



2014 Community Benefit Report

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



Prepared May 2015

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Executive Summary

John Muir Health is a community-based, not-for-profit, organization that is governed locally in Contra Costa County. 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.

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. 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.

In 2014, John Muir Health contributed over \$101 million to improve health in our community. John Muir Health is proud to provide quality care to everyone who needs our services. We are a resource that belongs to this community – and all its residents. Please see our economic valuation of community benefit on page 11 and full community benefit plan on page 23.

John Muir Health develops collaborative partnerships with local organizations in order to be responsive to the needs of the most vulnerable and underserved populations in our community. We conduct a comprehensive Community Health Needs Assessment and Community Health Improvement Plan every three years in order to guide our community benefit investments and measure community health improvement. In 2014, almost 91 percent of our investments were focused on vulnerable populations. Program examples include providing surgical care through Operation Access, placing public health nurses in low-income schools, providing mobile health clinic services in underserved communities, and treating patients referred by local community clinics for specialty care services. For additional information on our community programs for vulnerable populations, refer to attachment D.

In addition to this direct delivery of care and community benefit programs, 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.

John Muir Health is proud of the benefits we provide to the community. This report outlines the importance and impact of these efforts, which are consistent with our mission to improve the health of the communities we serve with quality and compassion.

Who is John Muir Health?

About John Muir Health

John Muir Health is a nationally recognized, community-based, not-for-profit health care organization east of San Francisco serving patients in Contra Costa, eastern Alameda and southern Solano Counties. It includes a network of more than 1,000 primary care and specialty physicians, more than 5,500 employees, medical centers in Concord and Walnut Creek, including Contra Costa County's only trauma center, and a Behavioral Health Center. John Muir Health also has partnerships with San Ramon Regional Medical Center, UCSF Medical Center and Stanford Children's Health to expand its capabilities, increase access to services and better serve patients. The health system offers a full-range of medical services, including primary care, outpatient and imaging services, and is widely recognized as a leader in many specialties – neurosciences, orthopedic, cancer, cardiovascular, trauma, emergency, pediatrics and high-risk obstetrics care. For more information, visit www.johnmuirhealth.com.

Mission, Vision, Values

John Muir Health, a private, community-based, 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.*

Community Commitment

John Muir Health's (JMH's) mission reflects our community health efforts as a corporate leader and community partner. JMH's community health leadership role is rooted in our excellence as a health care provider and our commitment to building partnerships with organizations that also exemplify excellence.

JMH views its commitment to community service initiatives as core to our mission. This commitment is seen through every facet of the organization from volunteers to physicians and in our emergency department and in our outpatient centers, as well as at events in the community. Most clinical service lines lead and operate a community service initiative. For example, our clinical research group runs a lung cancer screening

program while our Cancer Institute leads the La Clínica Specialty Care and Every Woman Counts programs.

The Community Benefit Oversight Committee provides governance for these initiatives and is comprised of executive leaders from across the health system and key community leaders. Additionally, JMH administration and the JMH Board of Directors oversee community benefit investments through frequent reporting.

Our community benefit contributions would not be possible without the important work of our employees in all departments. JMH's Magnet® recognized nurses, the highest recognition in nursing, are leaders in community services through their initiatives to promote health and wellness outside the hospital. Employees contribute when they participate in departmental programs, when they volunteer for JMH-sponsored community events and programs, and when they volunteer in their own communities to make them better places to live and work.

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. 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 C.

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

Ongoing Community Input

During 2014, John Muir Health kept abreast of current health issues of importance to the community by active participation within the Dental Collaborative of Contra Costa, Access to Care Stakeholders, East County Access Action Team, Healthy and Livable Pittsburg, Healthy and Active Before Five, Bay Point Family Partnership, Contra Costa Health Ministries Network, Faith and Action Collaborative-Interfaith Council, African American Health Collaborative, Pittsburg Unified School District Wellness Committee, Families CAN (Coalition for Activity and Nutrition) and other ongoing collaborations with community-based organizations. These sources of information provide current information regarding community health status and also help identify emerging needs in the service area population.

John Muir Health is fortunate to benefit from the input and expertise of the county health department, 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, and Fall Prevention Program of Contra Costa.

Where Is John Muir Health Focusing Its Efforts?

Community Health Improvement Plan

In 2014, John Muir Health adopted a triennial Community Health Improvement Plan in response to 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 established criteria to select the community health needs that John Muir Health would address as an organization from 2013 to 2016:

- Primary care services and information (health literacy) including adequate Spanish capacity
- Specialty care
- Affordable, local mental health services

The Community Health Improvement Plan (attachment D) 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 time frames. Please see the 2014 Community Health Improvement Plan annual update that includes 2014 program year-end results and 2015 program objectives in attachment D.

Community Benefit Guiding Principles

The community health need focus areas outlined in the Community Health Improvement Plan outline the high level plan for addressing community health. The 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.

The JMH Community Benefit Oversight Committee has adopted *Community Benefit Guiding Principles* to inform community benefit investment:

- Provide subsidized care to patients served at John Muir Health facilities according to the Patient Assistance/Charity Care Program Policy.
- Engage in activities that align with John Muir Health Community Benefit focus areas as defined in the triennial Community Health Improvement Plan.
- Focus investments in the John Muir Health community benefit service area.
- Target activities on vulnerable populations, defined as those meeting one or more of the following characteristics:
 - Economically disadvantaged
 - Evidenced-based disparities in health outcomes
 - Significant barriers to care
- Conduct long-term sustained activities with trusted partners.
- Partner with organizations that have expertise and specific capabilities to better leverage John Muir Health resources.
- Invest in activities with demonstrated outcomes in achieving community health improvement.
- Invest in activities that emphasize quality and continuity of care.

Economic Valuation of Community Benefit

Community Benefit—What Does It Mean and How is it calculated?

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.

JMH uses a cost accounting methodology that aligns with Catholic Health Care Association guidelines for community benefit accounting and industry best practices. Program costs are tracked and reported using CBISA, a community benefit database program. Indirect costs are applied based on data obtained through the cost accounting system.

The cost of charity care is calculated using annual charity care charges pursuant JMH's financial assistance policy and an annual cost to charge ratio based on total operating expenses and total operating revenues. The cost of Medi-Cal is calculated using the total cost of care, as determined by the cost to charge ratio as filed in the annual cost report, and the total payment received from Medi-Cal.

2014 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 Centers, Concord and Walnut Creek, the Behavioral Health Center, John Muir Physician Network and John Muir/Mt. Diablo Community Health Fund. Contributions are shown for Fiscal Year 2014 in total and then detailed by program categories. These categories align with the IRS Form 990, Schedule H. A separate 2014 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Health Behavioral Health Center.

For more information on each of the categories, see attachment A.

<u>Community Benefits by Activity Type – Form 990</u>	Total Benefit
Charity Care	\$18,964,434
Medi-Cal Shortfall	\$64,903,612
Subsidized Health Services	\$891,130
Community Health Improvement	\$7,234,305
Community Building	\$736,263
Financial and In-Kind Contributions	\$2,146,054
Health Professions Education	\$4,863,140
Research	\$1,036,085
Community Benefit Operations	\$733,330
TOTAL COMMUNITY BENEFIT	\$101,508,353
Medicare Shortfall (not included in total)	\$171,692,359

Community Benefits by Population Served - OSHPD

Charity Care	\$18,964,434
Medi-Cal Shortfall	\$64,903,612
Vulnerable Community	\$8,369,142
Broader Community	\$3,371,940
Health Professions Education & Research	\$5,899,225
TOTAL COMMUNITY BENEFIT	\$101,508,353
Medicare Shortfall (not included in total)	\$171,692,359

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 2014:

- John Muir Health's commitment to environmental sustainability is evident through many initiatives. In 2014, we replaced four dietary water-cooled condensers to air-cooled condensers, ultimately saving 1,524,000 gallons of water a year. Additionally, John Muir Health installed thirty six vehicle charging stages that are estimated to have displaced 301,794 gallons of fuel and offset 701,560 pounds of carbon dioxide in 2014.
- 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 donate backpacks with school supplies to foster youth through the annual Foster a Dream Backpack challenge. In 2014, employees provided 1,005 backpacks to Foster a Dream.
- John Muir Health and our employees actively participate in disease awareness events in order to promote health in our community. Events in 2014 included, the Heart Walk, the Esophageal Cancer 5k walk/run, the American Cancer Society's Relay for Life and the annual Bay Area NAMI (National Alliance on Mental Illness) Walk.

How to Contact Us

Please contact us with feedback regarding John Muir Health's community benefit programs and services by emailing info@johnmuirhealth.com or calling (925) 941-7906.

Attachments

Attachment A – Economic Valuation of Community Benefit – Detailed

PURPOSE	DESCRIPTION	CONTRIBUTION AMOUNT
CHARITY CARE	Charity care is providing health care services for those that have no insurance and are otherwise unable to pay. John Muir Health provides charity care through its Concord and Walnut Creek medical centers and Physician Network for people regardless of their ability to pay. This includes the critical emergency and trauma services at our medical center campuses. The amount listed are costs not charges and do not include bad debts.	\$18,964,434
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 received 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.	\$64,903,612
SUBSIDIZED HEALTH SERVICES	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.	\$891,130
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.	\$7,234,305
COMMUNITY BUILDING	Community Building includes workforce development activities and community collaborative development.	\$736,263
FINANCIAL AND IN-KIND CONTRIBUTIONS, GRANTS	Financial and In-kind contributions and grants include the John Muir/Mt. Diablo Community Health Fund, which provides grants to fund 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. Also included in	\$2,146,054

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.

<p>HEALTH PROFESSIONS EDUCATION</p>	<p>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.</p>	<p>\$4,863,140</p>
<p>RESEARCH</p>	<p>Research includes clinical research funded by government agency or tax-exempt organizations where findings are available to the public.</p>	<p>\$1,036,085</p>
<p>COMMUNITY BENEFIT OPERATIONS</p>	<p>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.</p>	<p>\$733,330</p>
<p>TOTAL</p>		<p>\$101,508,353</p>

Attachment B – Board Lists

John Muir Health 2015 Board of Directors

JOHN MUIR HEALTH
JOHN MUIR PHYSICIAN NETWORK
JOHN MUIR BEHAVIORAL HEALTH
Effective January 1, 2015

Community Members–Voting

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

Physician Members-voting

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

Ex-Officio non-voting

Deborah Arce, M.D.
Steven M. Kaplan, M.D.
Johannes Peters, M.D., Walnut Creek Medical Center Chief of Staff
John K. Merson, M.D., Concord Medical Center Chief of Staff
Lee Huskins, President & CAO for Physician Network

John Muir/Mt. Diablo Community Health Fund 2015 Board of Directors

The John Muir/Mt. Diablo Community Health Fund (CHF) has a ten (10) member governing board. The John Muir Association (JMA) appoints five (5) members, the Concord/Pleasant Hill Health Care District (CPHCD) appoints three (3) members and the City of Pleasant Hill (PH) appoints two (2) members.

Officers and Directors

Susan Woods, Chairman
Art Shingleton, Vice Chairman
Ernesto Avila, Treasurer
Allison Koerber, Secretary
Linda Best
Ken Carlson
Bill Gram-Reefer
Laura Hoffmeister
Tom Noble
Rina Shah, MD

Attachment C – Map of Service Area

**Attachment D – John Muir Health Community
Health Improvement Plan:
2014 Year End Results and 2015 Objectives**

John Muir Health 2014 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 need 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.

2014 Objectives

Outcomes

1. During the 2013-2014 school year, the Community Nurse will track all referrals received and issued and will provide appropriate 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.
5. 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.
6. Health interventions provided will result in improved health status for children utilizing services.

- From August 2013 to June 2014, a total of 443 referrals were received by the Community Nurse and 391 referrals were then made to external community resources. (Note: 1 nurse on medical leave for four months of school year)
- Referrals resulted in a total of 4,871 interventions including medical, family consultations first aid, notification letters and screenings.
- In 2013-2014, 100% of K, 2nd and 5th graders received the mandated screenings.
- 100% of the students with missing immunizations completed their requirements by year end.
- In 2013-2014, 5 asthma classes were taught reaching 27 students each, a nutrition assembly was held reaching 700 students, and a personal grooming & hygiene class for 5th graders reaching 300 students.
- 62% of the interventions resulted in improved health status, which includes: follow through with medical appointments, having appropriate medications and authorizations at school, obtaining eye exams and glasses, and results from first-aid and other interventions.

2015 Objectives

- All objectives remain the same for 2015.

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.

2014 Objectives

1. The Mobile Dental Clinic will provide dental services to 500 children.

Outcomes

- In 2014, the Mobile Dental Clinic provided oral health services to 301 children for a total of 963 visits. In 2014, the Collaborative provided the following in schools: 11,381 dental education encounters; 5,466 screenings; 5,064 fluoride; 782 sealants.

2. The Mobile Dental Clinic will provide enrollment assistance to all patients in need.
3. 95% of patients will be connected to a Dental Home (Lifelong Brookside, La Clínica de la Raza, Contra Costa Health Services Clinics).
4. 90% of patient survey respondents will report high levels of satisfaction.
5. The Mobile Dental Clinic will have increased access to dental care.

- A total of 185 families were provided with insurance enrollment assistance.
- 100% 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, 91% of patients report that they would recommend the Mobile Dental Clinic and experienced high levels of quality and satisfaction with the oral health services.
- 74% of patients had never been to a dentist prior to their visit to Mobile Dental Clinic.

2015 Objectives

- All objectives remain the same for 2015.

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.

2014 Objectives

1. The Mobile Health Clinic will serve 550 individuals during Saturday Clinic.
2. The Mobile Health Clinic target goal is to serve 2,500 patients through partnership programs.
3. 100% of services will meet the linguistic needs of the population served.
4. 95% of patients will be uninsured.

Outcomes

- The Mobile Health Clinic served 396 patients during the Saturday Clinic.
- The Mobile Health Clinic served 1,859 patients through partnership programs (RotaCare and Healthcare for the Homeless).
- 69% of patients were non-English speaking and 100% of services met their linguistic needs (primarily Spanish).
- 94% of patients served were uninsured.

5. 100% of patients who need additional care will be referred to a specialist or other health organization (report on referrals rates to various orgs).
6. 50% of referrals will be tracked and monitored by MHC staff and among them, 75% will report follow-through with the referral.
7. 90% of patient survey respondents will report high levels of satisfaction on services received.
8. 90% of patient survey respondents will report high levels of satisfaction on services offered.
9. The Mobile Health Clinic will reduce the number of avoidable Emergency Department visits.

- 100% of patients who needed additional care were referred to a specialist or other health organization (report on referrals rates to various orgs).
- 42% of referrals were tracked and monitored by MHC staff and among them, 80% reported follow-through with their referral.
- 100% of patient survey respondents reported high levels of satisfaction on services received.
- 100% of patient survey respondents reported high levels of satisfaction on services offered.
- If the Mobile Health Clinic was not available, 8% of patients reported that they would have sought care at the Emergency Department. In addition, 11% of patients reported use of the ED during the 6 months prior to their MHC visit.

2015 Objectives

- All objectives remain the same for 2015.

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.

2014 Objectives

1. CCCC will provide care to eligible individuals who consent to services.
2. In 2014, clients will report improvement in access to benefits including Medi-Cal and county programs.

Outcomes

- In 2014 a total of 70 referrals were made for a total patient load of 82 individuals (which includes patients ongoing from the previous year). CCCC started receiving referrals in July 2014.
- 91% of patients are enrolled in Medi-Cal, Medicare, Basic Adult Care or are covered by another insurance plan, while 7 patients lack coverage.

3. Provide on average 20 interventions per client annually.

4. 50% of discharged clients will complete goals.

Note: Finance report was not generated in 2014 so ED utilization and inpatient rates could not be obtained.

- Provided on average 71 interventions per client for a total of 5,846 interventions related to benefits, appointment, care plan, case management, communications, housing, mental health, site visit, transportation or other.
- In 2014, 58% of discharged clients fully completed their goals and 13 partially completed their goals.

2015 Objectives

- In addition to the above objectives, others for 2015 include:
- 80% of eligible individuals who consent to services will be accepted to care and among them, 100% will receive services.
- Reduce ED utilization rate during program participation by 20% in comparison to ED utilization rate prior to program participation.
- 70% of clients will maintain a "moderate" to "extreme" level of engagement during participation.
- 50% of all client encounters will show an improvement in clinical, behavioral and social services measures from Initial Assessment.

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

2014 Objectives

5. John Muir Health Case Managers/Social Workers will identify patients that meet criteria for respite and refer qualifying patients to the Respite Center.
6. 50% of patients referred will be admitted to respite.
7. Medical diagnoses will be tracked in 100% of individuals at intake and appropriate medical linkages will be provided.
8. Mental health and substance abuse history will be tracked in 100% of individuals with a MH or SA history at intake and appropriate mental health & substance abuse linkages will be provided.

Outcomes

- In 2014, 121 patients were referred to the Respite Center.
- In 2014, 72% of the patients referred were accepted and among them, 42 patients were admitted to respite.
- In 2014, on average, admitted patients were provided with nearly 7 medical linkages and stayed in the program for an average of 29 days. There was an average of 3.1 admission purposes, 3.5 medical conditions.
- For patients with a mental health history, they had an average of 1.4 conditions (depression as most common – 48%). For patients with a substance abuse history, they were using on average 2 substances (methamphetamine & other amphetamines as most common – 32%). There were 28 mental health treatment linkages provided, 29 substance abuse counselor linkages and 7 substance abuse treatment linkages.

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| <ul style="list-style-type: none"> 9. Maintain a less than 20% rate of delayed discharge (pending rates). 10. The Respite Center will save approximately 4 hospital days for every patient admitted to respite. | <ul style="list-style-type: none"> • In 2014, 65% of patients (n=26) completed the program and 20% (n=8) experienced a delay in discharge due to pending housing plan or shelter placement. • In 2014, patients who were admitted to respite from John Muir Health saved 168 hospital days. |
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2015 Objectives

- All objectives remain the same for 2015.

Tactic 3: 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.

2014 Objectives

1. In 2014, the Medication Assistance Program will serve at least 50 Medicare patients and will track total number of prescriptions provided.
2. The Medication Assistance Program will track the value of medications provided.
3. 75% of seniors served through the Medication Assistance Program have incomes of 200% or less of the Federal Poverty Level.
4. Medication Assistance Program tracked referral sources for new program participants.

Outcomes

- In 2014, 66 Medicare patients who have medication costs that exceed their ability to pay were served from Central and East Contra Costa County. The 66 patients were provided with 316 prescriptions.
- Medications provided were worth \$245,603.
- In 2014, 90% of people assisted (n=56) in this program had incomes of 200% or less of the Federal Poverty Level.
- In total, the Medication Assistance program completed 122 referrals, primarily to Physicians and Case Management.

2015 Objectives

- All objectives remain the same for 2015.

Tactic 4: 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.

2014 Objectives

1. MCSSO will accept program participants from Monument Community partners, faith based communities, Monument

Outcomes

- In 2014, MCSSO received 509 referrals, primarily from agency, word of mouth and church/faith community resources.

<p>Community residents, and older adults who participate in Monument Community activities.</p> <ol style="list-style-type: none"> 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. MCSO 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 success plan. 6. At least 20 older adults will report involvement in neighborhood civic or community projects. 7. Participating older adults will report increased knowledge of community resources as a result of the presentations attended and education received. 8. Older adults will report improved health outcomes as a result of the services received. 9. Older adults will report increased hope for the future as a result of the services received. 	<ul style="list-style-type: none"> • In 2014, MCSO provided case management services, where a success plan was developed, for a total of 60 older adults. • In 2014, MCSO organized a total of 76 health-related presentations in the community, where a total of 1,380 older adults were in attendance. • In 2014, MCSO initiated a total of 603 referrals for social well-being, health and safety issues. • In 2014, among those seniors who identified as “closed cases” (n=28), 14 seniors (88%) were able to achieve one or more goals identified in their success plan and 3 seniors were unable to be contacted • In 2014, 25 older adults were involved in neighborhood civic or community projects. • In 2014, 25% of participating seniors are aware and know how to access and share resources. • After participating in the program, 56% still report having an untreated illness or need immediate care and 44% report that they are receiving the care they need or have no urgent health needs. • 62% of seniors were “pretty” or “very” hopeful that their lives would improve in the upcoming year.
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2015 Objectives

- All objectives remain the same for 2015.

Tactic 5: 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.

2014 Objectives

Outcomes

<ol style="list-style-type: none"> 1. Enable at least 130 frail, isolated, and disabled seniors get to medical appointments and provide at least 950 one-way assisted rides. 2. At least 18% of the seniors served will be Spanish-speaking. 3. Seniors will utilize STP's transportation services on average of 8 times per year. 4. 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 2014, STP provided 1162 one-way assisted rides, serving 165 seniors in total. • In 2014, 8% 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 98% reported increased convenience to pick up medications.
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2015 Objectives

- All objectives remain the same for 2015.

Tactic 6: 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.

2014 Objectives	Outcomes
<ol style="list-style-type: none"> 1. In 2014, 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 2014, 95% of the referred cases will be resolved. 3. In 2014, physicians will report high satisfaction with the services provided by the Patient Navigator Program as reported by the Physician Satisfaction Survey. 4. In 2014, 90% of patients will report high satisfaction with the services provided by the Patient Navigator Program as reported by the Patient Satisfaction Survey. 5. In 2014, 90% of patients will report quality of life improvements as reported by the Patient Satisfaction Survey. 	<ul style="list-style-type: none"> • In 2014, information was provided to 1616 seniors by either by mail or phone to patient, family or caregiver. A total of 1336 resources were provided to these seniors. • In 2014, 99% of the cases referred were resolved. Resolved cases are those that end in an outcome, such as information requested by the patient is provided and billing issues. • In 2014, physician surveys were not conducted. • In 2014, 100% of patients reported high levels of satisfaction with the services received by the Patient Navigator Program. • In 2014, 86% of respondents reported that their quality of life is better as a result of the Patient Navigator Program.

6. In 2014, 90% of the patients will report that information they received was helpful.

- In 2014, 82% of patients reported that the information they received was helpful.

2015 Objectives

- All objectives remain the same for 2015.

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%.

2014 Objectives

1. 100% of referrals will be reviewed - and contacted (if criteria met) in regards to participating in the program.
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 participate in these programs. Maintain a readmission rate below 10% for CTI, TA CHF and TA COPD patients.
5. In 2014, define and report length of participation.

Outcomes

- In 2014, the Tel-Assurance program received a total of 462 referrals from these sources; double the number of referrals received in 2013. The majority of referrals (81%) came from “other sources” while the remainder (19%) came from CCHP – 100% were reviewed. For CTI, 816 referrals were reviewed (100%) and 403 met criteria and were contacted.
- A total of 231 low income patients were engaged in all programs in 2014 (TA, CTI, Case Management), an 8% increase from 2013.
- Due to Epic implementation, CTI surveys were not conducted in 2014.
- In 2014, CTI 30-day readmission rate was 7.3%. The readmission rate for CHF patients in Tel-Assurance was 8.3% in comparison to a control group of 9.5%. The readmission rate for COPD patients in Tel-Assurance was 5.6% in comparison to a control group of 10.6%.
- Average length of participation varies per patient and ranges from 7 days to 7 years. In 2014, patient participation was the shortest for the Case Management program ranging from 7 days to 6 years.

2015 Objectives

- All objectives remain the same for 2015.

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.

2014 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 managing daily activities as reported by the patient satisfaction survey. 7. GCC will demonstrate avoided emergency department visits, hospital admissions and readmissions for participating patients. 	<ul style="list-style-type: none"> • Referrals in 2014 to the GCC Program totaled 1,603. • Referrals from John Muir Health providers for 2014 were 1,260, a 7% decrease from the previous year. • In 2014, 64% of patients receiving in home assessment, who were agreeable to disclosing their incomes, had incomes less than 350% of the Federal Poverty Guidelines. • In 2014, 100% 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 2014. • In 2014, 76% of participating patients reported that they are more effectively managing daily activities. • As a result of the services provided by the GCC program, 40 hospitalizations, 13 readmissions, and 86 emergency department visits were avoided in 2014.
2015 Objectives	
<ul style="list-style-type: none"> • All objectives remain the same for 2015. 	

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.

2014 Objectives	Outcomes
<ol style="list-style-type: none"> 1. In 2014, convene the Fall Prevention Coalition quarterly. 2. Among individuals the program serves, 80% have household incomes up to 200% of the Federal Poverty Line. 3. Among individuals the program serves, 80% are vulnerable individuals who reside in Contra Costa County communities. 4. In 2014, programming will be provided in multiple languages, as needed, to meet the linguistic needs of patients seeking services. 5. Coordinate seniors with referrals to fall prevention services and other internal and external programming, as relevant. 6. In 2014, 85% of seniors report that they would not have access to fall prevention services had they not participated in the program. 7. In 2014, conduct 15 fall prevention education presentations with a target reach of 500 seniors. 8. In 2014, 90% of participating seniors will report increased knowledge about fall prevention, risk factors, fall reduction strategies (e.g., exercise, medication, reducing hazards, maintaining strong bones), protection strategies and knowledge on where to access help. 	<ul style="list-style-type: none"> • In 2014, 4 coalition meetings were held and on average 30 individuals representing 52 agencies attended. • In 2014, 97% of individuals had incomes at or below 200% FPL. • In 2014, there were a total of 187 interventions, of which 73% were residents of Central and East Contra Costa County (36% in East and 37% in Central) • Just over 10% of older adults who received Home Safety Modification services reported a language other than English as their primary language. The majority of these are Spanish speaking. The FPP hired a part time program assistant this year who is fluent in Spanish. • In 2014, FPP received 270 referrals and conducted home safety assessments and modifications in the homes of 187 low income older adults. Educational material packets on Fall Prevention were sent to all homes, including 83 homes that did not qualify for home modification services or are on the waiting list. FPP referred 22 clients to other Meals on Wheels and Senior Outreach Services programs and 5 to outside programs for further assistance. • In 2014, 85% of seniors reported increased access. • In 2014, FPP conducted 26 education presentations, reaching 565 seniors and 64 caregivers. • In 2014, on average 96% of seniors reported increased knowledge about fall prevention, risk factors, fall reduction strategies.

9. In 2014, conduct at least 140 home assessments and complete home modifications for at least 75% of those assessed.
10. In 2014, 85% of seniors who have received a home modification will report positive changes in their lives.
11. In 2014, conduct at least 5 exercise sessions each offered in both English and Spanish.
12. In 2014, 85% of seniors who attend exercise sessions will report positive changes in their lives.
13. In 2014, 70% of high-risk fallers in the intensive in-home exercise program will report improvements.

- In 2014, FPP conducted 187 home assessments and completed home modifications in 96% of those assessed.
- In 2014, 90% of seniors who received a home modification reported positive changes in their lives.
- In 2014, 7 total exercise sessions were offered with a total of 136 participants. No Spanish classes offered due to inability to find Spanish-speaking instructor.
- In 2014, 88% of seniors who attended exercise sessions reported positive changes in their lives.
- In 2014, 71% of high-risk fallers in the intensive in-home exercise program reported improvements.

2015 Objectives

- All objectives remain the same for 2015.

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.

2014 Objectives

1. Caring Hands will serve 325 seniors.
2. Caring Hands will maintain and manage 175 volunteers.
3. Caring Hands will be stable with the number of Hispanic seniors served. They will not refuse any new Spanish speaking seniors.
4. Caring Hands will decrease senior isolation and increase healthcare access to seniors.
5. 85% of seniors will report increased convenience in getting to medical appointments and improved social interaction as a result of their involvement with Caring Hands service.
6. At least 80% of seniors who participated in Caring Hands will report their quality of life as “good” or “excellent” in the 2014 Quality of Life Survey.

Outcomes

- In 2014, Caring Hands served 218 seniors.
- Caring Hands maintained and managed 200 volunteers.
- Caring Hands maintained a group of 14 Spanish-speaking volunteers who served 8 Spanish-speaking seniors.
- 62% of seniors served live alone and 28% live in East County.
- 65% of seniors reported increased convenience to get to medical appointments and 77% reported improved social interaction.
- Since receiving Caring Hands services, 76% of seniors reported their quality of life as “good” or “excellent.”

2015 Objectives

- All objectives remain the same for 2015.

Tactic 3: Support community wellness, health promotion and disease prevention through the Community Health Partnership Program (CHP)

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.

2014 Objectives

- Maintain strong relationships with all health ministries.
- CHP will enlist John Muir Health staff to participate in health education events and conduct screenings in collaboration with community-based organizations, faith organizations, and service groups in Central and East Contra Costa County. Participate in 4 community events annually.
- Provide health education resources to health ministries.
- Provide technical assistance to health ministries.
- 20% of participating health ministries will implement a change project.

Outcomes

- In 2014, there were a total of 20 churches participating in health ministry outreach reaching an approximate 25,430 members in their respective congregations.
- Community screenings and events:
 - Unity for Community – October (200 people)
 - African American Health Summit – September (120 people)
 - Monument Health Fair – October (458 people)
- Co-sponsored health promotion events:
 - African American Baby Shower – August (200 people)
 - Food Day – October (250 people)
 - Good Vibes Presentation – November (36 people)
- Activities reached a total of 1,264 individuals.
- 16 churches received health education resources in 2014, providing a total of 38 resources covering topics that include diabetes, nutrition, heart health, tobacco cessation, stress management and youth-focused.
- A total of 57 technical assistance services were provided to 16 churches.
- In 2014, 75% of churches implemented a change project in areas that address physical activity, health education and youth-focused.

2015 Objectives

- All objectives remain the same for 2015.

Tactic 4: Support Monument Impact (formerly Monument Community Partnership).

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.

2014 Objectives

Outcomes

1. Organize the annual Monument Community Health Fair as a health education event with a target reach of 1,200 people.
2. 30% of Monument Community Health Fair attendees (appx. 400 individuals) will receive screenings for dental services, vision needs, blood sugar tests, and child development evaluations.
3. Report on percentage of individuals screened who receive a diagnosis or need further follow-up. Target of 250 referrals to be made post-screening.
4. Provide resources and referrals to at least 150 drop-in residents to include: health care, senior services, domestic-violence, housing, immigration, financial and job assistance.
5. Referrals will be made to at least 10 community organizations.
6. Train the Trainer - 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.
7. Work with schools and apartment complexes to engage 400 low-income individuals (infants, children and adults) to consistently consume healthy food and beverages.
8. Work with schools and apartment complexes to engage 600 low-income individuals (infants, children and adults) in physical fitness activities.
9. 85% of the population who attended a healthy food and beverage activity will report that they are consuming more nutritional food.
10. 85% of the population who attended a healthy food and beverage activity will report that they are exercising more.

- In 2014, Monument Impact held the annual Monument Community Health Fair and had over 1,200 people in attendance with 847 who officially registered (409 adults and 438 children).
- Dental screenings were provided to 119 individuals.
- Vision screenings were provided to 111 individuals.
- Blood sugar tests were provided to 400 individuals.
- Child development evaluations were not conducted, but information was provided to attendees.
- Provided 84 referrals for vision services and among them, 17 were referred to UCB for follow-up and 67 received reading glasses, bifocals. For dental, diabetes and child development, referral information was not provided by partner organization.
- In 2014, 182 drop-in residents were provided with resources.
- Referrals were made to 23 different organizations.
- In 2014, Monument Impact worked to coach and train 45 Promotores around mental health, emergency response, heart health and school wellness.
- In 2014, Monument Impact held 26 healthy food and beverage activities with an attendance of 1300 low-income individuals.
- In 2014, Monument Impact held 48 physical fitness activities with an attendance of 980 low-income individuals.
- Among attendees of a healthy food and beverage activity, 60% reported they consume more nutritional food.
- Among attendees of a healthy food and beverage activity, 50% reported they exercise more frequently.

2015 Objectives

- Organize the annual Monument Community Health Fair as a health education event with a target reach of 1,200 people.
- 30% of Monument Community Health Fair attendees will receive health screenings.
- Report on percentage of individuals screened who receive a diagnosis or need further follow-up. Target of 250 referrals to be made post-screening.
- Provide resources and referrals to at least 150 drop-in residents to include: health care, senior services, domestic-violence, housing, immigration, financial and job assistance.
- Referrals will be made to at least 10 community organizations for drop-in residents.
- Mental Health Promotora Program - Train 10 community health promoters to lead mental health education trainings.
- Mental Health Promotora Program - The promoters, in teams of two, will lead at least 8 mental health education training series for 64 community members.
- Broader Promotora Program - Train 24 promoters on providing community presentations on a variety of health topics
- Work with schools and apartment complexes to engage 600 low-income individuals in physical fitness activities.
- 60% of the population who attended a healthy food and beverage activity will report that they are consuming more nutritional food.
- 60% of the population who attended a healthy food and beverage activity will report that they are exercising more.

Tactic 5: 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.

2014 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. By December 2014, in collaboration with the Executive Committee, select and champion 1-3 new policy or advocacy ideas. 	<ul style="list-style-type: none"> • HAB45 convened two Leadership Council meetings in April and October 2014. Each meeting was attended by an average of 43 representatives from Contra Costa organizations that serve young children. Meeting evaluations were consistently positive. On average, 90% of attendees indicated that the meeting provided valuable opportunities to network with colleagues. • In 2014, designed a collaborative process to select 3 priority public policies to which HAB45 will advocate and during a retreat in March, decided to focus the organization’s Policy Agenda on: <ul style="list-style-type: none"> ○ Advocate for improved parks and play spaces for low-income families with young children ○ Advocate for policies that reduce availability and appeal of sugar-sweetened beverages

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 JMH, provide technical assistance around the assessment of JMH 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 & 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.

- Advocate for implementation of existing breastfeeding accommodation law
- Evaluations from the Leadership Council meetings indicated that 71% of meeting participants indicated that the presentation encouraged them to become more involved in advocacy and lobbying and 100% understood why HAB45 selected each of the three policies areas for its Public Policy Agenda.
- In 2014, HAB45 had one-on-one consultations with 27 community partners and provided information on the importance of modeling healthy behaviors for children and promoted our Pledge the Practice, Pass the Policy Initiative. We provided additional assistance to 20 of these organizations by helping them craft healthy policies, coaching them on how to enlist support of decision-makers within their organizations, and suggesting approaches to implementation.
- In October, HAB45 staff held a technical assistance call with JMH Community Health Improvement Program Manager to discuss lactation accommodation at JMH facilities. We learned of some of the challenges around implementing a lactation accommodation policy at JMH—namely lack of appropriate space.
- HAB45 is proud to report that in 2014, 20 Contra Costa organizations passed 21 formal, healthy policies within their organizations through our Pledge the Practice, Pass the Policy Initiative, serving approximately 6,903 children and 5,662 adults.
- HAB45 continued to partner with the East County Regional Group to provide staffing and technical support for the Group's work to assess and advocate for improved parks and plays paces in Pittsburg, Antioch and Bay Point and in 2014, produced the Antioch Park Assessment Report.
- In early July, the Concord Parks Team—a group of park advocates including HAB45, the Central County Regional Group, First 5 Contra Costa, and Contra Costa Health Services—presented to the Concord Parks, Recreation, and Open Spaces Commission on the Team's Monument Community park assessment work. The presentation highlighted community

- priorities to make immediate improvements to the lowest-rated parks: Meadow Homes and Ellis Park.
- In 2014, HAB45 partnered with community organizations and residents in West County to create a map of the best parks for young children in the Richmond Iron Triangle. Conducted the San Pablo Parks Assessment that took place on October 11th. Over 50 people participated, including a San Pablo City Council member, Promotores from the West County Health Center, parents from West County, and many community members.

2015 Objectives

1. By December 2015, convene at least 2 collaborative membership meetings to inspire progress in implementing the HAB45 Action Plan and policy agenda among local organizations serving young children in Contra Costa.
2. By December 2015, build capacity of collaborative members to advocate for public policy changes that will benefit families with young children, by providing training to backbone staff, Executive Committee members, and the Leadership Council, as well as by forging 3 new partnerships with key stakeholders.
3. By December 2015, provide support to 5 agencies to inspire staff at these agencies to adopt at least 5 new policies that establish healthy organizational practices.
4. By December 2015, support 3 agencies to deepen implementation of at least 3 existing healthy policies in order to ensure positive change to the food and activity environments of these agencies.
5. By December 2015, provide technical assistance to collaborative park improvement partners in order better advocate for safer, more accessible parks and play spaces for low-income families with young children.

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.

2014 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. 100% of accepted patients will be uninsured. Provide specialty charity care as budgeted. 3. 50% of referrals will be accepted to care and among them, 100% will receive program-specific services. (100% of eligible individuals will be accepted). 4. Monitor diagnoses of all procedures and interventions and provide necessary follow-up support for diagnosed patients. 5. 85% of individuals will respond "yes, definitely" to questions in patient interviews. 	<ul style="list-style-type: none"> • Providers were recruited to meet the needs of referred patients, which included gynecological oncologist, gynecologist, medical oncologist, radiation oncologist, gastroenterologist, surgeon, cancer geneticist, and urologist. • In 2014, 100% of patients were uninsured and 94% of patients referred indicated a non-English language preference and 94% identified as Hispanic/Latino. • In total, 267 patients were referred from La Clínica and among them, 226 were accepted into the Specialty Care Program (acceptance rate of 85%). The top referring health conditions include: gastrointestinal, gynecological, and breast. • In 2014, a total of 12 cancer diagnoses were made. In addition, 799 procedures and interventions were provided throughout the year. The majority of interventions were consultations and diagnostics. • 100% of patients reported that their provider listened carefully, explained things clearly and communicated in their preferred language. 100% experienced improvements in their daily life and 80% had a good understanding of where to access additional health resources.
2015 Objectives	
<ul style="list-style-type: none"> • All objectives remain the same for 2015. • In addition, 95% of patients will complete treatment or receive/be scheduled for follow-up services. 	

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.

2014 Objectives	Outcomes
<ol style="list-style-type: none"> 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. 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). 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. 10. OA will reduce Emergency Room utilization 	<ul style="list-style-type: none"> • In 2014, 44% of Operation Access surgical services in Contra Costa County were provided by John Muir Health. This amounted to a total of 56 surgical procedures, all of which were provided in a John Muir Health operating room. This represents a 2% increase from the previous year. • Data for this objective was not collected in 2014. • Data for this objective was not collected in 2014. • 89% of patients receiving surgical services identify as Latino and 3% identify as Asian. • In total, there were 27 active volunteer physicians at John Muir Health who served OA in 2014. • In 2014, there were a total of 5 general surgeons, 1 GI specialist and no vascular surgeons. • Data for this objective was not collected in 2014. • In 2014, 100% of patients were satisfied with surgery results and overall, had a good OA experience. 99% reported that OA staff was helpful, courteous and on time. • In 2014, all patient quality of life improvement measures remained high. Resulting from OA services, 98% of patients reported improved health, 94% reported improved quality of life, 91% improved work ability, 92% experienced and relief of symptoms and 91% improved ability to care for home and/or family. • Prior to utilizing OA services, 24% of patients reported that they visited the Emergency Room

2015 Objectives

- All objectives will remain the same in 2015.

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.

2014 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.
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.

Outcomes

- In 2014, there were 4 Cervical Cancer Screening Clinics and 29 Breast Cancer Clinics.
- In 2014, there were 361 breast cancer patients and 32 cervical cancer patients served in the clinics for a total of 490 encounters.
- In 2014, the majority of women served at the breast cancer (57%) clinics were between ages 40-49 and cervical cancer clinics (41%) were between the ages of 50-59. Out of the 361 breast cancer patients served, 64% identified as Hispanic and among them, 94% indicated a non-English language preference.
- A total of 12 (breast) and 2 (cervical) African American women were screened in 2014.
- In 2014, 88% of patients were screened within 18 months of their initial screening.
- 98% of breast cancer patients were provided with "one stop" services, including: breast exams, diagnostic mammograms, ultrasounds and biopsies.

7. Every Woman Counts will provide breast and cervical cancer screenings and will connect patients with appropriate referrals for any 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.

- In 2014, the program provided 30 breast biopsies. 11 women were diagnosed with Breast Cancer and provided with appropriate follow-up to monitor their diagnosis. The program provided 32 pap smears and 3 women were further evaluated and treated for abnormal pap smears, and one was diagnosed with Cervical Cancer (stage III).
- All 11 women who were diagnosed with Breast Cancer and the 1 woman diagnosed with Cervical Cancer were enrolled in Breast and Cervical Cancer Treatment Program.

2015 Objectives

- All objectives will remain the same for 2015.
- Cervical Cancer screenings will not occur in 2015.

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.

2014 Objectives

1. 80% of referrals will be accepted to care (among new referrals).
2. The Lung Cancer Screening Program will perform at least 100 CT screening exams.
3. 20% of individuals served are low income individuals who live 200% below the Federal Poverty Line (FPL).
4. 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.
5. The Lung Cancer Screening Program will provide scan results and recommendations within 10 working days to 100% of the participants.
6. 85% of individuals will report: a. increased knowledge; b. high levels of satisfaction as a participant in a research study.

Outcomes

- 92% of new referrals were accepted to receive lung cancer screenings.
- In 2014, a total of 121 screenings were conducted.
- Of the total participants receiving screens in 2014, 10% lived in households with incomes less than 200% of the FPL.
- Of the total participants who disclosed their demographic information, 87% identified as males over the age of 60 and 89% identified White as their race/ethnicity (7% identified as Asian).
- In 2014, 99% of participants were provided scan results within 10 working days.
- 60% of participants rated their experience as a subject in a research study as “excellent” and 24% as “very good.”

7. 85% 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.
8. 85% of individuals will report that as a result of their participation, they: a. were more likely to make lifestyle changes; b. felt more proactive and involved in their healthcare.
9. Participants of the Lung Cancer Screening program will provide appropriate treatment and follow-up services, which are proxies for lives saved or extended.

- According to the Participant Survey, 70% of participants reported increased knowledge about their health condition and 73% feel more engaged in their healthcare as a result of the education services provided.
- According to the Participant Survey, 64% of participants reported that they are more likely to make a lifestyle change as a result of the education and services received and 73% reported that they felt more proactive in their healthcare.
- As a result of the screenings provided, 17 participants were recommended for follow-up care, and one participant received a biopsy and 7 received treatment. One participant was diagnosed with lung cancer and received treatment.

2015 Objectives

- All objectives will remain the same for 2015.

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.

2014 Objectives	Outcomes
<ol style="list-style-type: none"> 1. 80% of eligible individuals (based on violent injury and lives/injured in eligible cities) will be referred to Beyond Violence and 60% will consent to services and will be accepted as Beyond Violence clients. 2. Signed consents will be obtained from 100% of referred patients. 3. 70% of clients will complete the program or continue participation in the following year. Maintain a less than 30% dropout rate. 4. 80% of clients will maintain a high or medium level of engagement throughout their participation in the program (excluding dropouts, based on encounter). 5. 95% of clients will avoid re-injury, arrest and retaliation (excluding dropouts, based on encounter). 6. 100% of clients will remain alive. 7. 70% of clients will have pursued one or more of the following support services: <ol style="list-style-type: none"> a. enrolled/re-enrolled in school (including traditional middle/high schools, alternative schools, college, and home school/independent study) b. participated in an educational support program (includes tutoring & GED preparation) c. received employment assistance d. found a new job e. received housing assistance f. received legal advocacy g. received mental health counseling h. received assistance with health care services i. conflict resolution j. family intervention 	<ul style="list-style-type: none"> • In 2014, there was a total client load of 66 individuals. There were a total of 95 violent injuries among which 42 met the eligibility criteria, referred to the program and agreed to participate (44% referral rate). The program also continued to support 23 ongoing clients from the previous year and one re-referral. • In 2014, 100% of clients consented to services. • In 2014, 82% of clients either completed the program or continued participation in the following year and 18% dropped out. • In 2014, 62% of clients maintained a high or medium level of engagement throughout their participation in the program and 38% had a low level of participation. • In 2014, 87% of clients avoided re-injury, 98% avoided retaliation and 96% avoided re-arrest. • In 2014, 100% of clients remained alive. • 100% of Intervention Specialists pursued one or more support services for clients, totaling 402 interventions.
2015 Objectives	
<ul style="list-style-type: none"> • All objectives remain the same for 2015. 	

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.

2014 Objectives

1. By December 2014, the Clubhouse will have an average daily attendance of 35, and members will spend 50,000 hours participating in Clubhouse activities. Measured by program logs and member sign-in sheets.
2. By December 2014, the number of members under the age of 30 will increase by at least 10 people.
3. The Clubhouse will provide education support.
4. At least 80% of respondents in the annual member satisfaction survey will report an increase in their independence.
5. At least 80% of respondents in the annual member satisfaction survey will self-report improved quality of life from participation in the Clubhouse program.
6. At least 15 additional members will be placed in unsubsidized employment, at an average (unsubsidized) wage of \$8.50 per hour.
7. In 2014, there will be a statistically significant decrease in hospitalizations and out-of-home placements (residential treatment) following membership.

Outcomes

- In 2014, there was an average daily attendance of 36 members representing a total of 303 members who participated in program activities, where they spent a total of 49,896 hours participating in Clubhouse activities.
- 14 new members under the age of 30 joined the Clubhouse during 2014.
- In 2014, 14 members returned to school.
- 85% of members who responded to the survey reported an increase in their independence.
- In 2014, 93% of members who responded to the survey reported an improvement in their emotional wellbeing and 92% reported an improvement in their mental wellbeing.
- During 2014, 30 members found jobs at an average (unsubsidized) wage of \$11.70 per hour.
- 94% of members who provided hospitalization data showed a decrease in hospitalizations or out-of-home placements (p<.01).

2015 Objectives

- All objectives will remain the same for 2015.
- In addition:
 - Maintain an average monthly attendance of 100 members.
 - Increase membership overall by 60 of which 15 will be young adults (age 30 and under).
 - Among those members who indicate education in their career plan, 80% will be referred to appropriate education resources within 14 days.

- At least 80% of members indicating employment as a goal in their career plan will be referred to employers, apply for jobs, and/or have a job interview within 3 months of indicating goal.
- JMH to provide health education materials around top 5 health topics for distribution at the Clubhouse.
- JMH to provide 3 on-site member presentations or workshops.
- 80% of family members who complete the Annual Family Member Survey will report that they experienced improvements in mental, physical and emotional wellbeing.

The John Muir/Mt. Diablo Community Health Fund

In addition to the programs listed, the John Muir/Mt. Diablo Community Health Fund plays an integral role in supporting the expansion and enhancement of health care and wellness services for those who need them most in central and east Contra Costa County. The John Muir/Mt. Diablo Community Health Fund supports the planning and implementation of sustainable health initiatives that address current and emerging health care needs. To do so, they distribute grants to and partner with community-based health centers and nonprofit organizations that provide high quality, affordable primary, dental, behavioral health and specialty care or innovative wellness services that contribute to improved health of those most vulnerable populations in John Muir Health’s service area.

In 2014, 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 Nursing Care Expansion Initiative
 - Electronic Health Technology Initiative
- **Planned Parenthood Northern California**
 - Contra Costa Electronic Health Technology Initiative
- **RotaCare Bay Area, Inc. Concord Clinic**
 - Concord Mobile Health Clinic
- **Brighter Beginnings- Antioch Family Health Center**
 - East County African American Health Initiative

Specialty Care Organizations

- **Operation Access**
 - Contra Costa Specialty Care Initiative

Health & Wellness Organizations

- **Food Bank Of Contra Costa & Solano**

- Contra Costa CalFresh Enrollment Expansion Partnership
- **Meals On Wheels & Senior Outreach Services**
 - Contra Costa Coordinated Care Initiative
- **Women's Cancer Resource Center**
 - East County Center for Cancer Support Initiative
- **Cancer Support Community**
 - East County Center for Cancer Support Initiative
- **The Society Of St. Vincent de Paul Of Contra Costa County**
 - RotaCare Pittsburg Clinic Care Coordinator
- **Contra Costa & Solano Community Clinic Consortium**
 - Contra Costa Access to Care Collaborative:

Program Related Support

For additional details on the John Muir/Mt. Diablo Community Health Fund, visit their website at: <http://www.jmmdcommunityhealthfund.com>

Attachment E – Community Partner Organizations

John Muir Health collaborates with the following organizations (not all organizations are represented here):

- AARP
- Alameda Contra Costa Medical Association
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Red Cross
- Bay Point African American Health Initiative
- Bay Point Partnership
- Lifelong Community Health Center
- Catholic Charities of the East Bay
- Center for Human Development
- Child Abuse Prevention Council
- City of Concord
- Concord Chamber of Commerce
- Concord Rotary Club
- Concord United Methodist Church
- Contra Costa County Health Services
- Contra Costa County Office of Education
- Contra Costa Fall Prevention Program
- Contra Costa Health Ministries Network
- Contra Costa Health Plan
- First Five of Contra Costa County
- Food and Nutrition Policy Consortium
- Kaiser Permanente
- La Clínica de la Raza
- Local Contra Costa County police and fire departments
- Monument Impact
- Mt. Diablo Unified School District
- National Alliance on Mental Illness (NAMI) of Contra Costa County
- One Day at a Time
- Operation Access
- Pittsburg Unified School District
- Planned Parenthood
- Ronald McDonald House Charities of the Bay Area
- RotaCare Free Clinic, Concord
- RYSE
- STAND! for Families Free of Violence
- The Williams Group
- West Contra Costa County Unified School District
- Women, Infants and Children (WIC) Pittsburg
- Youth Alive!
- Village Resource Center

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

