall experience with OA, the service they received from John Muir Health and with their surgery results. • In 2013, all patient quality of life improvement measures remained high. Resulting from OA services, 98% of patients reported improved health and 96% reported improved quality of life and relief of symptoms.

2014 Objectives

- All objectives were expanded upon for 2014 and include:

Surgical Activities

1. Increase the number of surgical services provided by John Muir Health by 5% (approximately 3 additional, totaling 58 surgical services) in 2014.
2. Decrease surgery wait times by scheduling preliminary physician’s appointment within 60-90 days of referral and the subsequent surgical procedure within 90-120 days of referral.
3. Reduce proportion of patients in Contra Costa County who have to travel to other counties for referrals from 57% to 50%.
4. Provide surgical services to underrepresented minority patients in Contra Costa County.

Physician Volunteer Recruitment & Retention

5. Retain at minimum 75% of active volunteer physicians at John Muir Health.
6. Recruit one new volunteer John Muir Health physician per quarter, specifically targeting GI, general and vascular surgeons.
7. In an effort to increase the number of volunteer physicians from John Muir Health, OA will lead 9 total promotional activities (e.g., 4 department meetings/presentations, 4 John Muir Health internal newsletter and/or Contra Costa Times write-ups, 1 major recognition event/activity).

Satisfaction Reporting

8. 90% of volunteer physicians, clinic and patient survey respondents will report high levels of satisfaction with OA.
9. 90% of Contra Costa County patient survey respondents will report improvements resulting from their participation with OA in the following five categories: health, quality of life, ability to work, relief in symptoms, and ability to care for home and/or family.

Strategy: Support and/or provide screening programs and referral services in order to detect and treat conditions early

Tactic 1: Every Woman Counts Program 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

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.

Outcomes

- In 2013, there were 16 Cervical Cancer Screening Clinics and 16 Breast Cancer Clinics.
- A total of 548 patients were seen through the 32 Every Woman Counts clinics (breast cancer and cervical cancer) that were held in 2013. The majority of patients seen (79%) were for breast cancer screenings and diagnostics.
- In 2013, the majority of women served at the breast cancer (43%) clinics were between ages 40-49 and cervical cancer clinics (49%) were between the ages of 50-59. Out of the 548 patients served,

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% of returning breast cancer screening patients will be re-screened.
6. Every Woman Counts will provide 90% 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 and refer to community partners for treatment.

56% identified as Hispanic and 48% identify having a language barrier.

- Outreach to African American women continued through collaboration with the Faith and Health Partnership and the Women's Cancer Resource Center. A total of 27 African American women were screened in 2013.
- In the year 2013, 86 % of patients were screened within 18 months of their initial screening.
- 85% of breast cancer patients were provided with "one stop" services, including: breast exams, diagnostic mammograms, ultrasounds and biopsies.
- As a result of the screening and education efforts provided by Every Woman Counts, 17 women were diagnosed with Breast Cancer and provided with appropriate follow-up to monitor their diagnosis. 2 women were further evaluated and treated for abnormal pap smears, but none were diagnosed with Cervical Cancer. Of the diagnosed women, 88% were new patients and 33% were diagnosed with Stage 2.
- All 17 women who were diagnosed with Breast Cancer were enrolled in Breast and Cervical Cancer Treatment Program.

2014 Objectives

- All objectives will remain the same for 2014.

Tactic 2: 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.

FY 11 Baseline: A total of 37 screenings were conducted, among which 48% were for low income individuals. 88% of participants were provided scan results within 10 working days. 91% of participants reported increased knowledge about their health condition and 88% felt more engaged in their healthcare. 71% reported that they are more likely to make lifestyle changes. 32% of participants were referred to follow-up care, 6% received biopsies and 6% were diagnosed.

2013 Objectives

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).

Outcomes

- In 2013, a total of 102 screenings were conducted.
- Of the total participants receiving screens in 2013, 14% lived in households with incomes less than 200% of the 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.

- Of the newly enrolled participants who disclosed their demographic information, the majority identified as males over the age of 60 and White as their race/ethnicity (13% identified as Asian).
- In 2013, 99% of participants were provided scan results within 10 working days.
- 82% of participants rated their experience as “excellent” and 18% as “very good.”
- According to the Participant Survey, 91% of participants reported increased knowledge about their health condition and 90% feel more engaged in their healthcare as a result of the education services provided.
- According to the Participant Survey, 40% of participants reported that they are more likely to make a lifestyle change as a result of the education and services received.
- As a result of the screenings provided, 14 participants were recommended for follow-up care, and two participants received a biopsy and treatment. One participant was diagnosed with lung cancer and received treatment.

2014 Objectives

- All objectives will remain the same for 2014.

Community Health Need: Affordable, local mental health services

Long Term Goal: Improve access to behavioral health support for vulnerable communities

- Intermediate Goals: 1. Reduce youth community violence in vulnerable populations
2. Link patients to mental health services in East and Central Contra Costa County

Strategy: Provide intervention and referrals to violence related trauma victims in order to prevent recidivism and retaliation

Tactic 1: Reduce recidivism and retaliation by connecting victims of intentional injuries to the Beyond Violence Program.

FY 10 Baseline: John Muir Health 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
<ol style="list-style-type: none">1. John Muir Health social workers will obtain signed consents from 85% of eligible patients2. Interventionists will obtain signed consents from 75% of referred patients3. 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">• In 2013, there were 58 eligible patients who were admitted to the John Muir Health Trauma Department and met the eligibility criteria. John Muir Health Social Workers obtained consents from a total of 26 patients who were referred (12 referrals to partners in Antioch and 14 referrals to a partner in Richmond).• In 2013, the combined consent rate for both the Richmond and Antioch pilot was 100%.• In 2013, among clients who entered the program at least 3 months prior, 91% remain engaged at 3 months and among clients who entered the program at least 6 months prior, 83% remain engaged at 6 months.• 100% of clients remain alive at both 3- and 6-month follow-up.• 100% of clients avoided re-injury and 92% remained uninvolved in a criminal incident at both 3- and 6-month follow-up.

6. 70% of clients will have pursued one or more of the following support services:
 - 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
7. Implement tracking of community capacity building and other community engagement activities.

- For the Richmond partner organization, all clients have pursued at least one support service. The Antioch partner organizations did not collect these data in 2013.
- Developed tracking system to be implemented in 2014.

2014 Objectives

- All objectives remain the same for 2014.
- In 2014, the Antioch partners will track support service activities for their clients (Richmond partner already tracks these data).

Strategy: Support and/or provide behavioral health intervention services to vulnerable populations

Tactic 1: Support the Putnam Clubhouse in Concord to provide peer support and vocational rehabilitation intervention for adults recovering from severe mental health illness.

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.

2013 Objectives

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. At least 80% of respondents in the annual member satisfaction survey will report an increase in their independence.

Outcomes

- In 2013, there were a total of 288 members who participated in program activities, where they spent a total of 48,104 hours participating in Clubhouse activities.
- 18 new members ages 18 to 25 joined the Clubhouse during 2013.
- The Member Satisfaction Survey was completed by 80 members. 98% agreed or strongly agreed that they were satisfied with the

4. 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. 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.

Clubhouse activities they attended during 2013. Additionally, 92% agreed or strongly agreed that their independence increased during the year.

- In the 2013 Member Satisfaction Survey, 90% of respondents reported that their emotional well-being had increased and 89% reported that their mental well-being increased.
- During 2013, 23 members gained jobs in unsubsidized employment at an average (unsubsidized) wage of \$12.05 per hour.
- In terms of episodes, 91% of members who provided hospitalization data showed a decrease in hospitalizations or maintained zero hospitalizations.

2014 Objectives

- All objectives will remain the same for 2014.
- In addition:
 1. By December 2014, John Muir Health will provide presenter and content for three on-site member workshops in conjunction with the Clubhouse's Health Navigation for Adults Recovering from Mental Illness project.
 2. By December 2014, 80% of members participating in the Clubhouse's Health Navigation for Adults Recovering from Mental Illness project will report improved physical health.

The John Muir/Mt. Diablo Community Health Fund

In addition to the programs listed, the John Muir/Mt. Diablo Community Health Fund is integral in expanding and enhancing the health care services for those who need them most in Contra Costa County. The John Muir/Mt. Diablo Community Health Fund supports health initiatives that sustainably address current and emerging health care needs. To do so, they distribute grants to and partner with community-based, nonprofit organizations that provide high quality, affordable primary, specialty, dental, and behavioral health care or innovative wellness and support programs that contribute to good health.

The John Muir/Mt. Diablo Community Health Fund defines a health initiative as an organization committed to:

- Employing an innovative vision and new strategies for delivering needed care and services
- Measuring and documenting the value of its strategies
- Sustaining its efforts after CHF funding has ended

In 2013, John Muir/Mt. Diablo Community Health Fund supported the following community health initiatives and activities at community organizations:

Community Health Centers

- La Clínica De La Raza
 - Contra Costa Electronic Dental System Initiative
 - Contra Costa Coordinated Senior Health Care Delivery Initiative
- Planned Parenthood Shasta-Pacific
 - Contra Costa Electronic Health System Initiative

Specialty Care Organizations

- Operation Access
 - Contra Costa Specialty Care Initiative
- Rotacare Bay Area, Inc.- Concord Mobile Medical Clinic
 - Program Support for Direct Patient Care Costs

Health & Wellness Organizations

- Food Bank Of Contra Costa & Solano
 - Central & East Contra Costa Community Produce & Health Education Initiative
- Meals On Wheels & Senior Outreach Services
 - Contra Costa Care Management Initiative
- Women's Cancer Resource Center
 - Contra Costa Cancer Navigation Partnership
- Women's Cancer Resource Center & Cancer Support Community
 - Contra Costa Multicultural Cancer Initiative

Community Capacity Building

- Contra Costa Health Resource Guide & Website Application
 - Beneficiary Organizations: La Clínica de La Raza, Contra Costa Health Ministry Network, Contra Costa Health Services, Mt. Diablo Unified School District:

For additional details on the John Muir/Mt. Diablo Community Health fund, visit their website at <http://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-fund.html>.

Attachment E – 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 Clínica 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 F – John Muir Health Patient Assistance/Charity Care Program Policy

Patient Assistance / Charity Care Program Policy

John Muir Health is committed to a fair and equitable process for providing financial assistance to patients who have sought medically necessary care at John Muir Medical Centers, but have limited or no means to pay for that care. We hope that patients work with us in determining their qualification for financial assistance under this Policy, and to pay for their care to the extent of their ability to pay.

Services Eligible Under This Policy

This Policy applies to any emergent or trauma services resulting in either outpatient treatment in an emergency room setting or an inpatient admission following emergent or trauma services in an emergency room setting.

This Policy does not apply to any medical or ancillary health care services provided by physicians or any other provider other than the Medical Centers. In addition, John Muir Health does not pay for or reimburse services performed by physicians or any services rendered by any other provider.

Financially Qualified Patients

A patient shall qualify for financial assistance under this Policy if:

1. His or her gross income before taxes, including wages and salary, welfare payments, social security payments, strike benefits, unemployment benefits, child support and alimony, dividends and interest, rental payments and other direct sources of income ("Family Income") is no greater than 400% of the Federal Poverty Guidelines ("FPG").

AND

He or she does not have third-party insurance coverage from HMO, PPO, EPO, Medicare, Medicaid or any other commercial third-party payor, and his or her injury is not a compensable injury for purposes of workers' compensation, automobile insurance or other insurance.

— OR —

2. He or she has some form of third-party insurance coverage, but does not receive a discounted rate from John Muir Health as a result of such coverage

AND

His or her annual out-of-pocket costs for medical expenses exceed 10% of his or her family Income in the prior 12 months.



Patient Responsibility for Financial Assistance

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

- i. Cooperate with John Muir Health in identifying and determining alternative sources of payment or coverage from public and private payment programs
- ii. Submit a true, accurate and complete application for financial assistance
- iii. Provide a copy of his or her most recent pay stubs (or certify that he or she is currently unemployed)
- iv. Provide a copy of his or her most recent federal income tax return (including all schedules)
- v. If the patient is applying for charity (i.e., free) care, provide such documents and information regarding his or her monetary assets as may be reasonably requested by 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. It will in no way play a role the medical care that the patient receives.

Qualification for Charity Care

Financially Qualified Patients who have the following are eligible to receive free care on a case-by-case basis based on their specific circumstances:

- Family Income is at or below 200% of the federal poverty guidelines
- Qualifying Assets do not exceed an amount

equal to 200% of his or her billed charges for services rendered at the Medical Centers

For purposes of this Policy, "Qualifying Assets" 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, deferred-compensation plans and any real property or tangible assets (residences, automobiles, etc.).

Qualification for Discounted Care

Financial Qualified Patients whose Family Income is not more than 400% of the federal poverty guidelines, and who otherwise do not qualify for free care (as described in Qualification for Charity Care section above), are eligible to receive services at the average rates for which the Medicare program would make payment for similar services. This qualification is determined on a case-by-case basis based on the patient's specific circumstances.

In the event there is no established payment amount by the Medicare program for services received by a Financially Qualified Patient, the PAC shall establish an appropriate discounted rate that is consistent with the rates generally paid by the Medicare program for similar services.

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 at the Medical Centers, and is subsequently determined to qualify for free or discounted care under this Policy, John Muir Health shall promptly refund the amount of the overpayment.

Extended Payment Plan

John Muir Health offers an extended payment plan, at no interest, to permit Qualifying Patients to

pay their financial responsibility under this Policy in no less than 12 monthly payments. When determining an appropriate payment plan for Qualifying Patients, financial responsibilities and family income are taken into consideration along with other relevant factors.

Appeal Regarding Application of this Policy

In the event that a patient believes their application was not properly considered, they may submit a written request for reconsideration to the Chief Financial Officer of John Muir Health.

Non-Discriminatory Application of this Policy

Any decisions made, 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 age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Procedures

Finding out about the Policy:

1. If a patient's financial circumstances are revealed during an interview with a Financial Counselor, then the patient will be advised about the availability of financial assistance under this Policy.
2. Patients will be informed of available assistance through a standard message placed on the patient's bill, as well as either a handout available at the Medical Centers and through the Business Office.

3. The Patient Assistance Program's availability and referral number(s) will be placed within any notification on the patient's bill.
4. Information and instructions for enrollment in this policy are also posted in the emergency room, and the main Admitting Department.

Application Process:

5. A patient, or a patient's guardian or legal conservator, may apply to the Patient Assistance Program by calling the Patient Accounting Office and requesting an application from a program representative, or by requesting an application from a financial counselor on site at the Medical Centers.
6. A patient may apply for multiple outstanding balances on the same Application.
7. Applications to the program for outstanding balances less than \$1,000, will be first examined and approved by the assigned program representative to ensure the patients are Financially Qualified Patients for the program and then have a second approval signature from the Associate Director of Patient Accounting.
8. Applications to the program for outstanding balances in excess of \$1,000 will be prepared by the Patient Account Representative for presentation to the Patient Assistance Committee (PAC) for approval.

Decision and Result Process:

9. The Patient Assistance Committee will meet once every month at a set time and place, to consider the submitted completed applications for the program. The committee is chaired by the Chief Financial Officer or designated representative. The voting membership of the PAC includes the chair, one member of the Senior or Director management staff from each medical

center, the Controller, the Director of Patient Financial Services and the VP/Executive Director of the Community Health Alliance.

10. The decision of the committee will be sent, in writing, to the patient by the program representative in Patient Accounting.
11. Balances approved by the committee will be submitted for write-off to a transaction code assigned to Patient Assistance, and will follow the signature authority of the John Muir Health Write-Off Guidelines.
12. 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 Assistance adjustment code to ensure the diminished Charity Care is reflected appropriately in the general ledger.

Contact Patient Financial Services

Monday - Friday, 8:15 a.m. - 4:15 p.m.
(925) 947-3336

Contact a Financial Counselor

Monday - Friday, 8 a.m. - 4:30 p.m.

John Muir Medical Center, Concord:
(925) 674-2425

John Muir Medical Center, Walnut Creek:
(925) 947-5352

