

# ***COMMUNITY BENEFIT REPORT FOR CALENDAR YEAR 2011***

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

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

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

May 2012



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## Executive Summary

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

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

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

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

During Fiscal Year 2011, John Muir Health made over \$58.9 million in community benefit contributions.

<b>In Thousands of Dollars</b>	
Charity Care	20,231
Government Sponsored Health Care (Medi-Cal shortfall)	19,922
Subsidized Health Services	1,116
Health Improvement	8,551
Community Building	636
Financial and In-Kind Contributions, Grants	2,886
Health Professions Education	3,408
Research	818
Community Benefits Operations	1,391
<b>Total</b>	<b>58,959</b>

In addition, John Muir Health provided care to Medicare inpatients and outpatients whose estimated costs exceeded payments made by the Medicare Program. The Medicare shortfall, the difference between the cost of care for Medicare beneficiaries and the payments for those services, was over \$174 million. This is not included in the above total. These categories are also consistent with IRS Form 990 Schedule H for Hospitals definitions.

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

<b>In Thousands of Dollars</b>	
Charity Care	20,231
Medi-Cal Shortfall	19,922
Vulnerable Populations	9,293
Broader Population	5,287
Health Professions Education and Research	4,226
<b>Total Benefits Reported</b>	<b>58,959</b>

Community benefit contributions include programs at John Muir Medical Center – Walnut Creek, John Muir Medical Center – Concord, John Muir Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network. A separate 2011 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Behavioral Health Center.

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

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

In 2011, our community benefit activities further focused on those with disparities in health outcomes. We continued our partnerships with La Clinica de la Raza and the Contra Costa Health Services Department to serve low income residents through the John Muir Mobile Health Clinic and the Dental Collaborative of Contra Costa. We continued our Teen Pregnancy Resource program to educate low-income pregnant teens and to encourage appropriate pre- and post-natal care for the mother and infant. We partnered with the organization Foster A Dream to create physical and mental health resources for foster youth going through the critical transition from foster care into independent adulthood.

John Muir Health outreach also seeks to serve at-risk older adults in the community. Among the programs we support is the Caring Hands Volunteer Caregiver Program, which creates one-to-one matches between volunteers and seniors who are frail, isolated, and/or disabled. Free, non-medical in-home assistance enables these seniors to stay in their homes and remain independent and safe. The Fall Prevention Program of Contra Costa County, which is also supported by John Muir Health, works with senior groups to generate awareness and reduce injuries due to falls through home safety assessments and home modifications for low income seniors. Our Senior Services Department also offers an array of programs including memory screening, geriatric care coordination and medication assistance for low income seniors who too often have to choose between their medications and other life necessities. For additional information on our community programs for vulnerable populations refer to page 14 of the 2011 Community Benefit Report or [www.johnmuirhealth.com](http://www.johnmuirhealth.com).

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

## Who is John Muir Health?

### Mission, Vision, Values

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

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

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

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

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

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

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

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

See attachment A: John Muir Health Community Health Guiding Principles

### Structure

John Muir Health consists of three acute care hospitals and two major outpatient facilities in Contra Costa County and a physician network of primary care and specialty physicians.

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

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<sup>1</sup> JMMDHS Community Health Guiding Principles. Purpose Statement. Fall 2000. p. 3.  
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John Muir Medical Center, Walnut Creek is a 416-bed acute care facility that is designated as the only trauma center for Contra Costa County and portions of Solano County. Recognized as one of the region's premier health care providers by *U.S. News and World Report*, areas of specialty include high and low-risk obstetrics, orthopedics, rehabilitation, neurosciences, cardiac care, and cancer care. John Muir Medical Center, Walnut Creek is accredited by The Joint Commission a national surveyor of quality patient care. President and Chief Administrative Officer is Jane Willemsen.

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

John Muir Medical Center, Concord is a 317-bed acute care facility that serves Contra Costa County and southern Solano County. Recognized as one of the region's premier health care providers by *U.S. News and World Report*, the medical center has long been known as a preeminent center for cancer care and cardiac care, including open heart surgery and interventional cardiology. Other areas of specialty include general surgery, orthopedic and neurology programs. John Muir Medical Center, Concord is accredited by The Joint Commission. President and Chief Administrative Officer is Michael Thomas.

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

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

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

This state-of-the-art facility offers a variety of outpatient services to residents of Brentwood, Antioch, Oakley, Discovery Bay, Byron, Knightsen, Bethel Island and surrounding areas. Services offered include family practice physicians and pediatricians; urgent care; outpatient surgery; digital medical imaging, including mammography, CT, and MRI; laboratory services; rehabilitation services including PT and OT; cardiac conditioning (rehabilitation and education), a diabetes exercise program and pulmonary rehabilitation. Independent physician offices are also located in the building, as well as more than two dozen medical specialists who either have permanent offices or see patients in our "Timeshare" Suites. Senior Services offers information and referral and geriatric care coordination services. Other programs available include the Behavioral Health Partial Hospitalization Program, and the Women's Health Program offers classes on child birth and parenting. Executive Director is Jacqueline Hanel.

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

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

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

The John Muir Physician Network is a not-for-profit public benefit corporation, whose sole corporate member is John Muir Health. Since its inception in 1996, it has become one of the largest medical groups in Northern California, with more than 925 primary care and specialty physicians who deliver coordinated patient care. Physicians associated with the Physician Network belong to either John Muir Medical Group (JMMG) or Muir Medical Group IPA, Inc. The Physician Network owns and operates primary care practices staffed by JMMG physicians in 23 locations from Brentwood to Pleasanton. The Group also provides hospitalists (in-patient medical services) at John Muir Health's two hospitals. The Physician Network is active in community service, health education and clinical research. The Physician Network currently holds contracts with six major health plans for more than 63,000 commercial and senior HMO members. Additionally, the Physician Network provides a physician panel, medical management and claims services for more than 6,000 John Muir Health employees and dependents participating in the Exclusive Provider Organization health plan. The Physician Network manages health plan contracting for John Muir Health and its hospitals and engages in physician recruitment to meet community needs.

Other important components within the John Muir Health organization include four urgent care centers and three other entities that serve the two medical centers in Concord and Walnut Creek: Walnut Creek Campus Auxiliary, Concord Campus Volunteers and John Muir Foundation.

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

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

The Community Health Alliance, a department of John Muir Health, was created to assist the community in achieving optimal health through education, collaboration and health and wellness services. The John Muir Community

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

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

In addition to funding from John Muir Health, the Community Health Alliance received grant funds for the Dental Collaborative of Contra Costa which operates the Ronald McDonald Care Mobile® from Wells Fargo, The California Wellness Foundation, California Dental Association Foundation and Ronald McDonald House Charities. We are grateful for their support and recognition of the critical needs of our community. We are also grateful for funding for outreach programs to address disparities in health outcomes in Pittsburg and Bay Point, California from the Los Medanos Community Healthcare District, Heffernan Insurance Brokers, Vesper Disaster Preparedness and the Department of Health and Human Services Office of Women's Health.

Vice President/Executive Director is Lynn H. Baskett who reports to Marti Tarnowski, Senior VP, Marketing and Strategy, John Muir Health.

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

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

Many programs that receive their start from the Community Health Fund continue long past the grant periods and to this day deliver critical health care services. Consequently, many thousands of Contra Costa residents who might have slipped through the cracks in our healthcare system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support services for conditions that range from cancer and chronic disease through dental caries and mental illness. It is our mission to deliver the same kinds of results to the many more in central and east Contra Costa who still struggle to find adequate care. More detailed information about the Fund, its governance, grant program and community benefit reports can found on its website: [www.jmmdcommunityhealthfund.com](http://www.jmmdcommunityhealthfund.com).

President is Grace Caliendo.

## John Muir Health Highlights

	2010	2011
Patient Beds	657	716
Admissions	29,226	29,661
Emergency patients or visits	90,777	92,596
Urgent Care patients	78,917	84,085
Newborns	2,199	2,189
Surgeries	11,951	12,510
Laboratory tests	3,652,078	3,875,865
Diagnostic Imaging procedures	318,381	320,534
Radiation Therapy	54,021	56,877
Cardiac Catheterization procedures	2,975	3,236
Respiratory Procedures	227,770	246,980
Physical Rehabilitation visits	593,737	552,733
Home Health visits	70,722	69,669
Mobile Health Clinic visits	3,960	3,240
Mobile Dental Clinic visits	1,502	1,454
Employees	6,186	6,217
Physicians	926	1,249
Volunteers	1,600	1,600
Volunteer hours	202,744	205,795

Attached are the following:

John Muir Health Organizational Chart (Attachment B)

Board lists (Attachment C) for

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

### How Do We Define Our Community?

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

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

## **What Are the Needs of Our Community?**

### Community Assessment

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

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

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

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

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

In 2011 John Muir Health updated its Community Benefit Plan goals, priorities and strategies in light of the 2010 community assessment. The goals, priorities and tactics make up our Community Benefit Plan or Implementation Strategy and are included in Attachment F and G.

### Community Input

John Muir Health used various mechanisms to incorporate community input into the annual Community Benefit Plan. During 2011, John Muir Health kept abreast of current health issues of importance to the community by active participation within the Monument Community Partnership, Dental Collaborative of Contra Costa, Contra Costa Council Health Task Force, East County Access Action Team, Primary Care Access Stakeholders Group, Bay Point Family Partnership, Contra Costa Health Ministries Network, Families CAN and other ongoing collaborations with community-based organizations. These sources of information provide current information regarding community health status and also help identify emerging needs in the service area population.

Community organizations also seek out John Muir Health as a partner. The Community Nurse program developed out of the 2007 community assessment which identified childhood

overweight and diabetes prevention as areas of focus. Subsequently a second school district asked John Muir Health to expand its community nursing program during 2010.

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

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

### Community Survey Highlights

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

### **Where are the needs greatest?**

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

### **Where Is John Muir Focusing Its Efforts?**

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

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

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

#### *What are Disparities in Health Outcomes?*

Disparities in health outcomes refer to gaps in the quality of health and health care across racial, ethnic and socioeconomic groups. In the United States, health disparities are well documented in ethnic populations such as African Americans, Asian Americans, Latinos and Native Americans. When compared to Caucasians, these ethnic groups have a higher incidence of chronic diseases and poorer health outcomes.

#### *What are the Causes of Disparities in Health Outcomes?*

It is generally accepted that disparities can result from three main areas:

- From the personal, socioeconomic and environmental characteristics of ethnic and racial groups,
- From the barriers certain racial and ethnic groups encounter when trying to access the health care delivery system; and
- From differences in health care that ethnic and racial groups receive

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

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

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

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

In 2011, John Muir Health undertook a review of its community benefit strategies and focus areas using the 2010 Community Health Indicators in Contra Costa report while also considering the changes in the delivery system in Contra Costa County under health care reform and

reductions in Medicare reimbursement. These changes will require all hospital systems to make strategic choices to focus community benefit contributions on the greatest needs in the community and to maximize the positive impact of those contributions.

We developed multiyear goals, strategies and focus areas for 2012-2014. As we have in the past, our criteria for selecting focus areas and programs will start with the three funding criteria described above: needs of vulnerable populations, programs that will have a measurable impact and delivered in partnership with community based organizations. John Muir Health acknowledges that the health needs of vulnerable residents in Central and East Contra Costa County cannot be met by any one public or private organization. John Muir Health selects focus areas based on its clinical and organizational strengths, the availability and willingness of appropriate community organization partners, the incidence and prevalence of the need, the potential for making a positive impact and available financial and staff resources.

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

### **2011 Community Benefit Plan Year End Results**

The John Muir Health 2011 Community Benefit Plan, Attachment F, outlines specific strategies, tactics and outcomes for 2011 under each Community Benefit Plan goal, all of which were developed in cooperation with John Muir Health's management, as well as appropriate physicians, service line staff and community partners.

For many hospitals, much of the charity care costs recorded in annual community benefit reports is generated in the course of regular Emergency Department operations. In 2010 John Muir Health began tracking charity care costs generated by specific, proactive community benefit programs. Of our total 2011 charity care costs reported in our economic inventory of contributions, \$642,803 was provided through the Operation Access, Mobile Health Clinic, Every Women Counts and the new La Clinica-John Muir Health Specialty Care program.

The John Muir/Mt. Diablo Community Health Fund made planning, program implementation, capacity building and evaluation grants to Operation Access, La Clinica, St. Vincent de Paul, Food Bank of Contra Costa and Solano Counties, and the Eastern and Central County Access Action Team

For additional details on the Community Health fund, visit their website at [www.jmmdcommunityhealthfund.com](http://www.jmmdcommunityhealthfund.com).

## Community Benefit Program Impact Highlights

Below are highlights of some of the 2011 John Muir Health Community Benefit programs and activities which address health disparities in the John Muir Health service area of Contra Costa County:

Program	Description/Highlight	Impact Statements
<b>Access to Disease Prevention</b>		
<b>Goal 1: Uninsured, underserved and vulnerable populations in the service area have access to the full range of disease prevention and health care services.</b>		
<b>Every Woman Counts</b>	<p>John Muir Health has a unique model of providing free breast and cervical cancer screening and diagnostic services through the State of California’s “Every Woman Counts” Program (EWC). John Muir Cancer Institute developed “one-stop shopping” monthly Clinics in which most breast health services are provided at one location on the same day to low income, uninsured women at risk for breast cancer with a focus on underserved populations. In 2010, John Muir Health added cervical cancer screening to the Every Woman Counts Program.</p> <p>At the Clinics, patients receive culturally appropriate education and information on early detection, breast self exam instruction, Clinical Breast Exams, pelvic exams, and pap smears by physicians and/or nurse practitioners with expertise in breast cancer, screening and diagnostic mammography, ultrasound and same day ultrasound guided core breast biopsy may also be provided. Interpreters are available at every Clinic, and transportation can also be arranged. Providing culturally sensitive, seamless quality breast health services on the same day requires the collaboration and resources of multiple John Muir Health system departments and community agencies in an effort to decrease barriers for women, prevent loss to follow-up and diagnose breast cancer as early as possible.</p> <p><i>Success Story: Lani’s Story: It was shocking to discover a mass in my left breast on a morning after exercise class. I tried to wrap my mind around something that was so unfamiliar and frightening. I never considered I would ever have to deal with this alone. Besides that, this just couldn’t be happening to me! The Every Woman Counts Program was absolutely essential to my situation. The devoted and caring staff helped me navigate the process and provided me with answers to my questions. The diagnostic mammogram, ultrasound, and core needle biopsy were all done in one day. The diagnosis was breast cancer and the staff took immediate action in developing a custom care plan. I was enrolled in the Breast and Cervical Cancer Treatment Program and referred to a specialist for treatment. If the program didn’t exist I think I would have panicked and stopped moving forward. I am so grateful for the support, confidence, education, referrals and guidance that I received through the Every Woman Counts Program. Most importantly, my life was at stake and I didn’t lose precious time thanks to the expedited services and treatment.</i></p>	<ul style="list-style-type: none"> <li>• In 2011, there were 19 Cervical Cancer Screening Clinics and 16 Breast Cancer Clinics.</li> <li>• A total of 525 patients were seen through the 35 Every Woman Counts clinics.</li> <li>• 54 percent of breast cancer patients were new patients, compared to 8 percent in 2010.</li> <li>• Out of the 525 patients served, 50 percent identified as Hispanic and 43 percent identified having a language barrier.</li> <li>• A total of 37 African American women were screened in 2011 compared to 6 in 2010; an increase of 83 percent.</li> <li>• 99 percent of patients were provided with “one stop” breast services.</li> <li>• 16 women served were diagnosed with Breast Cancer and provided with the appropriate follow-up and treatment necessary to monitor their diagnosis. These are lives extended or saved.</li> </ul>

<p><b>Faith and Health Partnership</b></p>	<p>The Faith and Health Partnership (FHP) creates opportunities for faith communities and surrounding neighborhoods to collaborate with JMH and other health and social service agencies to develop and implement needed health education programs, preventive screening, chronic disease education, and resource referrals in an effort to promote healthy living, reduce health disparities, and save lives. Leaders and members of faith and community-based organizations have a relationship with their congregation that is built on trust. This relationship allows them to communicate important health information, mentor, and model healthy lifestyles. The congregations served by FHP are diverse in denomination, size, race, ethnicity, and income level. FHP assists each congregation in developing their unique vision for health and wellness by customizing support and implementing plans to sustain their vision.</p> <p>Success Story: <i>Power for Living Ministry (PFLM) has worked with the Faith and Health Partnership (FHP) for the past three years. Pastor Liddell enthusiastically embraced the concept of a health ministry and in year two of their health ministry program, PFLM implemented an internal food policy for meals served during their meetings and church events. Additionally, PFLM has created and piloted the Greatest Loser Program which uses many of the components of the popular weight loss TV program the Biggest Loser. In 2011, 37 participants registered in the program. Of these, 23 completed the program and lost a total of 105 lbs. One of the members shares: "As a senior joining the program for the first time, it changed the way I eat and I always think about it all the time, I'm exercising more and my blood pressure is so much better. I'm never too old to learn".</i></p>	<ul style="list-style-type: none"> <li>• In 2011, the FHP reached out to over 12,971 individuals in the John Muir Health service area through faith-based and community outreach programs.</li> <li>• The FHP partners with 31 faith communities, reaching over 11,000 congregants in 2011 through the health related activities and change projects.</li> <li>• At three FHP health ministry events, 361 people were screened, resulting in the identification of 110 abnormal results, of which 100 percent were referred to appropriate care and were followed-up on the referral.</li> <li>• Through the 31 partner faith community programs: <ul style="list-style-type: none"> <li>a) 15 churches changed their food policy to be more healthy</li> <li>b) 10 churches implemented fitness programs</li> <li>c) 4 churches began peer counseling programs</li> </ul> </li> <li>• The FHP conducted health promotion campaigns that delivered customized health messages at 7 local salons where 250 salon patrons received health information.</li> <li>• FHP organized and implemented five health fairs, which resulted in over 548 screenings, and twenty-one community activities reaching 1,723 individuals.</li> </ul>
<p><b>Teen Pregnancy Resource Program</b></p>	<p>The Teen Pregnancy Resource Program offered by the John Muir Women's Health Center, provides free educational classes for pregnant teens in the Central and East Contra Costa County. Through partnerships with community school and agencies in the following cities: Antioch, Brentwood, Pittsburg, Concord, Byron, Oakley, Bay Point, Walnut Creek and San Ramon. The program includes emotional support and free educational classes including Online Childbirth Class, Childbirth Personal Class, Infant and Child CPR and Safety, Infant Breastfeeding, Newborn Care Financial Literacy and Car Seat Safety Check. Post Partum classes include mom's groups and breastfeeding support.</p> <p>Success Story: <i>Dionne, 17, is pregnant for the first time. She currently lives with her mother, She was offered the opportunity to take the "financial literacy" class along with her selections of Infant and Child CPR/Safety, Newborn Care, Breastfeeding and Prepared Childbirth classes. She stated that the classes were extremely helpful in preparing for the birth and care of her child but was most helpful was the financial class. She and her baby's father attended the class together. Before this class "I never really thought about money. I knew I would need some to take care of my baby but never thought about how to manage what little I had," she admitted. She</i></p>	<ul style="list-style-type: none"> <li>• In 2011, a total of 18 community organizations and physician offices were identified as participating sites</li> <li>• 29 teens participated in the program</li> <li>• 100 percent of the teens referred participated in the program</li> <li>• Of the 29 teen participants, 44 percent completed 4 prenatal or parenting education courses</li> <li>• Teens reported an increase in knowledge after participating in the classes offered.</li> <li>• Participant satisfaction surveys reported that 100 percent of the teens found the Teen Pregnancy Program to be very valuable.</li> <li>• Of the moms that delivered, 100 percent delivered at full term without complications and 91 percent were breastfeeding after 3 weeks</li> </ul>

	<p>said the financial literacy class shocked her into the reality of the benefits of budgeting and saving. She said, “no matter how much or little you have, budgeting and saving just makes sense.” She thanked the Women’s Health Center for helping her think beyond childbirth and child care.</p>	
<p><b>Community Nurse</b></p>	<p>The Community Nurse Program funds nurses in low income area schools, where the majority of students are eligible for the Federally Qualified School Lunch Program. The Community Nurse advances the well being, academic success, and life-long achievement of students through promoting health and safety, intervening with health problems, providing care management services and actively connecting the students and their families with community resources to build student/family capacity for a healthy life.</p> <p><i>Success Story: After winter break a fifth grade teacher reported that she suspected a female student of cutting herself. The student had not shown this behavior earlier in the school year. The student was called in to see the Community Nurse. She admitted to cutting her hand and wrist. The student showed the cuts, some cuts were healed and some appeared new. No other signs of cutting were noted. The student tearfully explained that her family had recently moved to a new apartment complex. She was being harassed, left out and suffering from low self esteem and social isolation. By the end of the first meeting the student entered into a verbal contract to not cut or harm herself. The principal, teacher, school psychologist, and parents were notified of the situation. It was agreed that the student was allowed to visit the Community Nurse anytime she needed. Upon meeting with the student’s parents it was noted that they were hesitant to let the student see a therapist as recommended; they preferred the student see their priest. After explaining self mutilation disorder / cutting disorders and the possibility of the behavior intensifying with the added stress of middle school, the parents agreed to counseling. Assistance was provided to the student’s mother with a mental health referral, arranging for an interpreter, and with making the initial appointment. The student continued to meet with the Community Nurse and the school psychologist. The student was required to complete a daily log noting her feelings and if she felt like self mutilating. She attended counseling sessions through mental health and with the family priest. At the end of the school year she had not cut herself for 3 months and she was able to identify coping skills. After a year end conference, the student’s parents reported that the behavior / mood had greatly improved and they had not noticed cutting. They were very thankful for the assistance and education.</i></p>	<ul style="list-style-type: none"> <li>• The Community Nurse received a total of 523 referrals from teachers, staff, family and students, which was a 52 percent increase from the previous year.</li> <li>• The referrals received and made during the 2010-2011 school year resulted in a total of 4,227 interventions including notification letters (26 percent), screenings (25 percent) and first aid care (24 percent).</li> <li>• In 2010-2011 100 percent of K, 2<sup>nd</sup> and 5<sup>th</sup> graders received the mandated screenings.</li> <li>• 62 percent of interventions resulted in improved health status.</li> <li>• 100 percent of the students with missing immunizations completed their requirements by year end.</li> </ul>
<p><b>Fall Prevention Program of Contra Costa County</b></p>	<p>The Fall Prevention Program of Contra Costa County strives to reduce deaths, preventable injuries, and loss of independence associated with falls of seniors and persons with disabilities. The program provides educational support and home safety repairs.</p> <p><i>Success Story: Ms. Lin: A stair railing and a grab bar provided by the FPP made a great difference in the daily life of a Ms. Lin, a 71 year-old woman in Antioch with income at 125% of poverty level. She was unable to get her mail because she could not</i></p>	<ul style="list-style-type: none"> <li>• In 2011, a total of 891 people were served through community outreach events, which was a 14 percent increase in older adults and 1 percent increase in care providers served from the previous year.</li> <li>• The county-wide fall prevention coalition held 4 coalition meetings with an average of 34 attendees and 33 agencies.</li> </ul>

	<p><i>safely go down her front steps without a railing to steady herself. She now benefits from the exercise and fresh air as well as being able to get her mail. She was also unable to get up for several hours after falling in the bathtub. This was frightening and the consequences could have been life threatening. Now she has a securely installed grab bar to safely pull herself up; she can relax and bathe with less fear.</i></p> <p><i><u>Ms. Harding:</u> Ms. Harding, a 78 year-old Pittsburg woman, was referred because of pain when standing and difficulty maintaining her balance. Following the installation of a shower chair and hand held shower head, she is ecstatic that she can take a regular shower and does not have to use a wash basin. In addition due to the elevated toilet seat with support rails she is now able to safely get off the toilet without having to call for assistance.</i></p>	<ul style="list-style-type: none"> <li>• FPPCCC received 162 referrals and conducted home safety assessments and modifications in 89 homes for 145 low income older adult residents of Central and East Contra Costa County.</li> <li>• As a result of fall prevention presentations, 93 percent of older adults reported having a greater awareness about why falls happen and learned something new about preventing falls as a result of the presentations provided by FPP.</li> <li>• Older Adults who received in home assessment and modifications in 2011 reported high quality of life improvements. Of these older adults, 74 percent report that they have not fallen since the intervention.</li> </ul>
<p><b>Beyond Violence</b></p>	<p>The Beyond Violence program was launched in 2010 in the cities of Richmond and Antioch with the collaboration of John Muir Health’s Trauma Department, Contra Costa Health Services (CCHS) and community based organizations. JMH identifies trauma patients between the ages of 14-25 who are victims of intentional injuries (e.g. knife assault, gunshot, assault) and reside in the cities of Antioch or Richmond. Identified patients are referred to a Beyond Violence Intervention Specialist (IS) from their community. The IS supports the injured patient and their family and friends cope with the injury, and assists the patient with follow-up care and connects them to community resources to promote healthy choices and avoid re-injury and involvement law enforcement.</p> <p>Success Story</p> <p><i><u>Marco:</u> Marco, 19, was shot four times – twice in the stomach, once in the foot and once in the arm. He is currently unable to use his left arm because it was shattered by the bullet. Marco has had no previous injuries, gang affiliations, or history with law enforcement. Marco was connected with Beyond Violence Intervention Specialist while he was in the hospital. Marco and the Intervention Specialist worked together to empower Marco’s life going forward. The Intervention Specialist assisted Marco in locating resources to help him pay for additional services, such as medical insurance, dental treatment, and mental health counseling. He is also helping Marco to submit an application for assistance from Victims of a Violent Crime. Marco is doing progressively better each day. He has not been re-injured or the perpetrator of any violence. He has had no contact with the police and continues to work on his daily goals. Marco recently achieved one of his short-term goals when he was able to walk across the stage to receive his High School diploma. “I almost didn’t make it to see this day come true,” Marco reflects about his journey. He dreams of eventually going on to college after he progresses physically. Until then, his short term goals include finding a better job with more hours and preparing for college. Beyond Violence will continue to help Marco realize his potential as a hopeful young man.</i></p>	<ul style="list-style-type: none"> <li>• In 2011, a total of 38 patients were identified by JMH staff as eligible for the Beyond Violence program; 100 percent of the eligible patients consented to participate in the program and were referred to an Interventionist.</li> <li>• The Beyond Violence Interventionists received consents from all 38 (100 percent) of the referred clients.</li> <li>• In 2011, 82 percent of referred clients were engaged in Beyond Violence after 3 months.</li> <li>• 100 percent of clients remain alive and avoided re-injury at the 3 month and 6 month follow-up.</li> <li>• 95 percent of clients were not involved in a criminal incident at the 3 month follow up and 100 percent were not involved at the 6 month follow up.</li> </ul>

	<p><i><u>Juan:</u> Juan is an 18 year old Latino man who lives with his parents and two siblings. When he was 17 years old he was shot in the upper arm while driving in a bad neighborhood. Juan has no previous injuries of run-ins with law enforcement, but has been involved in gang activity that was unassociated with the shooting. The traumatic incident has had a significant impact on Juan’s emotional well being. At times he has difficulty sleeping due to nightmares surrounding the violent incident and he has become paranoid. He fears being around a lot of people because, “someone will finish him off.” His mother is constantly worried because Juan knew what he wanted to do and cared about school before the shooting, but now his confidence often waivers. His behavior has changed significantly since the shooting – “I used to always be out and about, hanging around lots of people,” remarks Juan, but now he spends most of his time indoors around family and a few very close friends. The Beyond Violence staff has helped Juan to reestablish his goals and confidence by providing emotional support. Beyond Violence has also helped Juan and his family with the stress associated with his medical care by assisting his uninsured family access resources to pay medical bills, helping Juan apply for Victims of a Violent Crime compensation for lost work hours, and connecting him to other resources. Beyond Violence will continue to support Juan’s emotional recovery as he regains his confidence and purpose.</i></p>	
<p><b>Healthy and Active Before 5</b></p>	<p>Healthy and Active before 5 is dedicated to creating healthy food and activity environments in neighborhoods and organizations that support children 0-5 and their families. The collaborative includes an 8 member executive committee, and 45 Leadership council and community members who wrote a comprehensive action plan based on research and best practices. The Leadership council and Executive Committee members represent almost all stakeholders impacting low income children in Contra Costa, including government, health care, children’s services, the faith community, businesses, education, public safety and non-profit organizations. These leaders have not only guided the collaborative’s efforts but also have committed to making sustainable changes within their organizations so that programs, policies and practices are in alignment with the Healthy and Active Before 5 Action Plan and Policy agenda.</p> <p>Success Story: <i>One of the missions of Healthy &amp; Active before 5 (HAB45) is to build partnerships and environments for healthy eating and active play in children ages 0-5 years old. One of the most successful and promising partnerships is with the Michael Chavez Center for Economic Opportunity, a hardworking nonprofit struggling to meet the pressing needs of the Monument Corridor and the wider Concord community. The center offers community opportunities in job training, career coaching and employment connections. They empower individuals to become financially self-sufficient, realizing their personal potential and to actively participate in the community. The Michael Chavez Center staff continues to take the best practice research and inspiration they get at the HAB45 Leadership Council meetings back to their agency and the clients they serve. They understand that in addition to the resources they provide, they also have an opportunity to</i></p>	<ul style="list-style-type: none"> <li>● In 2011 HAB45, improved their website, produced three newsletters, and integrated social media feeds in order to promote healthy food and activity environments.</li> <li>● HAB45 facilitated two collaborative meetings in 2011 which helped to inspire progress among local organizations serving young children in Contra Costa and provide opportunities for networking, technical assistance, and sharing best practices. The meetings engaged over 90 individuals and 60 organizations.</li> <li>● HAB45 has received 138 pledges from local organizations committing to make healthy changes in their organization.</li> <li>● According to the individuals who have collaborated with HAB45, 82 percent reported that HAB45’s work has helped to make their agency a healthier place for children &amp; families.</li> <li>● HAB45’s advocacy and technical assistance work has resulted in the formal adoption of 14 new local policies by local agencies.</li> <li>● At December’s Leadership Council Meeting, 80 percent of meeting participants replied that HAB45’s work has helped to make their agency a healthier place for children &amp;</li> </ul>

	<p><i>promote and model healthy behaviors. They understand that important disparities in obesity rates continue, with Hispanic children showing <u>significantly higher rates of obesity than their white and black peers.</u></i></p> <p><i>Over the past year, the Michael Chavez Center</i></p> <ul style="list-style-type: none"> <li><i>Passed a new Healthy Food Policy which states that only healthy foods and beverages will be provided to staff and program participants. This policy also limits food donations to healthy items.</i></li> <li><i>In December, they posted in their newsletter/blog about the importance of tap water, highlighting both the health benefits and economics of drinking tap water. The blog post was emailed to their long list of program supporters, and remains on their website</i></li> <li><i>Currently, HAB45 and Michael Chavez staff are discussing ways to include messages about the importance of breastfeeding, and breastfeeding accommodation when clients are returning to work.</i></li> </ul> <p><i>Although the Michael Chavez center is not a “health” agency, they have exemplified how an organization can affect behavior change. By continuing to share and role model healthy behaviors, the Center will continue to positively affect the health of its staff and the Monument Community.</i></p>	<p>families.</p>
<p><b>Lung Cancer Screening Program</b></p>	<p>The Lung Cancer Screening program offered by the John Muir Clinical Research Center in conjunction with John Muir Health Cancer Institute, provides low-dose, non-contrast computerized tomogram (CT) scans of the lungs to people at high risk of developing lung cancer. With early detection of lung cancer, better treatment options are available to the patient, ultimately leading to improved survival and quality of life for this population. Patients receive appropriate education and information about early detection and results of the CT scan are provided along with recommendations for any follow up if required. If an abnormality is found on the initial scan, the patient will be counseled about recommended follow up. Patients requiring additional studies will be closely followed by their primary care physician and the research team at John Muir Health.</p> <p><i>Success Story: A Family History - A mother from Sacramento who has lung cancer and a very strong family history of lung cancer including aunts, uncles, a child, and parents – found out that John Muir was participating in the I-ELCAP study and called to enroll her daughter who currently smokes. At the scheduled appointment time, her son joined them, hoping that he too could participate in the study. He had a smoking history, but had quit years previously. He was unemployed and had no way to pay for the scan. He had no primary care physician, however, the physician was willing to review the results and offer referrals if needed, and due to the funding available, he didn't have to worry about the cost of the scan. Incidentally, the daughter, who was still an active smoker at the time she entered the study, accepted smoking cessation information, coupons for available smoking cessation products, support phone numbers and general information about smoking cessation. She indicated that she was planning to utilize the study to assist her to stop smoking.</i></p>	<ul style="list-style-type: none"> <li>• In 2011, 37 screenings were conducted.</li> <li>• Of the total participants screening in 2011, 48 percent lived in households with incomes less than 200 percent of the Federal Poverty</li> <li>• During the second half of 2011, 100 percent of participants were provided scan results within 10 working days.</li> <li>• When participants were asked about their overall experience as a subject in the research study, 70 percent rated their experience as “excellent” and 28 percent as “very good.”</li> <li>• According to the Participant Survey, 98 percent rated their experience as excellent or very good, 91 percent reported increased knowledge about their health condition, and 88 percent feel more engaged in their healthcare as a result of the education and services provided. Additionally, 71 percent of participants reported that they are more likely to make lifestyle changes as a result of the education and services received.</li> <li>• As a result of the screenings provided, 32 percent of participants were recommended for follow-up care, 6 percent received biopsies and 6 percent were diagnosed.</li> </ul>

## Access to Health Care Services

Goal 1: Uninsured, underserved and vulnerable populations in the service area have access to the full range of disease prevention and health care services.

**Operation Access**

John Muir Health (JMH) includes two of five Contra Costa County hospitals that deliver free outpatient surgeries and procedures to uninsured patients through Operation Access (the other Contra Costa County hospitals are Kaiser Permanente Richmond, Walnut Creek and Antioch.). JMH collaborates with the Community Clinic Consortium of Contra Costa County to donate surgical care to low-income, uninsured county residents. The process for providing surgical resources, laboratory services, and pharmaceuticals begins with the patient presenting themselves at any of the consortium member community clinics. The community clinic medical provider identifies patients who are candidates to receive surgery and makes a referral directly to Operation Access. Operation Access screens the patients for financial eligibility. For those who qualify; a consultation with a volunteer surgeon from JMH is arranged at no charge. If the surgeon finds the case appropriate, the surgery is scheduled. Other medical services associated with the surgery such as diagnostic tests and pre-operative labs are also completed by volunteer JMH specialists at no cost to the patient. After the surgery, the patient attends a post-operative visit and then returns to the referring clinic for ongoing medical care.

*Success Story: A Personal Testimony from an Operation Access Patient: "My name is Jeannette and I arrived in the United States when I was thirty. I married soon after and had a little girl. The same year I had my daughter, I went to San Francisco General Hospital for severe abdominal pain, where they told me I had gallstones. On several occasions I tried to get surgery, but couldn't since I didn't have insurance. My husband and I had very little money to support ourselves and could not afford the expensive procedure. My condition worsened as I waited on several waiting lists. I spent the next twenty-six years dealing with the pain of my condition, including weight gain, a growing stomach and limited diet. I couldn't work because I couldn't lower myself or bend. When I felt I reached a dead end, I returned to my home country in search of alternative medicine. I found some and brought back enough to last me two years. I spent these past few years hoping the alternative methods would cure me. Despite my attempts, I could not sleep at night and had started vomiting frequently. It was difficult to walk and breathe normally. Many nights I would pray, asking for anything to alleviate the pain. Then, a couple months ago, I went to La Clinica de la Raza, where they did an ultrasound and told me I was being referred to Operation Access for a cholecystectomy. Shortly after my referral was sent, Operation Access sent me to see Dr. Fernando Otero at John Muir Walnut Creek. I was very nervous when I arrived as I had not received surgery before, but Dr. Otero's smile and reassurance helped me feel comfortable and safe. Dr. Otero is a wonderful surgeon with a big heart and I count my blessings for having received such amazing care. The surgery was a total success: I am now healthy and happy with the drive to live, work and support my family. Dr. Otero and Operation Access were my angels, sent down to save my life."*

- John Muir Health provided 51 surgical procedures, which accounted for 59 percent of Operation Access surgical services in Contra Costa County.
- John Muir Health surgeons provided an additional 55 services including evaluation only visits, diagnostic screenings, medical therapy, minor procedures and radiology.
- The number of surgeries provided by John Muir Health surgeons increased by 59 percent from the prior year.
- Patients rated their overall satisfaction with Operation access 4.8 out of 5.0.
- In 2011, 93 percent of patients reported improved quality of life and 100 percent of patients reported improved work ability and mobility.

<p><b>Mobile Dental Clinic</b></p>	<p>The Mobile Dental Clinic (MDC) offers free dental services through the Dental Collaborative of Contra Costa, which includes Ronald McDonald House Charities, the County’s Children’s Oral Health Program, La Clinica de La Raza, Brookside Community Health Center, and John Muir Community Health Alliance. Each partner provides a critical part of the service. Ronald McDonald House Charities provided the fully equipped clinic with 2 operatories including x-rays. The Children’s Oral Health Program (COHP) provides screening and triage in low income schools. La Clinica de la Raza and Brookside Community Health Center provide the dental care, patient registration, assistance with enrollment in programs for which the patient may be eligible and assistance in indentifying and establishing a connection to a dental and medical home for the child and the family. John Muir Community Health Alliance provides the clinic, driver, and coordinates the maintenance and operation of the mobile clinic and the Collaborative.</p> <p><i>Success Story: From patient email: “Jools came to live with us in June 2011. He was missing three front teeth and had multiple dental problems. Jools has been quiet, he doesn’t usually speak nor smile to anyone. He always used his hand to cover his mouth while he talked or laughed. I realized he was embarrassed because of his missing teeth. He was referred to La Clinica for the Mobile Dental Clinic and now he is in the process of having his dental procedures done. Jools was so happy to have his teeth taken care of, and joyed for having his stay plate on. In fact, he’s been carefree and finally brought a friend home and is now showing an increase of self-esteem and self-confidence.</i></p> <p><i>I would like to thank Dr. Arica, Mobile Dental Clinic and La Clinica Dental Clinic for the kindness and hard work you do to make one teenager to be himself and have a better future simply to be able to smile. Thanks A Million.”</i></p>	<ul style="list-style-type: none"> <li>• In 2011, the Mobile Dental Clinic provided oral health services to 655 children through 1454 visits, of which 69 percent were preventative.</li> <li>• In schools in 2011: <ul style="list-style-type: none"> <li>a) 9,632 received dental education</li> <li>b) 7,952 received dental assessments</li> <li>c) 6,147 received fluoride</li> <li>d) 1,142 received sealants</li> </ul> </li> <li>• 671 families were provided with insurance enrollment assistance.</li> <li>• 100 percent of patient seen through the Mobile Dental Clinic were connected with a dental home through referral partnerships with community clinics.</li> <li>• According to the 2011 Mobile Dental Clinic Patient Satisfaction Survey, 100 percent of patients reported that they would recommend the Mobile Dental Clinic, 96 percent were offered the services they needed, and 100 percent were satisfied with the quality of care.</li> <li>• 44 percent of patients seen at the Mobile Dental Clinic had not seen a Dentist in 1 or more years.</li> <li>• 8.3 percent of the patients seen would not have sought care if the Mobile Dental clinic was not available</li> <li>• The Mobile Dental Clinic expanded service to three new schools in 2011.</li> </ul>
<p><b>Mobile Health Clinic</b></p>	<p>The Mobile Health Clinic (MHC) operates Saturdays in Brentwood and East County, providing free preventive and urgent medical care. More than 60 doctors, nurses and support staff from John Muir Health and the John Muir Physician Network volunteer their time to provide these services. Mobile health services provide a link for patients to a medical care system through referrals and collaboration with area health care providers including La Clinica de la Raza and Contra Costa Health Services. In addition, the MHC also operates two days a week in the Monument Corridor area of Concord, one day in Bay Point and one day in Antioch with the Contra Costa County Public Health Department. The Public Health Department provides bilingual clinical and support staff while John Muir Health provides the MHC and the driver. The MHC operates on Thursday evenings and on the fourth Tuesday of every month in Concord supporting the Concord Rotary’s RotaCare Clinic.</p> <p><i>Success Story: Roza, 33 year old uninsured, undocumented Hispanic female presented at clinic early in 2011 with complaints of abdominal mass with increasing pain. A CT scan revealed a 12cm ovarian cyst. The patient was referred to La Clinica de La Raza for Operation Access. It was</i></p>	<ul style="list-style-type: none"> <li>• In 2011, the Mobile Health Clinic Saturday Clinic served 694 patients made 154 referrals for urgent, specialty or chronic care needs to La Clinica de la Raza, Pittsburg and Brentwood Health Centers, and other community providers.</li> <li>• The staff followed-up with 60 percent of patients and 75 percent of patients reported that they had followed through with their referrals.</li> <li>• Based on the 2011 Patient Satisfaction Survey, 100 percent of patients surveyed reported that they were satisfied with the services offered and received.</li> <li>• 27 percent of patients reported that they would not have sought care if the MHC was not available and another 23 percent reported that they would have gone to the Emergency Department to seek medical care.</li> </ul>

	<p><i>determined after a 3 month wait that the mass was too large to qualify for Operation Access. The patients only other choice was to apply for emergency Medi-Cal under PRUCOL. The patient was fearful of immigration issues, but was suffering from increased pain and nausea from the mass. After 28 telephone interventions by MHC staff, the patient applied for PRUCOL and had surgery at the County in August to remove the cyst which had grown to 18cm and repair a hernia which had also developed. The patient called after her surgery to thank the staff for their persistence and concern for her.</i></p>	<ul style="list-style-type: none"> <li>• The estimated Emergency Department costs avoided by use of the Mobile Health Clinic (including partnerships) in 2011 was \$489,000.</li> </ul>
<p><b>Foster A Dream</b></p>	<p>The partnership between Foster a Dream and John Muir Health helps East Bay foster children navigate a critical period in their lives: their transition to adulthood and independence. An unsuccessful transition can lead to homelessness, physical and mental health issues, and increased risk of unlawful activity. Foster youth who are prepared academically with career goals, life management skills, and knowledge of resources are more likely to succeed and thrive. In 2011 Foster a Dream had 1600 participants, 70% of the participating youth are 12-21 years of age and 30% under 13 years of age.</p> <p>Success Story: <i>This was the fourth year that the “Dare to Dream” academic scholarship was awarded to a foster youth. The Dare to Dream Scholarship was awarded to –Gabriela. Gabriela was the recipient of the John Muir Dare to Dream Scholarship in 2010 and was awarded it again in 2011. She is still attending San Francisco State University with a Nursing major and has a 3.35 GPA. She is still participating in the Guardian Scholar program at San Francisco State and will be the upcoming program President. Here is an expert from her personal statement on her 2011 scholarship application.</i></p> <p><i>“After being awarded the scholarship in 2010, my goals and determination were reinforced. Without that assistance, affording college would have been so hard, and not being able to pay for my education would definitely have been discouraging.....My first semester here at San Francisco State, I made the Dean’s List, which was absolutely exciting. I love knowing that I am doing well in college and that I am becoming one step closer to graduating and making a difference. I want my success to defy the odds, to show others, especially foster youth, that any dream is possible, and that there are people who want to help.”</i></p>	<ul style="list-style-type: none"> <li>• 1183 backpacks were filled with school supplies and distributed to foster youth. School supplies included backpacks, pens and pencils, folders, and notebooks.</li> <li>• 8 youth participated in the Get Set Program, which supports foster youth transition to emancipation. 50 percent met their immediate goals and are now working towards their next goals, with the support of Foster A Dream staff and volunteers.</li> <li>• There was an overall expansion of mentor and volunteer program with: <ul style="list-style-type: none"> <li>a) 100 new volunteers</li> <li>b) 14 mentors recruited</li> <li>c) 4 new Board members recruited</li> </ul> </li> </ul>
<p><b>Medication Assistance Program</b></p>	<p>Senior Services staff help eligible low- income Medicare patients receiving care from a John Muir Health physician complete the enrollment process for pharmaceutical companies’ patient assistance programs. The goal is to assist low-income older adults in obtaining free brand name prescription medications thereby enabling them to follow the treatment plan recommended by their physician and improve or maintain their health and quality of life.</p> <p>Success Story: <i>Mrs. Z, a bright and articulate 74 year old Hispanic widow, lives alone in Oakley with Social Security of \$1061.50/month as her only income, placing her at 100% of the federal poverty level. She has no family and few friends in her life. After paying rent, utilities, food and medical bills, she is unable to afford prescription medications. A medication prescribed to offset a family history of high</i></p>	<ul style="list-style-type: none"> <li>• 44 Medicare patients were provided with 406 medications free of cost.</li> <li>• The Medication Assistance Program provided patients with \$200,435 worth of prescription medications.</li> <li>• 78 percent of the persons served obtained multiple medications.</li> <li>• 84 percent of the persons served had incomes of 200 percent of the Federal Poverty Level and below.</li> </ul>

	<p><i>cholesterol and stroke has a very high co-pay. A second medication which controls debilitating and painful arthritis is not covered by her Medicare prescription drug plan. Without the medication she is unable to maintain her ability to perform daily tasks of living. The patient's primary physician referred her to the Medication Assistance Program which was able to apply and obtain both medications, a value of almost \$3000.00. The patient is now feeling good, remains independent, and lives in her own home.</i></p>	
<p><b>Specialty Care Program</b></p>	<p>One of the greatest needs in the County is specialty care for uninsured, low income residents. The County Health Services Department is no longer accepting undocumented adults who need care due to their budget constraints. In Central and East Contra Costa there are very few community clinics who provide primary care and those clinics do not have sufficient specialty care options for their patients who need specialty consultations, diagnostic studies and inpatient treatment. Low income, uninsured patients referred by a primary care provider from La Clinica de la Raza in Concord, Pittsburg or Oakley will receive diagnostic and inpatient care at JMH facilities from JMH affiliated physicians. The program will be based in the Cancer Institute and address needs for breast, cervical, lung and gastroenterology services. Diagnostic care provided will be for symptomatic patients rather than screening studies. JMH is contributing the hospital component of care as a community benefit program.</p> <p>Success Story: <i>Raul is a 47-year-old Latino male. He has been coming to the Monument clinic for two years for recurrent stomach irritation and pain and was being treated for Gastrophageal reflux disease (GERD) with persistent symptoms. When his sister developed breast cancer he became extremely anxious, fearing that his symptoms signaled stomach cancer. Raul works full time in a restaurant, has three children and he couldn't afford a upper endoscopy since he had no insurance. Through the Specialty Care Program, Raul received an endoscopy at John Muir Health. The physician was then able to confirm that the cause of the chronic heart burn and pain was GERD with a benign biopsy of gastritis. He is greatly relieved to know he doesn't have stomach cancer and is being treated medically.</i></p>	<ul style="list-style-type: none"> <li>• As of December 2011, 38 specialties have been recruited in addition to hospital-based physician groups.</li> <li>• SCP received 22 referrals of which 12 were accepted.</li> <li>• Out of the 12 accepted referrals, 7 received a consultation, 4 had diagnostic tests, and 1 received surgery.</li> </ul>

### Well Coordinated Care

**Goal 2: The continuum of care for vulnerable populations served is well coordinated and provided in the most cost-effective and appropriate setting**

<p><b>ED Referral Liaison</b></p>	<p>The Emergency Department Referral Liaison interacts with patients in the Emergency Department at John Muir Medical Center, Concord. For patients with a non-urgent diagnosis who have no primary care physician or insurance, the program helps them find appropriate community resources and a medical home for future primary care needs.</p>	<ul style="list-style-type: none"> <li>• In 2011, the ED Referral Liaison identified and contacted 8,130 eligible patients, an 11% increase from 2010</li> <li>• The majority of patients contacted in 2011 by the ED Referral Liaison were self-pay patients (56%)</li> <li>• Out of the 8,130 eligible patients contacted, 11% identified Spanish as their preferred language</li> <li>• In 2011, the ED Referral Liaison issued 13,825 referrals in the</li> </ul>
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		<p>following 4 categories: Insurance Assistance, 211 Resource Guide, Health Services, Community Resources</p> <ul style="list-style-type: none"> <li>• In 2011, the ED Referral Liaison had a referral rate of 81%</li> <li>• Only 1.1% of eligible patients contacted by the ED Referral Liaison had revisited the ED for a non-urgent reason in <u>3 months</u> or less from the time of their last visit, 0.3% in <u>6 months</u> or less from the time of their last visit and 0.2% in <u>12 months</u> or less from the time of their last visit.</li> <li>• In 2011, out of all patients where follow-up was conducted, 62% resulted in a success (an increase of 3% from 2010) and only 14% resulted in no success</li> <li>• Follow-up considered a “success” includes patients that have enrolled in Medi-Cal, made an appointment with a PCP/Clinic or attended a scheduled appointment with a PCP/Clinic. The majority of follow-up that resulted in a success were patients who made an appointment with a PCP/clinic (79%)</li> <li>• Follow-up considered “no success” includes patients that <u>did not</u> enroll Medi-Cal or connect with a PCP/Clinic. The majority of follow-up that resulted in no success were patients who did not connect with a PCP/Clinic (57%)</li> </ul>
<p><b>Geriatric Care Coordination</b></p>	<p>Geriatric Care Coordination (GCC) provides assistance to older adults and family members with concerns regarding health and aging through in-home assessments, phone consultations and family meetings. Information and referrals for JMH and community programs and services are provided to patients, families and caregivers. The program supports independence and health for older adults and provides support and guidance to caregivers. The Geriatric Care Coordinator also assists JMH physicians and other health care professionals as they address aging and health concerns of older adult patients. A care plan addressing the patient’s situation is developed and services coordinated with the primary care physician and other health care professionals.</p> <p><i>Success Story: Mr. H, an 80 year old well respected retired FBI agent, was widowed after 53 years of marriage. He was being tested for Parkinson’s disease and symptoms were increasing at a fast pace. Driving was a cause of concern as well as his ability to take care of himself at home. At night he was calling his daughter in an anxious state and in the morning he would deny this behavior. Also, he was spending most of his time with his daughter because he was lonely and</i></p>	<ul style="list-style-type: none"> <li>• 1337 referrals were made to GCC, which represents a 1 percent increase from 2010.</li> <li>• 70 percent of patients receiving in-home assessments had incomes less than 350 percent of the Federal Poverty Guidelines.</li> <li>• 94 percent of all patients surveyed reported being very satisfied or satisfied with the GCC Program</li> <li>• Physicians report a 99 percent satisfaction rate with the GCC program.</li> <li>• 79 percent of patients reported being able to more effectively manage their activities of daily living.</li> <li>• As a result of the services provided by the GCC, 24 hospitalizations, 6 readmissions and 30 ED visits were avoided.</li> </ul>

	<p><i>often afraid to be alone. Soon his daughter was overwhelmed with the amount of care and oversight required. Family members were divided by those who could see he needed more assistance and those who felt he needed to remain as independent as possible. The geriatric care coordinator worked with the primary care physician and neurologist to clarify Mr. H's diagnosis as Lewy Body dementia and not Parkinson's Disease. Based on this information, the family was able to better understand their dad's health and the level of care he needs now and in the future. After numerous family meetings, with and without Mr. H, he agreed to move to an assisted living facility close to his daughter's home. He is no longer anxious or depressed, has many female friendships that are important to him, and is thriving. His family feels his dignity was maintained. He now has a quality of life the family could not have provided without the understanding of his condition provided by the geriatric care coordinator and other health care professionals.</i></p>	
<p><b>Senior Transportation Program</b></p>	<p>The Senior Transportation Program of Caring Hands utilizes volunteer drivers to serve frail, isolated, and disabled individuals over the age of 60 with transportation services to medical appointments. The goal of the Senior Transportation Program is to provide transportation to medical appointments for frail, isolated, and disabled seniors by utilizing volunteer drivers.</p>	<ul style="list-style-type: none"> <li>• STP served 138 seniors, an 8 percent increase from 2010.</li> <li>• STP provided at total of 976 one-way assisted rides, a 9 percent increase from 2010.</li> <li>• 93 percent of seniors surveyed reported that STP made getting to doctors appointments more convenient to extremely convenient.</li> <li>• 89 percent of seniors surveyed reported that STP made picking up prescriptions more convenient or extremely convenient.</li> <li>• For many seniors STP is their only mode of reliable and safe transportation to and from medical appointments. Having access to health care is vital to their quality of life and health as many participating seniors manage at least one chronic illness and related disabilities.</li> </ul>
<p><b>Monument Community Partnership</b></p>	<p>The Monument Community Partnership (MCP) is a community change organization that promotes the capacity of residents of the Concord Monument Community to achieve their self-defined goals. The MCP is also a broad-based coalition of residents, human service agencies, health service agencies, the school district, city government, and local business owners. It is designed to improve the well-being of people who live in the Monument community, a severely under-resourced neighborhood in the heart of Concord, California.</p> <p>MCP works to involve residents of all ages, ethnicities, and immigration status as equal partners with local public and private organizations in productive, action-based collaboration. Through four primary programs and five focus areas, the MCP strives to improve the quality of life for Monument community residents and local businesses by</p>	<ul style="list-style-type: none"> <li>• The Monument Community Partnership has partnerships with over 47 different agencies to provide services to its five primary program areas.</li> <li>• Service Network: A total of 845 health screenings were conducted and 207 residents with provided with legal and housing assistance.</li> <li>• Resident Network: 1,000 families received new or gently used books to start home libraries and 25 volunteers read to 195 children per week.</li> <li>• Monument First Five Center: 629 families were served through the Monument First Five Center with 1,079 hours of programs.</li> </ul>

	<p>developing leadership and engagement skills and promoting a more effective voice for all stakeholders.</p> <p><u>Primary Programs</u></p> <ul style="list-style-type: none"> <li>• Resident Network</li> <li>• Service Network</li> <li>• Monument First 5 Family Resource Center</li> <li>• Business Alliance</li> </ul> <p><u>Focus Areas</u></p> <ul style="list-style-type: none"> <li>• Community capacity building and leadership development</li> <li>• Economic development</li> <li>• Educational resources, school readiness, and support</li> <li>• Health education, healthcare, and social services</li> <li>• Safe, decent, affordable rental housing and home ownership opportunities</li> </ul>	<ul style="list-style-type: none"> <li>• Business Alliance: MCP hosted and organized a business summit and provides support to local business through workshops and advocacy.</li> <li>• 100 percent of the MCP’s Service Network’s Family Support participants reported they would recommend MCP to others and 96 percent reported that MCP is a source of knowledge of community resources.</li> <li>• Residents provided over 5,456 volunteer hours to MCP’s community outreach events and programs.</li> <li>• The Earn it! Keep it! Save it! Program at MCP completed 51 tax returns, putting \$45,105 of federal funds back into the local community.</li> </ul>
<p><b>Chronic Care for Low Income Frail Elderly</b></p>	<p>The JMPN Transforming Chronic Care (TCC) Programs are comprised of four programs to address the fragmentation of the health system by improving the coordination of care for patients through telephonic support and site visits. The patients eligible for this report fall mainly into the first two programs and occasionally extend to the last two.</p> <ul style="list-style-type: none"> <li>• <u>Care Transitions Interventions (CTI)</u> is a program that supports the patient in the phase of care from the end of hospitalization until they are stable at home, by utilizing nurses and nursing students to reconcile medications help the patient produce a Personal Health Record, and coach the patients about their condition. Patients are evaluated at the end of four weeks and assessed for continuing case management needs.</li> <li>• <u>Tel-Assurance (TA)</u> is a program that helps monitor the status of patients with CHF and COPD between visits. Patients call in daily to an automated service and answer approximately six short questions. Nurses monitor the responses and follow-up with patients who signal a significant change in condition to determine the appropriate course of action (e.g., diet modification, medication adherence or adjustment, or physician intervention).</li> <li>• Patients who need education and support are referred to the <u>Disease Management</u> program and receive patient education materials regarding their specific illness and phone calls from a JMPN Case Manager on a quarterly schedule or as needed to assess the level of self-management skills.</li> <li>• The more severely ill patients are referred to the <u>Complex Case Management</u> program and receive monthly or weekly phone calls from a JMPN Case Manager who provides education, support and coordination of care.</li> </ul> <p><i>Success Story: Mrs. F is a 75 year old widow who has been a participant of the program since May 2008. She is on a fixed income, and has progressively declining lung function. She recently gave up her car due to the need for major repairs which she could not afford. Due to her worsening respiratory condition and lack of transportation she has had greater</i></p>	<ul style="list-style-type: none"> <li>• In 2011, 556 low income seniors with CHF and/or COPD were referred and 100 percent were contacted.</li> <li>• 536 low income patients were engaged in one of the four programs.</li> <li>• According to the Care Transitions Intervention Satisfaction Survey, over 90 percent of patients reported that they “agree” or “strongly agree” that they are more knowledgeable about their condition and are more aware of the questions to ask their physicians.</li> <li>• In 2011, the programs were able to demonstrate that they reduced inpatient readmissions from 7.7 percent to 6.7 percent for participating patients.</li> <li>• The 2011 readmission rate for CHF patients in Tel-Assurance decreased from 2010 (12.2 percent to 11.1 percent) and was less than control group rate of 19.2 percent.</li> <li>• The 2011 readmission rate for COPD increased to 6.01 percent but was significantly lower than the control group rate of 27.3 percent</li> </ul>

*difficulty grocery shopping and getting to appointments. Her limited mobility has also caused her to experience feelings of isolation. Through the program's case management services Mrs. F was connected to Senior Services. She is now seen weekly by a Friendly Visitor and has rides to physician appointments and the grocery store thanks to her new companion, a Caring Hands volunteer. Mrs. F's physical health is also in order. The tele-monitoring she receives detects any slight changes in her status and has resulted in prevented lung infections and hospitalizations. With the assistance of her case manager, she has completed her end of life planning and is regularly screened for depression. Mrs. F has stated about the program, "you have saved my life on more than one occasion."*

**Monument Community Senior Services Outreach Program**

The Monument Community Senior Services Outreach Program (MCSSO) provides outreach, case management and advocacy to promote safety, health and social wellbeing among seniors living in the Monument Corridor or attend the activities for seniors in the Monument Corridor neighborhood. Activities include outreach efforts, individual case management and organizing seniors to become involved in their community.

*Success Story: Mr. Jose Luna first learned about the Monument Corridor Senior Services Outreach (MCSSO) program by referral. Mr. Luna is 62 years old, slim and short, dark complexioned, and very sociable. At first Mr. Luna was quiet when attending the luncheons and other socialization activities, but he became more expressive after he gained confidence and became better acquainted with the other seniors. During 2011, Mr. Luna participated in several different community activities. He carried the flag from his country of origin, El Salvador, at the First Five Center Hispanic Heritage Celebration in September. Mr. Luna attended six nutrition classes at the First 5 Center and he also went to the Kaiser Permanente Thrive event for a free eye exam and new glasses. The Concord Senior Center adopted Mr. Luna for Christmas and helped him apply for food stamps. On three different occasions, Mr. Luna and a friend he made at MCSSO surprised us with their unexpected, yet much appreciated, janitorial and landscaping work at Queen of All Saint's church, Monument Community Partnership, and the First 5 Center. Mr. Luna has clearly enjoyed participating in the program and it has helped him make new friends and locate beneficial community resources. Even though he continues to struggle financially, through the case management and advocacy services provided by MCSSO, he is in a better position. New opportunities for work and sharing have developed through the friends and social network he has developed at MCSSO, and the case management services have also helped him find much needed community resources.*

- In 2011, a total of 658 older adults were referred to the MCSSO.
- In 2011, 65 older adults were provided with individual case management services, exceeding the objective by 30 percent.
- In 2011, 55 presentations were conducted within the community and a total of 607 older adults attended the presentations.
- A total of 448 referrals were made to community resources, the majority of which were to health resources.
- Out of the 37 older adults who completed case management services (closed cases), 73 percent achieved 1 or more goals identified in their success plan.
- In 2011, 33 older adults were involved in neighborhood civic or community projects.
- When asked in the post-test to describe their awareness of community resources, 43 percent of older adults reported that they are well aware or aware of community resources and can find most services, compared to 7 percent in the pre-test.
- According to the pre-test/post-test comparison, fewer report immediate health care needs, fewer reported having difficulty managing activities of daily living, more reported having affordable health insurance, and more reported being hopeful about the future.

**Cost Effective Setting**

Goal 2: The continuum of care for vulnerable populations served is well coordinated and provided in the most cost-effective and appropriate setting.

**Respite Care Shelter for Homeless Patients**

The Respite Care Shelter for Homeless Patients is a 24-bed respite program, the only one of its kind in Contra Costa County. The Respite Center is located next door to the County Homeless Shelter in Concord. It was developed in cooperation with local hospitals, the

- 95 patients were referred to the respite center.
- JMH avoided about \$344,000 in inpatient costs

	<p>Contra Costa County Health Services Homeless Program and the Healthcare for the Homeless program. The program provides recuperative care to medically fragile homeless adult individuals who are discharging from hospitals and have no permanent residence nor can return to the streets. The Respite Center also has on-site Mental Health and Substance Abuse Counselors that assist in resources for treatment and care. There is also a full time Case Manager who assists with many types of Social needs, including, obtaining CA-ID, applying for SSI, SSDI, Government Assistance, Food Stamps, Veteran Services, and formulating a housing plan.</p> <p>Success Story:  <i>Daniel, 46, arrived at the Respite Center from JMCC during his recovery from a fall from a second story building where he broke his legs severely. Daniel was using a walker to get around and had rods connected to his legs. Respite Center provided Daniel with a connection to Basic Adult Care services at Contra Costa Regional Medical Center, referrals to Mental Health Care because of his diagnosed Attention Deficit Disorder, a referral to and transportation provided for primary care physician, physical therapy, mental health appointments, and obtaining his medications. The Respite Center also assisted Daniel in accessing resources such as Social Security, an identification card, and housing. He was also seen by Respite Care on-site providers for urgent care needs. When Daniel left the Respite Center he had regained his mobility and was managing all his medical and mental health follow ups.</i></p> <p><i>James is 58 years old and homeless in Concord. He was admitted from JMCC to the Respite Center after having undergone surgery, chemotherapy, and radiation treatment for his stage four tongue cancer. When James came to the Respite Center, he was using a walker, was on multiple medications, and had a feeding tube and open throat wound. Despite these issues he was independent with all his care and hoping for a full recovery. His family was not involved and he only had one friend in Vallejo.</i></p> <p><i>The Respite Center provided James with the necessities to return to good health. They assisted with symptom and medication management. They connected him to Basic Adult Care services at CCRMC and coordinated the transfer of his medical care to Contra Costa County. They continued to serve James by referring him to Mental Health Care, facilitating appointments with the oncologist, primary care physician, speech therapy, lab and imaging-all with transportation provided by the Respite van and driver. James was also followed by the Respite Clinic providers weekly for his multiple symptom complaints, ranging for nausea to feeding tube complications. He was eventually sent to a local hospital where he received a Palliative Care consultation and decided he wanted hospice care. James was transferred to a skilled nursing facility where he eventually died with the support of hospice.</i></p>	<p>in 2011 for patients admitted to the Respite Center, at an average direct cost of about \$2,000 per day,</p>
<p><b>Cardiac Outpatient Education Program (COPE)</b></p>	<p>COPE began in June 2010 and is a home-based secondary preventative approach to conventional Cardiac Rehabilitation. Cardiac Rehabilitation staff establishes a therapeutic alliance with the patient through collaborative goal setting and assistance with risk factor modification. Patients exercise on their own with coaches providing information, motivation, and feedback. Research shows this approach addresses some of the barriers of traditional cardiac rehabilitation such as transportation, conflicting work schedules, and perceived lack of privacy.</p>	<ul style="list-style-type: none"> <li>• Since the COPE program began at the end of June 2010, 52 patients have been referred to the program and 28 signed up.</li> <li>• 88 percent of patients referred in 2011 were underinsured.</li> <li>• As of December 2011, 82 percent of the patients who</li> </ul>

		signed up are still engaged in the program.
<b>Putnam Clubhouse</b>	<p>Incorporated in April 2007, The Contra Costa Clubhouses, Inc. opened Putnam Clubhouse in 2008 in Concord to fill critical gaps in Contra Costa County’s continuum of care for adults recovering from severe mental illness through provision of an evidence-based, cost-effective, peer support, and vocational rehabilitation intervention. Few options exist beyond emergency services or hospital treatment, increasing vulnerability to homelessness, unemployment, and incarceration. The Clubhouse intervention, based upon the 36 International Standards promulgated by the International Center for Clubhouse Development (ICCD), originated in New York in 1948 and has since been replicated at more than 300 sites in some 29 countries. In 2011, the ICCD Clubhouse Model was added to the United States Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence Based Practices and Programs. Documented research on ICCD clubhouse programs indicates both participants (called members) and their communities benefit from higher employment rates, a decrease in hospitalization, reduced incarceration, improved well-being, and reduced cost of services in comparison to other programs. Also during 2011, following a rigorous multi-year review process, ICCD certified Putnam Clubhouse for a three year period as a credentialed ICCD program. Certification involved a comprehensive evaluation in terms of fidelity to the 36 International standards of the ICCD Clubhouse Model. Putnam Clubhouse is the first program in Northern California to achieve ICCD accreditation.</p> <p>Success Story: Putnam Clubhouse Member Ronald, a 44-year-old white male with a dual diagnosis that includes schizophrenia, tells his own story:</p> <p><i>“I was homeless when I first started attending the program and the Clubhouse assisted me with finding housing. Ever since, I’ve lived independently in an apartment. When I joined the Clubhouse, I’d been unemployed for about a dozen years and spent most of my time on the street panhandling. The Clubhouse helped me find a job and I’m proud to say I’ve been working for almost a year as a carpet cleaner. The Clubhouse is where I go to rebuild a meaningful and productive life while recovering from mental illness. From homeless to living in an apartment and from unemployed to having a job, the Clubhouse has supported me every step of the way. Recovery at the Clubhouse comes from being involved in productive work and from building positive relationships at the Clubhouse. I learned to cook while making meals with the other members to serve to members each day at the Clubhouse. And guess what? I discovered that I really like cooking. So when the Clubhouse multimedia lab started a cooking show, they asked me to be the chef. Our show is called Chef’s Corner. Each segment, produced by members and staff together, focuses on preparing a recipe that’s affordable, healthy, and doesn’t require a fancy kitchen. If you would like to see me in action, please link to our cooking shows at <a href="http://putnamclubhouse.org/chefs-corner-cooking-show">http://putnamclubhouse.org/chefs-corner-cooking-show</a>.”</i></p>	<ul style="list-style-type: none"> <li>• The Clubhouse achieved an average daily attendance of 30 members.</li> <li>• In 2011, there were a total of 240 members who participated in program activities during the year.</li> <li>• Members spent a total of 44,320 hours participating in Clubhouse activities during 2011, more than 25 percent greater than the goal set for the year.</li> <li>• During 2011, the percentage of Latino members increased by 63 percent, African American members increased by 56 percent, women members increased by more than 10 percent.</li> <li>• Member Satisfaction surveys found that 100 percent of members agreed or strongly agreed that they were satisfied with the Clubhouse activities they attended during the past year. Additionally, 90 percent of members agreed or strongly agreed that their independence increased during the year and 90 percent of respondents reported that their mental and emotional well being had increased as well as their contact with peers</li> <li>• During 2011, 29 members gained jobs in unsubsidized employment at an average wage of \$16 per hour. Additionally, 35 members returned to school, including ten who completed a 3 semester SPIRIT Certificate Program for peer providers.</li> </ul>
<b>Caring Hands Volunteer Caregivers</b>	<p>Our life-enhancing services include: transportation and escort to medical appointments and other needed services, assistance with shopping and errands, friendly phone calling (in conjunction with any other service), friendly visiting and companionship, respite care (or rest for the family caregiver), reading mail and letter writing, light household tasks and light meal preparation, minor home repairs and yard work. All services are generally provided 1 – 3 hours per week to meet a long term need and are based on the availability of volunteers.</p>	<ul style="list-style-type: none"> <li>• In 2011, 195 active Caring Hands volunteers provided services to 231 seniors.</li> <li>• Six percent of the seniors were Hispanic and served through the Hispanic Outreach component of Caring Hands.</li> </ul>

	<p>Success Story: <i>Jack, was in the first volunteer training class for Caring Hands in 1999. Jack and Ms. Day have been matched since 2004. Ms. Day is 98 and still lives alone. Jack sees Ms. Day at least once a week. Jack provides transportation to her appointments, to shopping and general errands. Ms. Days says that the best part of their match is the time they spend together. She told two stories of practical jokes they have played on each other and how much they laugh. Ms. Day lives alone and thanks Jack for being able to do that.</i></p>	<ul style="list-style-type: none"> <li>• 73 percent of seniors surveyed perceive their quality of life as “good” and “excellent” after participating in Caring Hands.</li> </ul>
<p><b>New Directions Program</b></p>	<p>New Directions is an innovative hospital and community case management program modeled after a ten-year-old program the Hospital Council of Northern and Central California operates in Santa Clara County. The New Directions model of care is an intensive hospital and community case management intervention that targets our frequent users in the emergency departments on both campuses. These individuals face barriers in accessing medical care, housing, mental health care, and substance abuse treatment, which contribute to their frequent emergency department visits.</p> <p>Starting July 2011, JMH employed two Social Worker Case Managers on the Concord Campus that manage a total of 30 of our most frequent ED users. The Social Worker Case Manager is responsible for assisting the identified patients with the following:</p> <ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Access to transportation</li> <li>• Assessment of safety and health issues at home</li> <li>• Access to financial assistance and health insurance</li> <li>• Assistance in accessing employment and training services</li> <li>• Assistance in finding and adjusting to permanent housing</li> <li>• Determination of the appropriate level of care for those who are unsafe at home alone</li> </ul> <p>Success Story:  <i>Cynthia, 21, has faced a lot in her life. She was exposed to methamphetamine in utero. She was also the victim of severe physical and sexual abuse growing up, witnessing a 12 year-old friend’s suicide. She now has 1 daughter and lives between family and friends homes.</i></p> <p><i>Cynthia has suffered from many chronic conditions including kidney infections, back pain, and recurring urinary tract infections. She also suffers from Post Traumatic Stress Disorder (PTSD) as a consequence of her childhood trauma. As a result of her multiple conditions, she visited JMH Emergency Department twelve times within one year.</i></p> <p><i>Cynthia was enrolled in New Directions to receive intensive case management interventions. Case Manager Susan provided Cynthia with help in accessing resources that stabilized and enhanced her health and overall well-being.</i></p> <p><i>Susan provided Cynthia with emotional support and the necessary documentation (medical records, school records, psych evaluation) for her Social Security Insurance (SSI) hearing in which she successfully obtained SSI benefits. Susan also ensured Cynthia had access to health care by assisting with Medi-Cal renewal and the Cal-Works process. She also connected Cynthia with a primary care physician, mental health therapist, and urologist. Susan works with Cynthia to ensure she makes it to appointments and understands the advice given by her</i></p>	<ul style="list-style-type: none"> <li>• In 2011, 14 patients enrolled in New Directions.</li> <li>• 100 percent have been assisted in accessing primary care, either a new Primary Care Physician or reconnecting with an existing medical home.</li> <li>• Reliable transportation has been made available for 100 percent of the patients.</li> <li>• New Directions successfully decreased inpatient days from 161 prior to enrollment to 28 after receiving services.</li> <li>• New Directions successfully decreased total ED visits for the 14 patients from 320 prior to enrollment to 67 after receiving services.</li> <li>• The negative contribution margin has gone down from \$-299,775 in the prior year to \$-119,530 after six months, which is a savings of about \$180,000.</li> </ul>

	<p><i>doctors.</i></p> <p><i>As a direct consequence of New Direction's case management services, Cynthia expresses feeling more empowered. She continually is in contact with Susan for questions and guidance. Susan continues to advise Cynthia on complex issues such as parenting and relationships.</i></p>	
<p><b>Patient Navigator</b></p>	<p>The Patient Navigator Program assists physicians and patients by providing individualized health resource information and assistance coordinating services. Patients age 65 and older receive a Senior Health Questionnaire, a validated tool to predict a person's likelihood of experiencing adverse health consequences including hospital admission within the next four years. The results are tabulated, compared with national benchmarks and formatted into a Senior Health Profile for each patient. The Patient Navigator reviews the health profiles with the physician and staff, identifying patients who would benefit from health education materials, community resources, and additional supportive services. The overall goal of the risk assessment is to maintain patients at the highest level of functioning while minimizing unnecessary hospital admissions, readmissions and emergency department visits.</p> <p>The Patient Navigator Program also provides in-depth assistance to patients, families and caregivers who call the Senior Services department. The Patient Navigator serves as a link to obtain and coordinate information regarding John Muir Health services and community resources.</p> <p>Success Story:  <u>Mr. Stevens:</u> <i>Because of extreme back pain Mr. Stevens was sleeping in a recliner and his wife was sleeping on the nearby sofa in case he needed something during the night. After seeing Senior Services at johnmuirhealth.com, their daughter called requesting help obtaining a hospital bed for her father. The patient navigator contacted the primary care physician and medical equipment company. The order was approved and a bed delivered within 36 hours from receiving the original request, allowing Mr. Stevens the additional support and Mrs. S was able to return to her bed. The next day Mrs. Stevens reported it was the first night in a long time that they both had a good night's sleep.</i></p> <p><u>Ms. Andalućía:</u> <i>Ms. Andalućía is an 88 year old who has received cancer treatment for several years. Her only family member, a son, lives in Europe. She has a good relationship with her primary care physician and oncologist who provided care in the hospital and skilled nursing facilities (SNF). Following a series of falls, Ms. Andalućía was hospitalized and then went to a SNF for physical therapy. Upon discharge home she received a bill from the SNF because her hospitalization was not long enough to qualify for Medicare payment. Ms. Andalućía called the patient navigator for assistance with setting up a payment plan based on the ability to pay \$25 per month. Despite the advance of her cancer she continues to manage her own money and received a grant from the Cancer Care Copayment Assistance for copayments related to the cancer treatment and the Episcopal Senior Communities to pay towards her oncologist bill. Ms. Andalućía is adamant about paying as much of her debt to providers as possible before she dies. The patient navigator assists in facilitating and tracking the payments of grant funds to various providers. Ms. Andalućía is able to remain at home with hospice care, enjoys frequent visitors and calls frequently to provide updates on her condition and inquire about the status of the grants.</i></p>	<ul style="list-style-type: none"> <li>• In 2011, information was provided to 1052 seniors by either mail or phone to patient, family or caregiver. A total of 2294 resources were provided to these seniors.</li> <li>• In 2012 the Patient Navigator program had 2198 patient interactions.</li> <li>• In 2011, 98 percent of the cases referred were resolved, which was an increase from 95 percent in 2010.</li> <li>• In 2011, physicians reported high levels of satisfaction with the services their patients received by the Patient Navigator Program and 100 percent of physicians reported that they would recommend the Patient Navigator Program to other physicians.</li> <li>• In 2011, 60 percent of patients reported that their health habits changed or improved based on the information they received and 96 percent of respondents reported that they would call again.</li> <li>• In 2011, 63 percent of respondents reported that their stress level related to medical bills has improved as a result of the Patient Navigator Program.</li> <li>• In 2011, 60 percent of respondents reported that their confidence in handling their issue is better as a result of the Patient Navigator Program</li> </ul>

<p><b>Community Health Fund</b></p>	<p>The John Muir/Mt. Diablo Community Health Fund performs one of John Muir Health's most important community benefit functions: Distributing grants to community-based, nonprofit organizations whose health care capabilities and trusted relationships with uninsured and under-served populations expand and enhance health care services for those who need them most in central and east Contra Costa County.</p> <p>The Community Health Fund' distributes that money through a unique process that nurtures long-term partnerships with and among community-based nonprofits, and which results in sustainable health initiatives and systemic change.</p> <p>Many programs that receive their start from us continue long past the grant periods and to this day deliver critical health care services. Consequently, many thousands of Contra Costa residents who might have slipped through the cracks in our health care system have ongoing access to high quality, culturally sensitive primary care, specialty care, dental care, and healthy aging support services for conditions that range from cancer and chronic disease through dental caries and mental illness.</p> <p>It is our mission to deliver the same kinds of results to the many in Central and East Contra Costa who still struggle to find adequate care. More detailed information about the Fund, its governance, grant program and community benefit reports can found on its website: <a href="http://www.jmmdcommunityhealthfund.com">www.jmmdcommunityhealthfund.com</a>.</p>	<ul style="list-style-type: none"> <li>• For complete details of Community Health Fund partners, funding and activities, please visit: <a href="http://www.jmmdcommunityhealthfund.com">www.jmmdcommunityhealthfund.com</a></li> </ul>
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## 2012 Community Benefit Plan/Implementation Strategy

The 2012 Community Benefit Plan, which includes only programs for vulnerable populations, is included as Attachment G. It outlines our objectives for 2012.

### Economic Valuation of Community Benefits

#### Community Benefit—What Does It Mean?

*Community benefit* is a term used to describe the many health programs and medical services supported totally or in part by John Muir Health that provide tangible benefits to the community and improve the health of its residents. In 2011, John Muir Health contributed more than \$58.9 million in community benefits. These benefits cover the entire spectrum of health care including high-tech procedures, trauma services, primary care, educational classes, health screening and support groups. They are services to the community for which we receive little or no payment.

The economic valuation of community benefit contributions includes community benefit activities provided by all John Muir Health entities: the Behavioral Health Center, the Community Health Alliance, the Community Health Fund, John Muir Medical Center-Concord and Walnut Creek and the John Muir Physician Network. Contributions are shown for Fiscal Year 2011 in total and then detailed by nine program categories. These categories the same as those reported in the IRS Form 990, Schedule H for Hospitals.

During Fiscal Year 2011, John Muir Health contributed over \$58.9 million in community benefits. These contributions include:

Purpose	Description	In Thousands
Charity Care	The largest proportion of our community benefit services are devoted to the most vulnerable individuals of our community. This means we provide health care through John Muir Medical Center – Concord and Walnut Creek and the John Muir Behavioral Health Center for people regardless of their ability to pay. This includes the critical emergency and trauma services at our medical center campuses. Charity care is a community benefit, providing health care services for those that have no insurance and are otherwise unable to pay. <i>Amounts listed here are costs not charges.</i> We believe that a portion of our bad debts would be classified as charity care if we had more complete information from our patients regarding their economic status. Bad debts are not included here.	20,231
Government Sponsored Health Care (Medi-Cal shortfall)	We provide care for patients who participate in government-sponsored programs such as Medi-Cal. The payment we receive from these programs rarely covers the full cost of services provided to these patients. As a community benefit, John Muir Health absorbs the difference between <i>the cost (not charges)</i> and the payment. In addition Medicare does not cover all the health care costs for patients over 65 years old. The Medicare costs are <b>not</b> included here.	19,922
Subsidized Health Services	These services are underwritten by John Muir Health. In some cases services are provided by John Muir Health even at a loss because the service is only available to the community at John Muir Health. We consider these losses a community benefit. Subsidized services include the Emergency Medical Services ambulance base station for the county at the Walnut Creek campus.	1,116
Health Improvement	John Muir Health also supports a wide range of activities and resources that promote health and wellness, including health education, libraries, health fairs, screening and support groups. The John Muir Community Health Alliance brings to the community an array of resources from John Muir Health, including health care professionals, mobile health services, information and education services. The John Muir Community Health Alliance also works in partnership with local	8,551

	communities, other nonprofit health systems, public health providers, nonprofit organizations and school districts to identify and address unmet health needs among uninsured and underserved populations.	
Community Building	This includes workforce development activities and community collaborative development. It includes John Muir Health support for the Monument Community Partnership.	636
Financial and In-Kind Contributions, Grants	The John Muir/Mt. Diablo Community Health Fund is a unique grant program that provides funds for health projects and initiatives conducted by community-based organizations. With an annual contribution of over \$1 million from John Muir Health, and through partnerships with other grant making foundations, the Community Health Fund focuses on ways to achieve fundamental improvements in the health status of uninsured, underserved and overlooked families, children and seniors. Also included in this area are grants to fund instructors for nursing and other health careers, donations to community based-organizations focusing on diseases such as heart, cancer, stroke and diabetes and in-kind donations of supplies, facilities and staff time.	2,886
Health Professions Education	Community benefits also include health professions education programs in the areas of nursing, physical therapy, ultrasound technology, radiologic technology, rehabilitation and clinical pastoral care.	3,408
Research	Clinical research funded by government agency or tax exempt organizations where findings are available to the public.	818
Community Benefits Operations	In order to coordinate our community benefit planning and execution of programs to maximize their impact, we also support a small dedicated staff and their office operations.	1,391
<b>Total</b>		<b>58,959</b>

In addition, John Muir Health provided care to Medicare inpatients and outpatients whose estimated costs exceeded payments made by the Medicare Program. The Medicare shortfall, the difference between the cost of care for Medicare beneficiaries and the payments for those services, was over \$174 million. This is not included in the above total.

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

<b>In Thousands of Dollars</b>	
Charity Care	20,231
Medi-Cal Shortfall	19,922
Vulnerable Populations	9,293
Broader Population	5,287
Health Professions Education and Research	4,226
<b>Total Benefits Reported</b>	<b>58,959</b>

Community benefit contributions include programs at John Muir Medical Center – Walnut Creek, John Muir Medical Center – Concord, John Muir Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network. A separate 2011 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Behavioral Health Center.

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*Attachment A – John Muir Health Community Health Guiding Principles*

# John Muir Health Community Health Guiding Principles

## Introduction

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

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

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

## Context

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

### Mission:

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

### Strategic Vision:

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

### Related Strategic Guiding Principle:

Build alliances that create healthier communities.

### Related Core Value:

Access to Care

## John Muir Health Healthy Community Vision

The following vision statement represents a general framework for John Muir Health activities and includes concepts from the World Health Organization, the National Conference of Cities and the Bay Area Partnership. John Muir Health's vision for all residents of Central and Eastern Contra Costa County is that:

- *All residents achieve and maintain optimal physical and mental health.*
- *Children succeed in school and reach their full potential.*
- *Residents are economically independent and have access to adequate, affordable housing.*

- *Neighborhoods are safe.*
- *Violence, discrimination and injustice are eliminated.*
- *The air and water are clean.*
- *Residents are politically, socially and culturally active.*

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

### **Philosophy**

It is the philosophy of John Muir Health to:

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

### **Program Funding Guidelines**

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

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

External data services used include:

- Healthy People 2010  
The Healthy People 2010 goals are national targets that are updated each decade. Based on scientific data and analysis, the 467 objectives in 28 focus areas in Healthy People 2010 represent a comprehensive, nationwide health promotion and disease prevention agenda. Further, Healthy People 2010 goals are designed to serve as a roadmap and provide health improvement opportunities for the next decade.
- Triennial Community Assessment  
An assessment is done every three years in conjunction with other non-profit hospitals in Contra Costa County and the County Public Health Department. The report tracks disparities in health outcomes in various areas of the County.

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

John Muir Health Community Benefit Funding Guidelines include:

2. Program addresses needs of a **vulnerable population** defined as a population with one or more of the following characteristics:

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

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

### Evaluation

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

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

1. *Charity Care*: Charity Care is the cost of free or discounted health services provided to persons who cannot afford to pay and who meet John Muir Health's criteria for financial assistance.
2. *Government Sponsored Health Care*: Government Sponsored Health Care community benefits include unpaid costs of public programs; the cost shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries.
3. *Subsidized Health Services*: Subsidized Health services are clinical services that are provided despite a financial loss and the financial losses are so significant that negative margins remain after removing the effects of charity care and Medi-Cal shortfalls.
4. *Community Health Improvement Services*: Community Health Improvement Services are activities carried out to improve community health and subsidized by John Muir Health.
5. *Community Building Activities*: Community building activities include programs that, while not directly related to health care, provide opportunities to address the root causes of health problems. These activities support community assets by offering the expertise and resources of John Muir Health.
6. *Financial and In-Kind Donations*: This category includes any in-kind services donated to individuals of the community at large.

7. *Health Professions' Education*: This category includes costs associated with preparing persons for future health care professions.
8. *Research*: Research includes clinical and community health research, as well as studies on health care delivery that are shared with others outside the organization.
9. *Community Benefit Operations*: Community Benefit Operations include costs associated with staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategies and operations.

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

### **Conclusion**

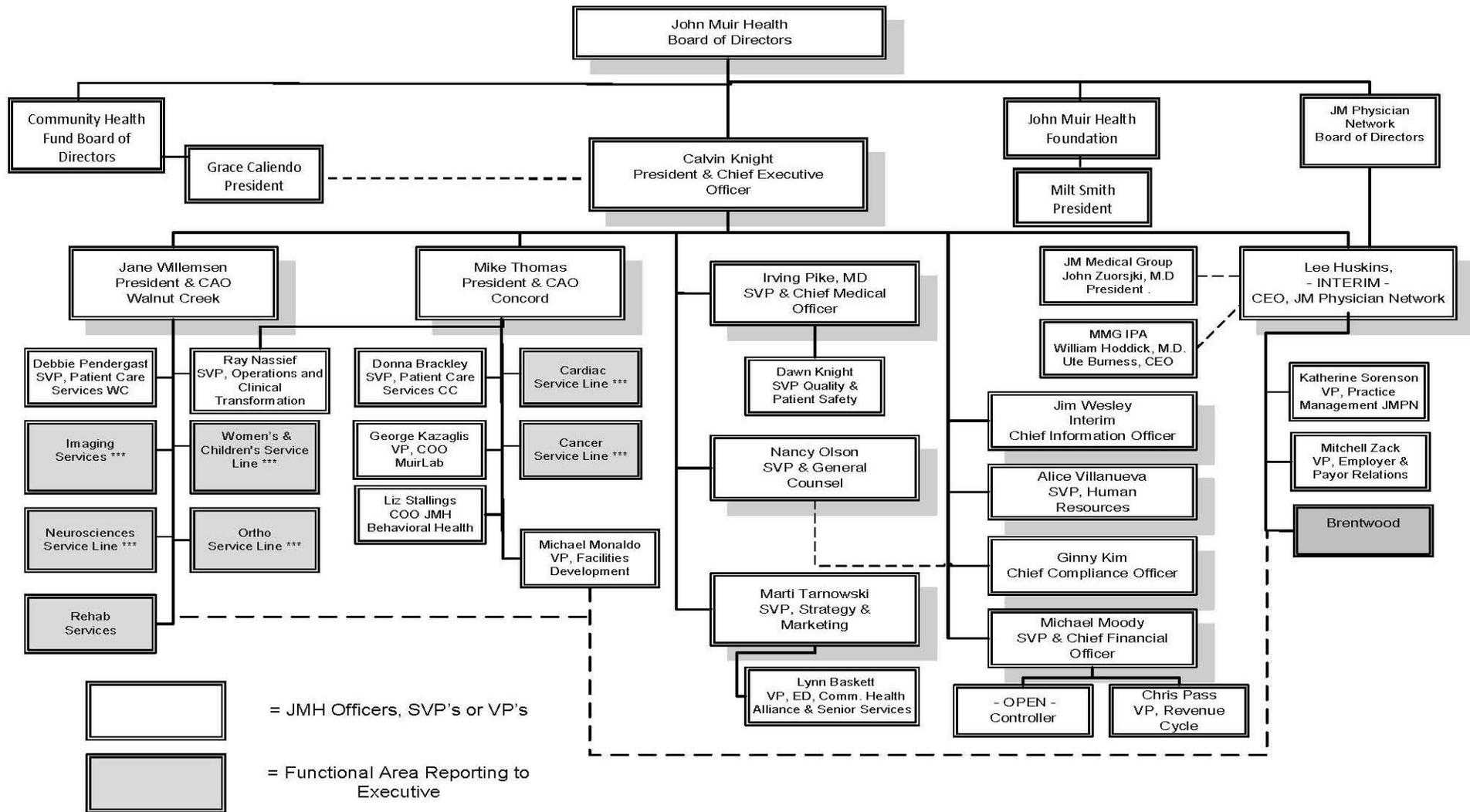
In order to fulfill its commitment to improving the health of the communities it serves, John Muir Health utilizes the expertise of its hospitals, Community Health Alliance, Community Health Fund and Physician Network. The hospitals and Physician Network focus on programs that utilize the clinical expertise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

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

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

*Attachment B – John Muir Health Organizational Chart*

# John Muir Health



*Attachment C – Board Lists*

# **John Muir Health 2012 Board of Directors**

Catherine O. Kutsuris, *Chair*

David L. Goldsmith, *Vice Chair*

Phillip J. Batchelor, *Treasurer*

Thomas G. Rundall, Ph.D., *Secretary*

William F. (Rick) Cronk, *Assistant Secretary*

Nancy Olson, *Assistant Secretary*

F. Ryan Anderson, M.D.

Linda Best

Patricia E. Curtin

Robert E. Edmondson

Marilyn M. Gardner

William K. Hoddick, M.D.

Deborah L. Kerlin, M.D.

Calvin Knight

Hartwell N. Lin, M.D.

Ronald K. Mullin

Stuart B. Shikora, M.D.

Thomas Tighe, M.D.

San S. Yuan, M.D.

John D. Zuorski, M.D.

# John Muir Physician Network 2012 Board of Directors

## **DIRECTORS**

Ron Banducci (*Chair*)

Arlene Sargent (*Secretary*)

Nancy Moschel (*Treasurer*)

Kenneth Bowers, MD

William Dow, PhD

William Hoddick, MD

Ravi Hundal, MD

Lee Huskins

Calvin Knight

Kathleen Odne

Michael Robinson

John Zuorski, MD

## **NON-VOTING REPRESENTATIVES**

Edward Becker, MD

Richard Kamrath, MD

Michael Kern, MD

# John Muir/Mt. Diablo Community Health Fund 2012 Board of Directors

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

## **OFFICERS:**

Linda Best, *Chair*

Gladys Grassini, R.N., *Vice Chair*

Tom Noble, *Secretary*

Arthur D. Shingleton, *Treasurer*

## **DIRECTORS:**

Nick Adler, R.N.

Grace Ellis

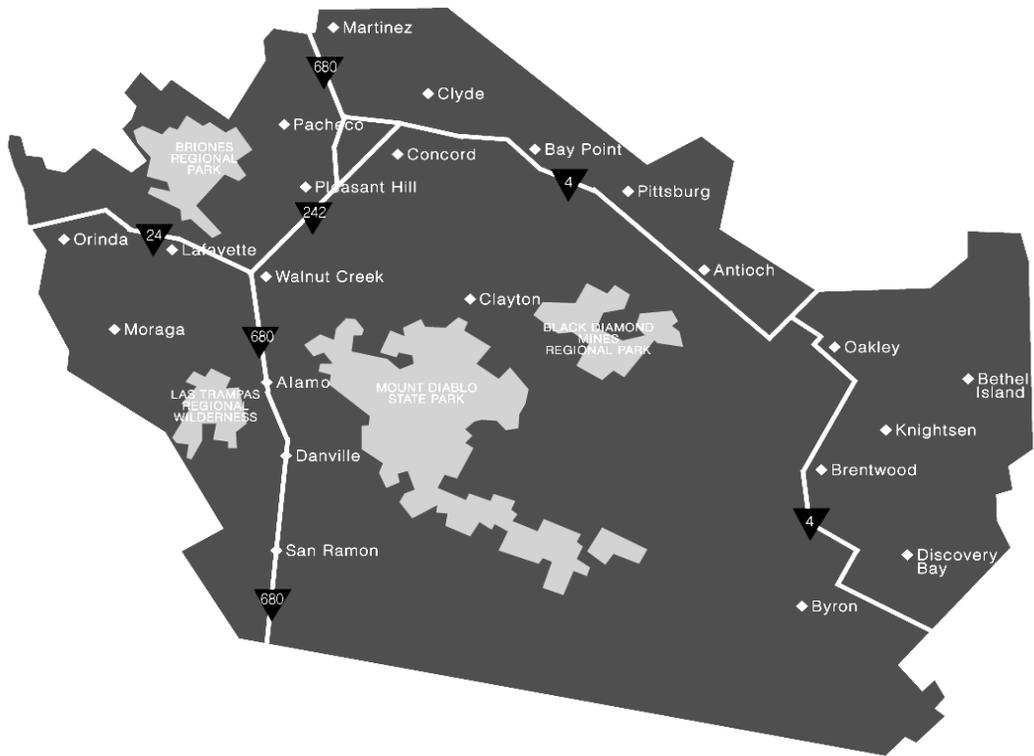
Jeffrey S. Kasper

Roy Larkin

Frank Manske

Bob Schroder

*Attachment D – Map of Service Area*



*Attachment E – John Muir Health 2011 Community Benefit Plan - Year End Results*

**John Muir Health  
2011 Community Benefit Plan – Year End Report**

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

**Access to Disease Prevention**

**Goal 1:** Uninsured, underserved and vulnerable populations in the service area have access to the full range of disease prevention and health care services.

**Strategy 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 year s 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 10 Baseline for Cervical Cancer Screening: Dedicated to program planning

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Cervical cancer screening will be provided to patients ages 25 and older</li> <li>2. The number of patients served by both programs will increase from 189 to 400</li> <li>3. African American women served will increase by 10%</li> <li>4. Within 18 months of screening date, 80% of patients will be rescreened</li> <li>5. 90% of breast cancer patients will be provided with “one stop” services</li> <li>6. As a result of screenings and outreach efforts, women will be diagnosed with cancer at earlier stages</li> </ol>	<ul style="list-style-type: none"> <li>• 19 Cervical Cancer Screening Clinics and 16 Breast Cancer Clinics were provided</li> <li>• 525 patients were seen through the 35 Every Woman Counts clinics</li> <li>• 37 African American women were screened in 2011 compared to 6 in 2010; an increase of 83%</li> <li>• 69 % of patients were screened within 18 months of their last screening. The decrease in percentage was due to the age restriction placed by the State of California which excluded women ages 40-49 in the year 2010</li> <li>• 99% of patients were provided with “one stop” breast services</li> <li>• 16 women served were diagnosed with breast cancer and provided with the appropriate follow-up and treatment necessary to monitor their diagnosis. As of December 2011, no women were diagnosed with cervical cancer</li> </ul>

**Strategy 2: Support faith communities' health ministry's through the Faith and Health Partnership (FHP) Program**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Faith communities participating in the FHP will increase by 20% (16 to 22)</li> <li>2. The number of Health Ministry Programs that regularly report program data will increase from 6 to 20</li> <li>3. 100% of abnormal screening results identified at health ministry events will be referred for appropriate follow-up</li> <li>4. 90% of those referrals with abnormal results will report follow through on their referral of the individuals reporting to health ministry liaisons</li> <li>5. 75% of 9 MOU signed churches will implement a change program</li> <li>6. 25% of 11 unsigned MOU churches will implement a change program</li> </ol>	<ul style="list-style-type: none"> <li>• The Faith and Health Partnership program collaborated with 31 faith communities in 2011. Participating faith-based organizations vary in membership, with congregation sizes range from 50-5,000 members</li> <li>• 16 faith communities report data regularly</li> <li>• Out of 361 screenings 110 abnormal results were identified. 100% of abnormal screenings identified were referred for follow-up care appropriately</li> <li>• Health ministry liaisons report 100% of the 110 referred for abnormal screening results reported following up as recommended</li> <li>• 100% (9) churches with MOUs implemented a change project</li> <li>• 27% (6) churches without MOUs implemented a change project</li> </ul>

**Strategy 3: The Teen Pregnancy Resource Program will provide childbirth preparation for pregnant teens**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Maintain relationships with current participating sites (participating sites=11)</li> <li>2. Maintain the number of teen participants (teen participants=36)</li> <li>3. Comprehensive prenatal and parenting educational classes will be offered to participating teens</li> <li>4. Teen participants will report high levels of satisfaction with the services offered by the program</li> </ol>	<ul style="list-style-type: none"> <li>• 18 community organizations and physician offices were identified as participating sites; an increase from the previous year</li> <li>• Through the course of networking with community resources and establishing participant sites, 100% of the teens referred (29) participated in the program</li> <li>• Of the 29 teen participants, 83% enrolled in one of the following classes: Online Childbirth or Childbirth Personal Class, Infant Breastfeeding, Newborn Care, Car Seat and Safety Checks, Infant and Child CPR, and Finance 101</li> <li>• Each teen was asked to evaluate the resources they received to determine that the class offered were valuable and to identify favorite and least favorite classes. Based on the results, the 100% of the teens found the Teen Pregnancy Program to be very valuable</li> </ul>

- 5. 80% of participating teens will deliver at full term without complications
- 6. 80% of participating teens will still be breastfeeding 3 weeks after delivery

- Of the 29 teen participants, 11 teens have delivered and 8 are still pregnant with due dates in 2012
- Follow-up was conducted with all 11 teen moms after delivery and the following outcomes were reported:
  - 100 % delivered at full term without complications
  - 91% breastfeeding after 1 week

**Strategy 4: Provide a Community Nurse in low-income schools in the Monument area of Concord and Pittsburg**

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

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

2011 Objectives	Outcomes
1. The Community Nurse Program will hire a Community Nurse to provide services in the Pittsburg Unified School District by May 2010.	<ul style="list-style-type: none"> <li>• In March 2010, a Community Nurse began providing services to the Pittsburg Unified School District. The Community Nurse Program began working with four elementary schools during the 2010-2011 school year:               <ul style="list-style-type: none"> <li>• Willow Cove Elementary School</li> <li>• Highlands Elementary School</li> <li>• Los Medanos Elementary School</li> <li>• Foothill Elementary School</li> </ul> </li> </ul>
2. The Community Nurse will track all referrals received and issued.	<ul style="list-style-type: none"> <li>• From September 2010 to April 2011, a total of 523 referrals were received by the Community Nurse. The Community Nurse received referrals from teachers, staff, family and students.</li> </ul>
3. The Community Nurse will provide appropriate interventions for all referrals received.	<ul style="list-style-type: none"> <li>• The referrals received and made during the 2010-2011 school year resulted in a total of 4,227 interventions.</li> </ul> <p>There were five main types of interventions:</p> <ol style="list-style-type: none"> <li>1. Medical Interventions: health related referrals</li> <li>2. Family Consultations: one on one conferences with students and their parent(s)/guardian(s)</li> <li>3. Screenings: vision, hearing and lice exams</li> <li>4. First-aid care: non-urgent health needs such as cuts, scraps, fevers, etc.</li> <li>5. Notification letters: letters sent home to advise parent(s)/guardian(s)</li> </ol>

4. 100% of K, 2<sup>nd</sup> and 5<sup>th</sup> grades will receive mandated screenings
  
5. Students contacted by the Community Nurse will report resulting outcomes from the interventions received.
  
6. 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.

- of missing vision, hearing, dental and physical screenings and immunizations.
- During the 2010-2011 school year, 7 mass screenings were conducted for all K, 2<sup>nd</sup> and 5<sup>th</sup> graders.
    - Vision: 6
    - Hearing: 7
    - Lice: 9
  - In 2010-2011 **100%** of K, 2<sup>nd</sup> and 5<sup>th</sup> graders received the mandated screenings
  - The majority of interventions resulted in improved health status (62%). Improved health status includes: follow through with medical appointments, having appropriate medications and authorizations at school, obtaining eye exams and glasses (23students), and results from first-aid and other interventions. The outcomes reported by students that pertain to improved health status are a proxy for improved attendance and ability to learn in class. Emergency department visits may also have been avoided.
  - The data tool to measure the above objective was implemented during the 2010-2011 school year. The data showed that 100% of the students with missing immunizations completed their requirements by year end. The Community Nurse will continue to track and report immunization completion rates.

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

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

2011 Objectives	Outcomes
1. The FPP will continue to participate in community outreach events to increase awareness of fall prevention to seniors, persons with disabilities and care providers	• 891 people were served through community outreach events
2. The FPP will maintain a county-wide fall prevention coalition to provide information and resources for fall prevention activities within agencies and for individuals.	• 4 coalition meetings were held and on average 34 attendees and 33 agencies attended
3. Home assessments and modifications will be conducted for low-income older adult residents of Central and East Contra Costa County	• 162 referrals were received and home safety assessments were conducted. Modifications in 89 homes for 145 low income older adult residents of Central and East Contra Costa County were done.
4. Older adults who attended a FPP presentation will report that	• Educational material packets on Fall Prevention were sent to all homes, including the 73 homes that did not qualify for home modification services. • 93% of older adults report having a greater awareness about why falls happen

they have a greater awareness about why falls happen and increased knowledge of risk factors

- 5. 85% of older adults who received a home assessment and modification will report that they have not fallen since the intervention

and learned something new about preventing falls as a result of the presentations provided by FPP

- Older Adults who received in home assessment and modifications in 2011 report high quality of life improvements. Of these older adults, 74% report that they have not fallen since the intervention

**Strategy 6: Reduce recidivism and retaliation by connecting victims of intentional injuries to the Beyond Violence Program**

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

2011 Objectives	Outcomes
<ul style="list-style-type: none"> <li>1. JMH social workers will obtain signed consents from 85% of patients</li> <li>2. Interventionists will obtain signed consents from 75% of referred patients</li> </ul>	<ul style="list-style-type: none"> <li>• John Muir Health Social Workers obtained consents from 100% of eligible patients and a total of 38 patients were referred to the Beyond Violence program in 2011</li> <li>• The combined consent rate for both the Richmond and Antioch was 100%</li> </ul>
<ul style="list-style-type: none"> <li>3. 70% of clients will remain engaged in the program for at least 6 months</li> <li>4. 90% of clients will still be alive in 3 and 6 months from the time they were enrolled in the program</li> <li>5. 75% of clients will not have been involved in a criminal incident or re-injured in 3 and 6 months from the time they were enrolled in the program</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of clients who were engaged after 3 months remain engaged at 6 months</li> <li>• <u>3 Month Follow-Up</u>: Out of the 38 engaged clients, 100% remain alive and avoided re-injury at the 3 month follow-up.</li> <li>• <u>6 Month Follow-Up</u>: Out of the 31 clients who were engaged at the 3 month follow-up, 100% remain alive and avoided re-injury at the 6 month follow-up</li> <li>• <u>3 Month Follow-Up</u>: At the 3 month follow-up, 95% of clients were not involved in a criminal incident.</li> <li>• <u>6 Month Follow-Up</u>: Out of the 31 clients who were engaged at the 3 month follow-up, 100% were not involved in a criminal incident at the 6 month follow-up</li> </ul>

**Strategy 7: Create healthy food and activity environments in neighborhoods and organizations that support children 0-5 and their families through the collaborative work of Healthy and Active Before Five (HAB45)**

FY 10 Baseline: Dedicated to program planning

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Disseminate HAB45’s Action Plan and model policies through at least 6 organizational newsletters, postings on the website and social media sites</li> <li>2. Convene and facilitate at least 2 collaborative partnership meetings</li> <li>3. Conduct presentations about Healthy and Active Before 5 to at least 3 interested professional groups working with JMH</li> <li>4. At least 20 JMH Leadership team members will pledge to commit to eat more fruits and vegetables</li> <li>5. Conduct an assessment of vending machines at JMH facilities and develop recommendations for healthier food choices</li> </ol>	<p>HAB45 implemented the following activities to further promote the message of healthy food and activity environments within the local community and organizations</p> <ul style="list-style-type: none"> <li>• HAB45 has produced 3 newsletters highlighting the program’s current projects, mission and successes.</li> <li>• HAB45 has improved their website. Sample policies and organizational practices can be downloaded.</li> <li>• HAB45 has also integrated social media feeds (e.g. Twitter and Facebook) and has purchased a second domain name, <a href="http://hab45.org">hab45.org</a> as a help to those using handheld devices.</li> </ul> <ol style="list-style-type: none"> <li>• 2 collaborative meetings were facilitated; these meetings helped inspire progress among local organizations <u>servng young children in Contra Costa</u> and provide opportunities for networking, technical assistance, and sharing best practices.</li> <li>• 2 conference sessions to John Muir nutritional services management and nursing administration were presented</li> <li>• HAB45 worked with the John Muir Health Women’s Health Center to write policies regarding sales of sugary snacks and drinks and provided information regarding healthy vending machines</li> <li>• 138 pledges from local organizations committing to make healthy changes in their organization were received</li> <li>• Policy change can had a widespread impact and is the first step in promoting healthy behaviors. At an organizational level, changes related to food and beverage policies provided a model to families and children and discourage unhealthy foods. According to the individuals who collaborated with HAB45, 82% reported that HAB45’s work has helped to make their agency a healthier place for children &amp; families</li> </ol>

**Strategy 8: Provide lung cancer CT screening services to people at high risk of developing lung cancer in an effort to decrease barriers to accessing appropriate and timely diagnosis and treatment of lung cancer**

FY 10 Baseline: Dedicated to program planning

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. 100 lung cancer CT screening exams will be conducted</li> <li>2. Outreach to diverse populations through the development of partnerships with community clinics and physicians will be conducted</li> <li>3. 95% of participants will receive their scan results and recommendations within 10 working days</li> <li>4. 80% of participants will report that they are more informed about lung cancer and early detection after receiving education</li> <li>5. Participants will report increased knowledge and/or positive behavior change or early detection as a result of the services provided, which saves or extends lives</li> </ol>	<ul style="list-style-type: none"> <li>• 37 screenings were conducted.</li> <li>• Information regarding the Lung Cancer Screening Program is provided to physician offices and community agencies to increase recruitment of participant from diverse backgrounds</li> <li>• Of the participants who disclosed their demographic information, the majority identified as Caucasian, with Asian being the largest minority group participating and were 60 years of age or older</li> <li>• 88% of participants were provided scan results within 10 working days</li> <li>• According to the Participant Survey, 91% of participants reported increased knowledge about their health condition and 88% feel more engaged in their healthcare as a result of the education and services provided</li> <li>• According to the Participant Survey, 71% of participants reported that they are more likely to make lifestyle changes as a result of the education and services received. Lifestyle changes include: better diet, more exercise, follow-up care, regular screenings, smoking cessation, treatment adherence, etc.</li> </ul>

**Access to Health Care Services**

**Goal 1: Uninsured, underserved and vulnerable populations in the service area have access to the full range of disease prevention and health care services.**

**Strategy 1: Provide low risk outpatient surgery through Operation Access**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Surgical services provided by JMH will increase from 32 to 40</li> </ol>	<ul style="list-style-type: none"> <li>• 59% of Operation Access surgical services in Contra Costa County were provided by John Muir Health. This amounted to a total of 51 surgical procedures provided by JMH surgeons, all of which were provided in a JMH operating room. Also, JMH surgeons provided an additional 55 services including evaluation only visits, diagnostic screenings, medical therapy, minor</li> </ul>

<ol style="list-style-type: none"> <li>2. Surgical services will be provided to underrepresented minority patients in Contra Costa County</li> <li>3. JMH patients will report high levels of satisfaction with the surgical services offered by Operation Access</li> <li>4. JMH patients will report improved quality of life as a result of their surgical procedure</li> </ol>	<p>procedures and radiology.</p> <ul style="list-style-type: none"> <li>• The number of Latino patients receiving surgical services in Contra Costa County decreased by 6%, along with the number of Asian and African American patients. The number of Caucasian patients increased by 5%</li> <li>• Patient’s report that their overall experience with Operation Access increased as did their satisfaction with the services received by John Muir Health</li> <li>• 93% of patients reported improved quality of life and 100% of patients reported improved work ability and mobility</li> </ul>
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**Strategy 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. A total of 875 patient visits. 63% of the patients seen were connected to a dental home. 100% of patients reported high levels of quality and satisfaction with the services offered. 58% of the patients seen at the Mobile Dental Clinic previously had no access to dental care.

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Oral health services will be provided to a minimum of 600 children</li> <li>2. Children screened will be provided with oral health education</li> <li>3. Enrollment assistance will be provided to eligible families</li> <li>4. A dental home will be identified and established for 100% of patients</li> <li>5. 90% of patients will report high levels satisfaction with services</li> </ol>	<ul style="list-style-type: none"> <li>• The MDC saw 655 children and provided 1454 visits</li> <li>• 9,632 children received dental education</li> <li>• 100 % of patients seeking care were in need of enrollment assistance. A total of 671 families were provided with insurance enrollment assistance. Having insurance increases access to care and provides these families with the opportunity to seek care that is continuous through a primary care provided</li> </ul> <p>100% of patients seen through the MDC were connected to a dental home through the MDC’s referral partnerships with the following community clinics:</p> <ul style="list-style-type: none"> <li>• Brookside Community Clinic</li> <li>• La Clinica de la Raza</li> <li>• Contra Costa Health Services Clinics</li> </ul> <ul style="list-style-type: none"> <li>• According to the MDC Patient Satisfaction Survey, 100% of patients reported that they would recommend the MDC to someone they knew and reported high levels of quality and satisfaction with the services offered and received</li> </ul>

**Strategy 3: Provide primary care via the Mobile Health Clinic for the uninsured in Brentwood and Far East County on Saturdays**  
 FY 07 Baseline: Served 260 patients through the Saturday Clinic. 17% of patients presented with an urgent health need and 8% reported that they would have gone to the ED if the MHC was unavailable

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>At least 600 patients will be served during the Saturday clinic</li> <li>Patients will be issued referrals for ongoing primary medical care</li> <li>Patients will report high levels of satisfaction with services</li> </ol>	<ul style="list-style-type: none"> <li>The MHC served 694 patients through the Saturday Clinic</li> <li>The MHC made 154 referrals. The referrals were made for patients that required more urgent care, specialty care services and/or chronic disease management</li> <li>Of the 154 referrals, the majority (87%) were concentrated in health agencies, particularly La Clinica-Pittsburg and Brentwood Health Center</li> <li>100% of patients were satisfied with the services</li> </ul>

**Strategy 4: Support RotaCare Free Clinic**  
 FY 10 Baseline: 14 Clinics have been held and 258 patient served

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>Use of the MHC will be provided to the Rotary Club for RotaCare Clinics in Concord on Thursdays.</li> <li>Lab and imaging services will be provided at cost for RotaCare patients</li> </ol>	<ul style="list-style-type: none"> <li>Expanded services to include monthly OB/GYN clinic</li> <li>50 Clinics held; JMH provided the driver</li> </ul>
<ol style="list-style-type: none"> <li>The number of avoidable Emergency Department visits will be reduced; urgent clinic visits are a proxy for ED visits avoided</li> </ol>	<ul style="list-style-type: none"> <li>Over \$48,000 in ancillary testing was provided for RotaCare Services.</li> </ul>

**Strategy 5: Support Foster A Dream which provides bridge services and mentoring opportunities for foster youth who are transitioning to emancipation.**  
 FY 08 Baseline: 400 backpacks filled and distributed. 3 career related workshops conducted and 62 youth participated. 5 mentors and 2 board members recruited. 1 foster youth awarded “Dare to Dream” academic scholarship

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>At least 500 backpacks will be filled and distributed</li> <li>Foster youth will participate in career development activities</li> <li>15 new JMH volunteers will be recruited</li> </ol>	<ul style="list-style-type: none"> <li>1183 backpacks were filled with school supplies and distributed to foster youth. School supplies included backpacks, pens and pencils, folders, and notebooks</li> <li>8 youth participated in the Get Set Program</li> </ul> <p><u>John Muir Staff participation:</u></p> <ul style="list-style-type: none"> <li>2 served as board members</li> <li>31 served as volunteers and as mentors</li> </ul>

<p>4. 50% of the foster youth that participate in Get Set will have their identified goals met</p> <p>5. A foster youth will be awarded with an academic scholarship</p> <p>6. 50% of foster youth who participate in “Get Set” will have their identified needs met</p>	<ul style="list-style-type: none"> <li>• Of the 31 volunteers, 8 are regular donors and of those donors 4 are Society members (donors who have pledged to give \$1,000 or more for 5 years)</li> <li>• 8 youth attended the two week camp. More than 50% have met their immediate goals and are now working towards their next goals, with the support of Foster A Dream staff and volunteers</li> <li>• Gabriela was the recipient of the John Muir Dare to Dream Scholarship in 2010 and was awarded it again in 2011. She is still attending San Francisco State University with a Nursing major and is caring a 3.35 GPA. She is still participating in the Guardian Scholar program at San Francisco State and will be the upcoming program President. Here is an expert from her personal statement on her 2011 scholarship application.</li> <li>• JMH was not able to host a 3-hour Career Day for foster youth, presenting on vocational opportunities in the health field in 2011</li> </ul>
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**Strategy 6: The Medication Assistance Program will provide low-income patients with free or low-cost medications**

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

2011 Objectives	Outcomes
<p>1. Low-income patients will be provided with free or low-cost medications</p>	<ul style="list-style-type: none"> <li>• The 44 patients were provided with 406 medications free of cost</li> </ul>

**Strategy 7: Support East County efforts to increase access to primary care**

FY 10 Baseline: A Health Access Enrollment Manager was hired

2011 Objectives	Outcomes
<p>1. Increase enrollment in Medi-Cal and Healthy Families</p> <p>2. Support La Clinica’s expansion in Oakley</p>	<ul style="list-style-type: none"> <li>• Baseline work completed with County Employment and Human Services and Health Services Departments which supported their coordination and planning efforts.</li> <li>• Application assistor training completed</li> <li>• La Clinica Oakley opened in November 2011</li> </ul>

**Strategy 8: Provide specialty care to low-income, uninsured patients referred by community clinics**

FY 10 Baseline: Dedicated to program planning

2011 Objectives	Outcomes
<p>1. Provide diagnostic and inpatient specialty care</p>	<ul style="list-style-type: none"> <li>• Out of the 12 accepted referrals, 7 received a consultation, 4 had diagnostic</li> </ul>

tests, and 1 received surgery

**Well Coordinated Care**

**Goal 2:** The continuum of care for vulnerable populations served is well coordinated and provided in the most cost-effective and appropriate setting.

**Strategy 1: Implement JMCC ED Referral Liaison Program to connect the uninsured to a medical home and other support services**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Identify and contact patients with no primary care physician or insurance who present at the ED for non-urgent reasons</li> <li>2. Provide contacted patient with appropriate referrals</li> <li>3. Maintain a referral rate of 70%</li> <li>4. Revisit rates of patients who return to the ED for non urgent reasons in less than 3 months, 6 months and 12 months from the time of their last visit will not exceed 1%</li> <li>5. At least 70% of patients who were issued a referral in will report successful follow-up outcomes (e.g. making an appointment with a PCP/Clinic, going to an appointment with a PCP/Clinic, enrolling in Medi-Cal or following through with community resource referral)</li> </ol>	<ul style="list-style-type: none"> <li>• Identified and contacted 7,320 eligible patients, a 12% increase from 2010</li> <li>• Issued 8,907 referrals in the following categories: Insurance assistance, health service and community resource.</li> <li>• Referral rate of 73%. The patients who were not issued a referral were either:               <ul style="list-style-type: none"> <li>• Disinterested in the services (4%)</li> <li>• Ineligible (10%)</li> <li>• Unable to be reached (13%)</li> </ul> </li> <li>• Revisit rates for eligible patients contacted by the ED Referral Liaison continued to remain below 1% in 2011</li> <li>• Out of all patients where follow-up was conducted, 59% resulted in a success and only 15% resulted in no success</li> </ul>

**Strategy 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, 787 referrals were from JMH providers. 90% of patients reported high satisfaction. 78% of patients reported more effectively managing activities of daily living

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. GCC will receive at least 1,320 referrals per year or greater</li> <li>2. 60% or more of patients receiving in-home assessments will have</li> </ol>	<ul style="list-style-type: none"> <li>• Referrals in 2011 to the GCC Program were 1,337</li> <li>• 70% of patients receiving in-home assessments had incomes less than 350% of</li> </ul>

<p>incomes less than 350% of Federal Poverty guidelines</p> <ol style="list-style-type: none"> <li>3. 95% of patients will report high satisfaction with GCC</li> <li>4. 95% of physicians will report high satisfaction with GCC</li> <li>5. 80% of patients will report that the program assisted them in effectively managing their activities of daily living (ADL)</li> <li>6. Participating patients will demonstrate avoided ED visits, hospital admissions and readmissions</li> </ol>	<p>the Federal Poverty Guidelines</p> <ul style="list-style-type: none"> <li>• 94% of all patients surveyed reported being very satisfied or satisfied with the GCC Program</li> <li>• Physicians report a 99% satisfaction rate</li> <li>• 79% of patients report being able to more effectively manage their activities of daily living</li> <li>• 24 hospitalizations, 6 readmissions and 30 ED visits were avoided</li> </ul>
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**Strategy 3: The Senior Transportation Program (STP) will provide transportation to medical appointments for frail, isolated and disabled seniors**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. At least 130 seniors will be enabled to get to their medical appointments</li> <li>2. 20% of the seniors served will be Spanish speaking</li> <li>3. At least 1,000 one-way assisted rides will be provided</li> <li>4. Seniors will utilize STP's transportation services on average of 10 times per year</li> <li>5. Seniors will report increased accessibility to medical services and prescription pick-up as a result of STP rides</li> </ol>	<ul style="list-style-type: none"> <li>• 138 seniors were served, an 8% increase from 2010</li> <li>• 16% of the seniors served are Spanish speaking</li> <li>• 976 one-way assisted rides, a 9% increase from 2010</li> <li>• On average, each senior was given 7 rides compared to 8.3 rides in 2010. The reason for the decrease in number of rides is due to the fact that not all 138 STP participants call for rides</li> <li>• STP made getting to doctors appointments "convenient," "somewhat convenient," and "very convenient" for 93% of the seniors surveyed</li> </ul>

**Strategy 4: Support the Monument Community Partnership (MCP)**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. The number of community residents participating in MCP programs will increase</li> </ol>	<ul style="list-style-type: none"> <li>• MCP Served about 5,000 residents through its various programs</li> <li>• Neighborhood Action Teams: <ul style="list-style-type: none"> <li>- Facilitated pedestrian and bikeway trail upgrades</li> <li>- Read to as many as 195 children a week</li> <li>- Distributed Vial of Life emergency information kits</li> <li>- Trained residents on personal financial strategies</li> </ul> </li> </ul>

<p>2. MCP will continue to provide policy input to the City of Concord and other agencies as appropriate</p>	<ul style="list-style-type: none"> <li>- Supported community gardens</li> <li>- Coordinated youth clean up day at Lake Ellis</li> <li>- Promoted domestic violence, prevention and gender respect</li> <li>• MCP Hope Campaign created a safe family zone at Frisbee Court where 90% of residents pledged to stop violence</li> <li>• VITA income tax return assistance volunteers helped complete 180 tax returns generating about \$274,800 for the residents and local economy</li> <li>• Coordinated the Monument Community Health Fair with over 30 participating agencies</li> <li>• Served 730 families with 1200 hours of programming for children 0-5 years of age and their families</li> <li>• Advocated with the City of Concord: Health Element of City General Plan; Food Policy Ordinance; Zoning and Land Use Sustainable Food System; Complete Streets</li> <li>• Advocated with Metropolitan Transportation Commission on issues related to health and the environment</li> <li>• Two MCP residents were placed on the County Public Health Advisory Board</li> </ul>
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**Strategy 5: Provide chronic care management for low income, frail elderly**

FY 09 Baseline: 268 low income seniors served. 90% of participating seniors reported that they are more knowledgeable about condition. 30 day readmit rate for Care Transitions Intervention (CTI) patients was 6.09% and for Tel-Assurance (TA) patients it was 0%

<b>2011 Objectives</b>	<b>Outcomes</b>
<ol style="list-style-type: none"> <li>1. 100% of patients referred by CCHP and other referral sources will be contacted</li> <li>2. Increase the number of low –income engaged patients by 25% in one or more of the Case Management programs (500 to 625)</li> <li>3. 90% of participating patients will report high levels of satisfaction</li> <li>4. Patients who participate in the CTI and TA programs will demonstrate low hospital admission rates.</li> <li>5. ED visits for TA and CTI participants will be tracked and reported</li> </ol>	<ul style="list-style-type: none"> <li>• 100% of all referrals were contacted through phone calls or participation packet mailers</li> <li>• 356 low income patients were engaged in 2011, a 29% decrease from 2010. Low income patients include those referred by CCHP and patients referred from JMH with incomes 300% below the Federal Poverty</li> <li>• Of the patients surveyed, an average of 95% reported high levels of satisfaction</li> <li>• Readmission rate for CHF patients in Tel-Assurance <b>decreased</b> from 2010 (<b>12.2%</b> to <b>11.1%</b>) and was less than control group rate of 19.2%</li> <li>• Readmission rate for COPD patients in Tel-Assurance <b>increased</b> from 2010 (<b>2.9%</b> to <b>6.0%</b>) and was significantly less than the control group rate of 27.3%</li> <li>• ED visits were not tracked as patients have many options during emergency situations, and it is extremely difficult to track when claims are paid by different entities</li> </ul>

**Strategy 6: Connect seniors in the Monument community with programs and services to address their safety, health and social well-being**

FY 10 Baseline: Dedicated to program planning

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Referrals will be received by community partners. Senior Monument community residents will be tracked and outcomes reported</li> <li>2. Individual case management services will be provided to 50 isolated seniors</li> <li>3. 6 health related presentations will be provided to the community</li> <li>4. 85% of seniors will achieve 1 or more goals identified in their success plan</li> <li>5. Appropriate referrals will be provided to participating older adults</li> <li>6. participating older adults will report increased knowledge of community resources as a result of the presentations attended and education received</li> <li>7. At least 5 seniors will report involvement in neighborhood civic and/or community projects</li> </ol>	<ul style="list-style-type: none"> <li>• 658 older adults were referred to the MCSSO</li> <li>• 65 older adults were provided with individual case management services, exceeding the objective by 30%</li> <li>• 55 presentations were conducted within the community and a total of 607 older adults attended the presentations</li> <li>• Out of the 37 older adults who completed case management services (closed cases), 73% achieved 1 or more goals identified in their success plan</li> </ul> <p>448 referrals were made to community resources.</p> <ul style="list-style-type: none"> <li>• The majority (44%) of referrals were made to health resources such as community clinics, primary care physicians, screenings, etc.</li> <li>• Out of the 448 referrals made, 21% were followed up with by the Case Manager</li> <li>• When asked in the post-test to describe their awareness of community resources, 43% of older adults reported that they are well aware or aware of community resources and can find most services, compared to 7% in the pre-test</li> <li>• 33 older adults were involved in neighborhood civic or community projects</li> </ul>

**Cost Effective Setting**

<b>Goal 2:</b>	<b>The continuum of care for vulnerable populations served is well coordinated and provided in the most cost-effective and appropriate setting.</b>
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**Strategy 1: Connect homeless patients discharged from hospital to Respite Care Center**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Identify and refer homeless patients requiring respite care at discharge</li> </ol>	<p>The patient must meet the following criteria for placement:</p> <ul style="list-style-type: none"> <li>• Homeless or lack adequate housing to support recovery</li> <li>• 18 years of age or older</li> </ul>

- Willing and able to comply with CCC Shelter and Medical Respite rules and agree to admission there
- Able to perform all activities of daily living independently, including taking meds
- Continent of urine and stool
- Not require IV therapy or any other skilled nursing care
- Medical condition that can be effectively addressed within a limited amount of time (< 6 wks)
- Alert and oriented
- Independent with wound care, or need assistance less than 4 times per week, or have Home Health nursing provided
- Independently mobile and able to self-transfer in and out of bed
- Behaviorally appropriate for group setting
- Have received benzodiazepine for alcohol withdrawal in past 24 hours
- 40% of patients referred will be admitted to respite

2. Track acceptance rates and patient days avoided

**Strategy 2: Partner with La Clinica and CCHP/CCHS to provide cardiac outpatient education for low-income patients unable to attend a traditional cardiac rehab program**

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Provide secondary rehabilitation to low-income patients with cardiovascular conditions</li> <li>2. COPE will measure program adherence, percentage of patients who complete the program.</li> <li>3. Participating patients will experience increased exercise frequency, duration and/or intensity, as measured through fitness testing in the first 3 months.</li> </ol>	<ul style="list-style-type: none"> <li>• 52 patients have been referred to the program. All referred patients were contacted, and 62% signed up to participate, 29% chose not to participate, and 9% qualified for traditional cardiac rehabilitation. As of December 30, 2011, 23 patients are participating in the program.</li> </ul> <p>The program is one year in length and very manageable for patients to adhere to the required program components:</p> <ul style="list-style-type: none"> <li>• Face to face contact twice a year, three months apart</li> <li>• Three months of bi-weekly phone contact</li> <li>• Six month and one year phone follow-up</li> <li>• Three patients participated in sub-maximal treadmill evaluations.</li> <li>• Starting MET Levels: 8.56</li> <li>• Post 3 month MET Levels: 11.4</li> </ul>

### Strategy 3: Support the Putnam Clubhouse in Concord

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. The Clubhouse will have an average daily attendance of 30, and members will spend 35,000 hours participating in Clubhouse activities</li> <li>2. The number of members ages 18 to 25 will increase by at least 10 people (from 15 to 25)</li> <li>3. 75% of respondents in the annual Member Satisfaction Survey will report an increase in their independence</li> <li>4. 75% of respondents in the annual Member Satisfaction Survey will report improved quality of life from participation in the program</li> <li>5. At least 6 additional members will be placed in unsubsidized employment</li> </ol>	<ul style="list-style-type: none"> <li>• 240 members participated in program activities during the year</li> <li>• The number of people ages 18 to 25 who joined the Clubhouse during 2011 is 24 members, more than double the goal</li> <li>• 73 members completed the survey. Of those completing the survey, 100% agreed or strongly agreed that they were satisfied with the Clubhouse activities they attended during the past year. Additionally, 90% agreed or strongly agreed that their independence increased during the year</li> <li>• 90% of respondents reported that their mental and emotional well being had increased as well as their contact with peers.</li> <li>• 29 members gained jobs in unsubsidized employment at an average (unsubsidized) wage of \$16 per hour. Additionally, 35 members returned to school, including ten who completed a 3 semester SPIRIT Certificate Program for peer providers</li> </ul>

### Strategy 4: Promote independence and enhance the quality of life of seniors through the Caring Hands Volunteer Caregivers Program

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

2011 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. 339 seniors will be served</li> <li>2. Caring Hands will increase the number of Hispanic seniors served by 10%</li> <li>3. 80% of seniors will report “good” and “excellent” quality of life outcomes after participating in the program</li> </ol>	<ul style="list-style-type: none"> <li>• Caring Hands served 231 seniors. Of these seniors 6.5% were Hispanic and were served with the assistance of our Department Secretary who is fluent in Spanish. She works closely with the seniors and our Social Workers to ensure they can get the assistance they need</li> <li>• The seniors were served by 195 Caring Hands Volunteers, of which 7% were Hispanic</li> <li>• As reported by the 2011 Quality of Life Survey, 73% of seniors surveyed perceive their quality of life as “good” and “excellent” after participating in Caring Hands</li> </ul>

## Strategy 5: Reduce avoidable ED visits and hospitalizations

FY 10 Baseline: Dedicated to program planning

2011 Objectives	Outcomes
<ol style="list-style-type: none"><li>1. Develop intensive case management program for frequent ED users at JMCC</li><li>2. Enroll JMH patients into the program</li><li>3. Reduce the number of avoidable ED visits by participants in the program</li></ol>	<ul style="list-style-type: none"><li>• The New Directions Program began at the end of July 2011. One Social Worker Case Manager was hired but returned to the Santa Clara New Directions program 11/2011. A replacement Social Worker Case Manager was immediately hired and is sharing a space with the ED Case Managers and ED Referral Liaisons on the Concord Campus. A second Social Worker Case Manager has also been hired</li><li>• 14 patients were enrolled</li><li>• In the first six months of the program, the number of ED visits, inpatient stays, inpatient days and losses for the participating patients have all gone down. Negative contribution margin has gone down from \$-299,775 (year prior) to \$-119,530 (6 months experience annualized) which is a savings of about \$180,000. Costs of the program in 2011 were \$130,000</li></ul>

### The Community Health Fund

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

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

***Attachment F – 2012 Community Benefit Plan***  
***1. 2012 John Muir Health Community Benefit Plan***  
***2. 2012 John Muir Behavioral Health Community Benefit Plan***

*Attachment F – 2012 Community Benefit Plan*  
**1. 2012 John Muir Health Community Benefit Plan**

**John Muir Health  
2012 Community Benefit Plan**

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

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

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

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

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

2012 Objectives	Outcomes
1. Increase the number of surgical services provided by JMH by 10 percent over 2011.	•
2. Operation Access will provide surgical services to underrepresented minority patients in Contra Costa County.	•
3. Contra Costa patients will report high levels of satisfaction with the surgical services offered by Operation Access.	•
4. Contra Costa patients will report improved quality of life as reported by patient surveys	•

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

FY 10 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
1. Recruit specialists to participate in the program as needed to meet the needs of the referred patients.	•
2. Provide specialty charity care as budgeted.	•

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

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

gone to the ED if the MHC was unavailable

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. The Mobile Health Clinic will serve at least 600 patients in the 2012 Saturday clinic.</li> <li>2. The Mobile Health Clinic will provide patients with referrals for ongoing primary medical care.</li> <li>3. The Mobile Health Clinic will maintain high levels of patient satisfaction.</li> <li>4. The Mobile Health Clinic will reduce the number of avoidable Emergency Department visits.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

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

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. The Mobile Dental Clinic will provide oral health services to a minimum of 600 children.</li> <li>2. The Mobile Dental Clinic will provide enrollment assistance to eligible patients.</li> <li>3. The Mobile Dental Clinic will identify and establish a dental home for patients.</li> <li>4. The Mobile Dental Clinic will maintain high levels of patient satisfaction.</li> <li>5. The Mobile Dental Clinic will have increased access to dental care.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

**Tactic 6: Support Concord RotaCare Free Clinic.**

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Provide the Mobile Health Clinic for evening use by the Concord RotaCare Clinic</li> <li>2. Provide lab and X-Ray services at discounted rates</li> <li>3. Provide technical assistance as requested</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>

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

FY 11 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
1. Collect and evaluated ED use rates from hypertension, diabetes and asthma	•
2. Assess programs to address findings including mobile health clinic, community clinic and health education programs as appropriate	•
3. Based on assessment, develop implementation plan and budget for 2013	•

**Strategy 2: Increase access to care through enrollment programs**

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

FY 10 Baseline: A Health Access Enrollment Manager was hired

2012 Objectives	Outcomes
1. Continue to work with East and Central County Access Action Team and East and Central County provider CEOs to develop collaborative programs to increase access to care	•

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

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

2012 Objectives	Outcomes
1. Continue to identify and contact patients with no primary care physician or insurance who present at the ED for non-urgent reasons	•
2. Provide contacted patients with appropriate health services, insurance assistance and community referral.	•
3. Maintain a referral rate of 70%	•
4. Revisit rates of patients who return to the ED for non urgent reasons in less than 3 months, 6 months and 12 months from the time of their last visit will remain below 1%	•
5. At least 70% of patients who were issued a referral will report successful follow-up outcomes	•

**Tactic 3: Reduce avoidable ED visits and hospitalizations for frequent users through the New Directions Pilot.**

FY 10 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
7. The frequent users will report improvement in access to benefits including Medi-Cal and county programs.	•
8. The frequent users will report better outcomes related to healthcare, housing, transportation, mental health, substance abuse, and employment.	•
9. Avoidable admissions and inpatient days will decrease for frequent users	•
10. ED visits for the identified frequent users will decrease within the first 6 months after they are enrolled and engaged in the program.	•

**Tactic 4: Explore the National Medical-Legal Partnership to determine JMH patient needs and benefits including enrollment in available health care programs and other support programs for low income residents.**

FY 12 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
1. Assess JMH patient needs	•
2. Determine appropriateness of National Medical-Legal Partnership model for JMH	•
3. If appropriate, develop implementation plan and budget for 2013	•

**Strategy 3: Support prevention, early diagnosis and early intervention**

**Screening**

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

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

FY 10 Baseline for Cervical Cancer Screening: Dedicated to program planning

2012 Objectives	Outcomes
1. Every Woman Counts will increase the number patients served by 6	•

<p>percent.</p> <ol style="list-style-type: none"> <li>2. Every Woman Counts will continue to support efforts to diversify the demographics of the patient population through expanded service reach.</li> <li>3. Every Woman Counts will increase African American women seen by 5 percent through outreach efforts.</li> <li>4. Within 18 months of their initial screening date, 80 percent of returning breast cancer screening patients will be re-screened.</li> <li>5. Every Woman Counts will provide 90 percent of breast cancer patients with “one stop” services.</li> <li>6. Every Woman Counts will provide cervical cancer screening patients with appropriate referrals for gynecological issues detected.</li> <li>7. Every Woman Counts will enroll diagnosed patients in the Breast and Cervical Cancer Treatment Program (BCCTP) and refer to community partners for treatment.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>
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**Tactic 2: Support faith communities healthy ministries through the Faith and Health Partnership (FHP) Program.**

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. FHP programs focus on program Development will result in:               <ol style="list-style-type: none"> <li>a. An increase in the number of faith communities in Phase I-Development from 9 to 15. (current = 11 in Development phase, goal =15)</li> <li>b. 7 of the 2011 faith communities in Phase I-Development will advance to the Phase II-Program Growth phase (current = 16 in Program Growth phase, goal =21)</li> <li>c. 2 faith communities from Phase I -Development, Phase II-Program Growth and Phase III-Sustainability will advance to Phase IV-Self-sufficiency (current =1, goal = 3)</li> <li>d. 23 of the faith communities in Phases I-Development, Phase II-Program Growth and Phase III-Sustainability will implement Change projects (current = 15 faith communities have implemented Change projects, goal = 23)</li> </ol> </li> <li>2. Faith communities health ministry programs will become sustainable and self-sufficient as evidenced by</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> </ul>

- a. 6 of the 11 faith communities in Phase I-Development will apply for support funds  
(current = 16 in Program Growth have applied for support funds, goal = 22)
  - b. 3 faith communities in Phase II-Program Growth will report applying for funds from other sources (current in Phase III-Sustainability who have applied for funds from other sources = 3, goal = 6)
  - c. 10 of the 19 faith communities in Phase II-Program Growth and Phase III-Sustainability will be assisted in obtaining grant writing skill
  - d. 1 faith communities in Phase III-Sustainability will establish a Faith Community Nurse position (current = 6, goal = 7)
3. In 2012, faith communities will conduct health screenings to detect adverse conditions:
- a. Three faith communities in Phase II-Program Growth will offer screening events to detect potential health risks
  - b. 16 of the 19 faith communities in Phase II-Program Growth and Phase III-Sustainability will provide FHP data related to the number of health ministry events that resulted in detection of abnormal screenings and their disposition
4. FHP will survey faith communities in Phase II-Program Growth, Phase III –Sustainability, and Phase IV-Self Sufficiency to obtain data on the following:
- a. The status of the health ministry to date
  - b. Health status of membership
  - c. Assets and needs of the faith community
5. FHP will hold the following education programs:
- a. A Faith Community Nurse certification course
  - b. Faith Community Nurses workshop to enhance his or her practice with 10 continuing education units
  - c. Two workshops for lay health ministers
  - d. Nine outreach education campaigns on health topics such as obesity, diabetes, and heart disease for faith communities, community-based organizations such as the First 5 of Contra Costa County and beauty salons
  - e. Conferences addressing Emergency Preparedness, Domestic Violence, and Mental Illness

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

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

FY 10 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
1. The Lung Cancer Screening Program will perform at least 100 CT screening exams for low income less than 200% of the Federal Poverty Level (FPL).	•
2. The Lung Cancer Screening Program will diversify the demographics of the population served through partnership development with community clinics, physicians and expanding the program outreach to the low income, underinsured populations.	•
3. The Lung Cancer Screening Program will provide scan results and recommendations within 10 working days to 95% of the participants.	•
4. Participants will highly rate their overall experience as a subject in the research study.	•
5. 80% of the participants will report increased knowledge and engagement in their healthcare as a result of the services provided by the Lung Cancer Screening Program.	•
6. Participants will report positive lifestyle changes as a result of the education and services received.	•
7. Participants of the Lung Cancer Screening program will receive appropriate treatment and follow-up services, which are proxies for lives saved or extended.	•

**Seniors**

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

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Medication Assistance Program will track total number of prescriptions obtained and value of medications received.</li> <li>2. Medication Assistance Program will track referral sources for new program participants.</li> <li>3. Medication Assistance Program will track the number of medications received per person and their value.</li> <li>4. Medication Assistance Program will identify monthly income of program participants in relation to percentage of federal poverty guidelines.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

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

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. FPP will continue to participate in community outreach events every month to increase awareness of fall prevention to seniors, persons with disabilities and care providers.</li> <li>2. FPP will maintain a county-wide Fall Prevention Coalition to provide information and resources that make a difference in fall prevention activities within agencies and for individuals.</li> <li>3. FPP will continue to conduct home assessments and modifications for low income older adult residents of central and east Contra Costa County based on available funds.</li> <li>4. Older adults who attended a FPP presentation will report that they have a greater awareness about why falls happen as reported by the post presentation survey.</li> <li>5. Older adults who received a home assessment and modification will report that they are satisfied with the home improvements and recommendations.</li> <li>6. Fall Prevention Coalition members will report that the meetings are useful and informative.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

7. 85% of older adults who received a home assessment and modification will report that they have not fallen since the intervention.
8. Older adults who attended a FPP presentation will report increased knowledge about fall risk factors; knowledge obtained is a proxy for preventing falls and serious injuries.
9. In collaboration with Catholic Charities of the East Bay and other agencies, fall prevention programs will be presented to monolingual Spanish-speaking older adults with results measured by post presentation surveys.
10. In collaboration with In Home Support Services (IHSS) FPP will explore providing fall prevention training materials to IHSS program participants and caregivers with evaluation of the effectiveness of the materials.
11. Fall prevention materials will be provided to all M OW home delivered meals program participants with follow-up survey to determine their benefit from the information.

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

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Caring Hands will serve 350 seniors.</li> <li>2. Caring Hands will increase the number of Hispanic seniors served by 2 percent.</li> <li>3. 85% of seniors will report increased convenience in getting to medical appoints and social interaction as a result of their involvement with Caring Hands service.</li> <li>4. At least 75% of seniors who participated in Caring Hands will report their quality of life as “good” and “excellent” in the 2012 Quality of Life Survey.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

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

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Enable at least 140 frail, isolated, and disabled seniors get to medical appointments.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> </ul>

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|---|---|
| <ol style="list-style-type: none"> <li>2. At least 18% of the seniors served will be Spanish speaking</li> <li>3. STP will provide at least 1000 one-way assisted rides.</li> <li>4. Seniors will utilize STP's transportation services on average of 10 times per year.</li> <li>5. 90% of seniors will report increased accessibility to medical services and prescription pick-up as a result of STP rides.</li> <li>6. A separate STP survey will be distributed and tabulated to better assess whether patient needs are being met.</li> </ol> | <ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul> |
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**Tactic 9: Provide chronic care management for low income, frail elderly.**  
 FY 09 Baseline: 268 low income seniors served. 90% of participating seniors reported that they are more knowledgeable about condition. 30 day readmit rate for Care Transitions Intervention (CTI) patients was 6.09% and for Tel-Assurance (TA) patients it was 0%

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. We will continue to contact 100% of patients referred by CCHP and all other referral sources.</li> <li>2. We will increase the number of engaged patients by 25% in one or more of the Case Management programs (e.g. increase from 140 patients in Tel-Assurance to 175 patients)</li> <li>3. We will maintain 85-90% patient satisfaction scores for the Tel-Assurance and Care Transitions programs.</li> <li>4. We will 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.</li> <li>5. We will define and report level of participation: 1) Patients contacted, 2) Patients engaged</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. MCSSO will receive referrals from community partners and Monument Corridor residents.</li> <li>2. Individual case management services will be provided to 30 isolated older adults.</li> <li>3. 10 health related presentations will be provided at St. Francis Church and</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> </ul>

<p>other community locations.</p> <ol style="list-style-type: none"> <li>4. MCSSO will provide appropriate referrals to participating older adults</li> <li>5. 85% of the older adults who have completed case management services will have achieved 1 or more goals identified in their success plan.</li> <li>6. At least 20 older adults will report involvement in neighborhood civic or community projects.</li> <li>7. Participating older adults will report increased knowledge of community resources as a result of the presentations attended and education received</li> <li>8. Older adults will report improved health outcomes as a result of the services received.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>
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**Tactic 11: The Geriatric Care Coordination (GCC) program will enable older adults, families and caregivers to access all medical, health and community services that may assist in promoting best quality of life.**

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Referrals to the GCC program will be 1,440 per year or greater.</li> <li>2. GCC will increase the number of referrals from John Muir Health providers as measured the monthly GCC log, spreadsheet, and MIDAS reports.</li> <li>3. 60% or more of patients receiving in-home assessments will have income less than 350% of Federal Poverty Guidelines.</li> <li>4. Participating patients will report a satisfaction rate of 95% or higher with the overall program as measured by the patient satisfaction survey.</li> <li>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.</li> <li>6. Participating patients in the GCC program will report that they are more effectively using the health care system as reported by the patient satisfaction survey.</li> <li>7. GCC will demonstrate avoided emergency department visits, hospital admissions and readmissions for participating patients and will quantify each.</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

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

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

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. COPE will provide secondary rehabilitation to low income patients with cardiovascular conditions.</li> <li>2. COPE will measure program adherence, percentage of patients who complete the program.</li> <li>3. Participating patients will experience increased exercise frequency, duration and/or intensity, as measured through fitness testing in the first 3 months.</li> <li>4. Participating patients will identify one change in eating behavior.</li> <li>5. Participating patients will select a 3<sup>rd</sup> risk factor (smoking, blood sugars, stress) and create a plan to implement change, with the assistance of the trainer.</li> <li>6. We will give COPE patients the opportunity to attend 8 exercise sessions in the Phase III Cardiac</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

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

FY 11 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
<ol style="list-style-type: none"> <li>1. Recruit approximately 20 participants from the Fall Prevention Program of Contra Costa County to participate in the In-Home Exercise program.</li> <li>2. Recruited individuals (20 participants) will receive in-home assessments by an Occupational Therapist and home modifications by a licensed contractor.</li> <li>3. Participants will report that the program made a difference in their daily life.</li> <li>4. Participants will lower their fall risk scores.</li> <li>5. Participants will demonstrate increased balance and strength.</li> <li>6. Participants will report an elevated level of self efficacy around fall</li> </ol>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>

- prevention and daily activities.
- 7. Participants will report an increased lift in their mood.
- 8. Participants will continue to exercise for 30 days, 60 days and 90 days post program.

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**Youth**

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

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

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

2012 Objectives for MDUSD	Outcomes
1. The Community Nurse will track all referrals received and issued.	•
2. The Community Nurse will provide appropriate interventions for all referrals received.	•
3. 100% of K, 2 <sup>nd</sup> , and 5 <sup>th</sup> grades will receive mandated screenings.	•
4. Students contacted by the Community Nurse will report resulting outcomes from the interventions received.	•
5. 100% of the students with missing immunizations at the start of the school year will complete their immunizations by the end of the school year.	•
6. Healthy nutrition and exercise will be promoted through various programs, activities, classroom lessons and parent education.	•

2012 Objectives for PUSD	Outcomes
1. The Community Nurse will track all referrals received and issued.	•
2. The Community Nurse will identify and develop a plan of care for all diabetic students in assigned schools.	•
3. The Community Nurse will identify and develop a plan of care for identified asthmatic students in assigned schools.	•
4. The Community Nurse will track and report on all interventions and report resulting outcomes for diabetic and asthmatic students.	•
5. The Community Nurse will coordinate asthma management classes for	•

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

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

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

2012 Objectives	Outcomes
1. JMH social workers will obtain signed consents from 85% of eligible patients	•
2. Interventionists will obtain signed consents from 75% of referred patients	•
3. 70% of clients will remain engaged in the program for at least 6 months	•
4. 90% of clients will still be alive in 6 and 12 months from the time they were enrolled in Beyond Violence.	•
5. 75% of clients will not have been involved in a criminal incident or re-injured in 6 and 12 months from the time they were enrolled in Beyond Violence.	•

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

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

2012 Objectives	Outcomes
1. Teen Pregnancy Resource Program will maintain relationships with current participating sites	•
2. Teen Pregnancy Resource Program will maintain the number of teen participants.	•
3. Teen Pregnancy Resource Program will provide comprehensive prenatal and parenting educational classes to participating teens from Central and East Contra Costa County.	•
4. The teen participants will report increased knowledge as a result of their participation in the classes offered.	•
5. The teen participants will report high levels of satisfaction with the services offered by the Teen Pregnancy Resource Program.	•

- 6. 80% of teen participants will deliver at full term without complications
- 7. 80% of teen participants will report that they are breastfeeding 3 week after delivery.

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

FY 10 Baseline: Dedicated to program planning

2012 Objectives	Outcomes
1. Convene at least 2 collaborative membership meetings to inspire progress among local organizations serving young children in Contra Costa in implementing the action plan and policy agenda.	•
2. Demonstrate measurable change in 10 Contra Costa organizational programs, policies, practices and partnerships that impact rates of obesity for young children in Contra Costa.	•
3. Provide technical assistance to 10 community partners in efforts to promote healthy changes in organizational practices. Include technical assistance to John Muir Nutritional Services resulting 2 practice policy changes around catering practices for department/physician meetings.	•
4. Present conference sessions about the Healthy and Active Before 5 collaborative to at least 3 interested professional groups working with John Muir Health, such as medical staff, administrative leadership committee or nursing administration.	•
5. Build collaboration among HAB45, John Muir and community partners that results in 3 local agencies or businesses adopting practices, policies and/or creating lactation spaces consistent with HAB45's breastfeeding-friendly standards. Implement breastfeeding-friendly standards into JMH policy for lactation accommodation.	•

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

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

2012 Objectives	Outcomes
1. Fill and distribute 500 backpacks	•

2. Foster youth will be supported in their transition to emancipation by participating in Get Set programs	•
3. Foster A Dream will expand mentor and volunteer capacity by recruiting new volunteers	•
4. Foster A Dream will expand overall mentoring program to include “Foster Link”	•
5. Youth who participated in the John Muir career day will report increased awareness of career opportunities.	•
6. Award a foster youth with a “Dare to Dream” Academic scholarship	•
7. 50% of the foster youth that participate in Get Set will have their identified goals met	•

**Coordination**

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

2012 Objectives	Outcomes
1. Train 500 residents in economic development programs (day labor, technology and career development).	•
2. Provide free VITA income tax services for at least 300 local low-income residents.	•
3. Establish and implement a Board approved resident engagement strategy.	•
4. Rebuild Neighborhood Action Teams (NATs) with regular participation of at least 12 new Monument residents.	•
5. Provide case management, referral and follow-up services to at least 100 residents.	•
6. Strategize product placement with at least 6 local grocery stores or minimarkets to promote healthier food choices.	•
7. Actively engage 350 local residents in learning about healthy lifestyles and relationships.	•
8. Implement training for 40 Monument First parents in ESL, technology,	•

work readiness and related skills.

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

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

2012 Objectives	Outcomes
1. 40% of patients referred will be admitted to respite 2. The Respite Center will decrease the hospital length of stay for eligible patients	<ul style="list-style-type: none"><li>•</li><li>•</li></ul>

**The Community Health Fund**

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

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

*Attachment F – 2012 Community Benefit Plan*  
*2. 2012 John Muir Behavioral Health Community Benefit Plan*

**John Muir Behavioral Health Center  
2012 Community Benefit Plan**

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

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

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

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

FY 11 Baseline: Dedicated to program planning

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

**Strategy 3: Support prevention, early diagnosis and early intervention**

**Tactic 1: Support the Putnam Clubhouse in Concord.**

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

1. By December 2012, the Clubhouse will have an average daily attendance of 30, and members will spend 40,000 hours participating in Clubhouse activities. Measured by program logs and member sign-in sheets (same ADA, increase to 5,000 hours for participation).
2. By December 2012, the number of members ages 18 to 25 will increase by at least 10 people (same).
3. By December 2012, at least 80% of respondents in the annual member satisfaction survey will report an increase in their independence (increase by 5%).
4. By December 2012, at least 80% of respondents in the annual member satisfaction survey will self-report improved quality of life from participation in the Clubhouse program (same).
5. By December 2012, at least 15 additional members will be placed in unsubsidized employment, at an average (unsubsidized) wage of \$8.50 per hour. Measured by program logs (increase by 9 members, wage same).
6. By December 2012, the overall membership will show a statistically significant decrease in hospitalizations and out-of-home placements following Clubhouse membership as measured by self-reported data

***Attachment H – Economic Valuation Tables***  
***1. Programs for the Vulnerable Population***

**John Muir Health**  
**Programs Targeted For...Vulnerable**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Behavioral Health Center: Free Discharge Medications Behavioral Health Center (87201)	2,686	0	2,686	19	48
Behavioral Health Center: NAMI: In Our Own Voice Behavioral Health Center (87201)	7,500	0	7,500	1	1
Behavioral Health Center: Putnam Club House Board Participation Behavioral Health Center (87201)	752	0	752	1	12
Birth Center: High Risk Infant Follow Up Program High Risk Infant (7406)	195,172	0	195,172	112	150
Cancer Institute: Breast and Cervical Cancer Treatment Program Cancer Institute (8702)	2,494	0	2,494	16	16
Cancer Institute: Every Woman Counts Program and Clinics Cancer Institute (8702)	359,705	0	359,705	525	35
Cancer Institute: Specialty Care Program Pro Fees Cancer Institute (8702)	1,535	0	1,535	12	1
Cardiology: Cardiac Outpatient Education Program Cardiac Conditioning (7597)	8,504	0	8,504	15	1
Caring Hands Program: Health Care Support Services Caring Hands (8672)	460,964	0	460,964	230	1
Caring Hands Program: Senior Transportation Program Caring Hands (8672)	129,729	0	129,729	138	1
Community Health Alliance: CATCH Program Community Health Alliance (8773)	1,978	0	1,978	100	2
Community Health Alliance: Community Contributions Community Health Alliance (8773)	32,400	0	32,400	9	9
Community Health Alliance: Community Health Nurse Community Health Nurse (8767)	255,004	0	255,004	523	2
Community Health Alliance: Faith Community Capacity Building Faith and Health Partnership (8760)	43,000	0	43,000	31	2
Community Health Alliance: Faith Health and Partnership Faith and Health Partnership (8760)	172,840	0	172,840	6	6
Community Health Alliance: FHP Campaign Outreach Faith and Health Partnership (8760)	128,197	0	128,197	10,501	9
Community Health Alliance: FHP Community Outreach & Education Faith and Health Partnership (8760)	52,237	0	52,237	1,068	11
Community Health Alliance: FHP Health Fairs Faith and Health Partnership (8760)	31,436	0	31,436	6	6
Community Health Alliance: FHP Nursing Education Faith and Health Partnership (8760)	10,200	0	10,200	85	3
Community Health Alliance: Foster A Dream Community Health Alliance (8773)	31,410	0	31,410	9	1
Community Health Alliance: Health Career Support Community Health Alliance (8773)	6,096	0	6,096	1	1
Community Health Alliance: Healthy Children Program Healthy Children (8761)	564	0	564	200	1

**John Muir Health**  
**Programs Targeted For...Vulnerable**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Community Health Alliance: In-kind Donations Community Health Alliance (8773)	10,120	0	10,120	1	1
Community Health Alliance: La Clinica Oakley Site Community Health Alliance (8773)	150,000	0	150,000	1	1
Community Health Alliance: Mobile Dental Clinic Mobile Dental Clinic (8776)	492,507	0	492,507	1,454	181
Community Health Alliance: Mobile Health Clinic Mobile Health Clinic (8777)	488,858	3,000	485,858	4,904	276
Community Health Alliance: Monument Community Partnership Community Health Alliance (8773)	110,000	0	110,000	4,000	1
Community Health Alliance: Other Resources Community Health Alliance (8773)	153,450	0	153,450	1	1
Community Health Alliance: Staffing Community Health Alliance (8773)	646,414	0	646,414	1	1
Community Health Alliance: Vulnerable Population Program Grants Community Health Alliance (8773)	90,000	0	90,000	241	2
Community Health Fund - Grants Community Health Fund (8619)	1,173,855	0	1,173,855	1	1
Community Health Fund - Other Resources Community Health Fund (8619)	213,650	0	213,650	1	1
Community Health Fund - Staffing Community Health Fund (8619)	377,487	0	377,487	1	1
Emergency Department: ED Referral Liaison Program Emergency Department (8768)	111,265	0	111,265	8,130	260
Emergency Services: Physician Pro Fees Emergency Services (7011)	113,517	0	113,517	50	1
Health System: Doctors Medical Center Health System Facilities (8340)	1,000,000	0	1,000,000	1	1
Health System: Donations - Vulnerable Health System Facilities (8340)	44,500	0	44,500	3	3
Laboratory: Screenings (non-health fair) Laboratory (7500)	301	0	301	55	2
Nursing Administration: Foster A Dream Backpack Challenge Nursing Administration (8721)	5,889	0	5,889	1,183	1
Pharmacy: Medical Relief Donations Pharmacy - JMWC (8391)	2,448	0	2,448	2	2
Pharmacy: Patient Assistance Program Pharmacy - JMCC (8390)	15,587	0	15,587	44	720
Physicians Network: Chronic Care Case Management John Muir Physician Network (8966)	388,719	0	388,719	556	1
Pulmonary Rehabilitation: Equipment Loans Pulmonary Rehabilitation (7088)	4,793	0	4,793	24	1
Pulmonary Rehabilitation: Maintenance Exercise Pulmonary Rehabilitation (7088)	12,626	0	12,626	25	1

**John Muir Health**  
**Programs Targeted For...Vulnerable**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs			
	Expenses	Offsets	Benefit	Persons	Encounters		
Pulmonary Rehabilitation: Senior Care Pulmonary Rehabilitation (7088)	1,948	0	1,948	35	1		
Pulmonary Rehabilitation: Transportation Pulmonary Rehabilitation (7088)	1,559	0	1,559	10	10		
Rehab-Outpatient: Vulnerable Population Donation Outpatient Rehab (7772)	792	0	792	1	1		
Rossmoor: Equipment Donations Rossmoor Outpatient Center (8972)	123,100	0	123,100	2,151	362		
Senior Services: Fall Prevention (Vulnerable) Senior Services (8792)	11,919	0	11,919	1	1		
Senior Services: Geriatric Care Coordination Senior Services (8792)	515,252	0	515,252	1,336	1,336		
Senior Services: Monument Community Senior Service Outreach Senior Services (8792)	94,790	0	94,790	556	1		
Senior Services: Monument Fall Prevention Senior Services (8792)	5,376	0	5,376	148	20		
Senior Services: Prescription Medication Assistance Program Senior Services (8792)	87,423	0	87,423	44	409		
Social Services: Continuing Care Services Social Services (8361)	63,301	0	63,301	16	4		
Social Services: Discharge Homeless Pts. Committee (BHC) Behavioral Health Center (87201)	311	0	311	9	4		
Social Services: Homeless Respite Social Services (8361)	101,559	0	101,559	69	2		
Social Services: Medication Assistance (JMWC/JMCC) Social Services (8361)	45,057	0	45,057	248	2		
Social Services: New Directions Social Services (8361)	138,779	0	138,779	14	1		
Social Services: Skilled Nursing, Board & Care, DME (JMCC) Social Services (8361)	133,440	0	133,440	24	3		
Social Services: Skilled Nursing, Board & Care, DME (JMWC) Social Services (8361)	183,419	0	183,419	154	3		
Social Services: Transportation Social Services (8361)	57,501	0	57,501	1,283	3		
Trauma: Beyond Violence Trauma (7016)	153,139	0	153,139	28	652		
Women's Health Center: Teen Pregnancy Resource Program Women's Health Center (7405)	37,044	0	37,044	29	1		
<b>Number of Programs</b>	<b>63</b>	<b>Grand Totals</b>	<b>9,296,098</b>	<b>3,000</b>	<b>9,293,098</b>	<b>40,443</b>	<b>4,595</b>

*Attachment H – Economic Valuation Tables*  
*2. Programs for the Broader Community*

**John Muir Health**  
**Programs Targeted For...Broader Community**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Behavioral Health Center: Donations Behavioral Health Center (87201)	1,000	0	1,000	1	1
Behavioral Health Center: Expressive Art Therapy Internships Expressive Arts Therapy (7802)	136,549	0	136,549	7	4
Behavioral Health Center: Nursing Student Clinical Practicum Behavioral Health Center (87201)	362,337	0	362,337	164	1
Behavioral Health Center: Social Work Internships Social Services (8361)	3,273	0	3,273	1	1
Behavioral Health Center: Suicide Prevention Conference Social Services (8361)	1,559	0	1,559	1	1
Brentwood Campus: Brentwood Corn Fest Brentwood Medical Center (8793)	18,283	0	18,283	1	2
Brentwood Campus: Clinician Education Brentwood Medical Center (8793)	4,116	0	4,116	40	4
Brentwood Campus: Community Donations Brentwood Medical Center (8793)	13,387	0	13,387	14	14
Brentwood Campus: Community Education Brentwood Medical Center (8793)	2,239	0	2,239	115	6
Brentwood Campus: Community Events Brentwood Medical Center (8793)	20,556	0	20,556	5	7
Brentwood Campus: Health Fairs Brentwood Medical Center (8793)	24,463	0	24,463	1	1
Brentwood Campus: Support for Youth Oriented Programs Brentwood Medical Center (8793)	1,906	0	1,906	301	3
Cancer Institute: Community Cash Donations Cancer Institute (8702)	39,000	0	39,000	2	1
Cancer Institute: Community Health Fairs Cancer Institute (8702)	9,882	0	9,882	3	3
Cancer Institute: Community Outreach Events Cancer Institute (8702)	14,668	0	14,668	1,160	14
Cancer Institute: Community Presentations Cancer Institute (8702)	9,147	0	9,147	326	8
Cancer Institute: Community Support Activities Cancer Institute (8702)	2,804	0	2,804	348	12
Cancer Institute: Conferences Cancer Institute (8702)	390	0	390	1	1
Cancer Institute: Health Career Support Cancer Institute (8702)	12,158	0	12,158	200	1
Cancer Institute: In-kind Donations Cancer Institute (8702)	9,498	0	9,498	200	1
Cancer Institute: Nursing Education Cancer Institute (8702)	50,247	2,480	47,767	411	14
Cancer Institute: Physician Education Cancer Institute (8702)	33,368	0	33,368	288	18

**John Muir Health**  
**Programs Targeted For...Broader Community**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Cancer Institute: Screenings Cancer Institute (8702)	12,263	0	12,263	130	2
Cancer Institute: Support Groups Cancer Institute (8702)	5,886	0	5,886	47	14
Cardiology: Cardiac Conditioning Education Classes Cardiac Conditioning (7597)	157	0	157	29	1
Clinical Research: Generalizable Research Clinical Research (8026)	964,819	146,706	818,113	2	2
Diabetes: Community Education Diabetes Center (7771)	1,325	0	1,325	242	4
Diabetes: Community Health Fairs Diabetes Center (7771)	1,092	0	1,092	2	2
Diabetes: Diabetes Support Groups Diabetes Center (7771)	779	0	779	111	9
Diabetes: Nursing Education Diabetes Center (7771)	624	0	624	106	3
Emergency Services: EMS Base Station Coordination Emergency Services (7011)	807,142	0	807,142	3,138	365
Health System: Administrative Intern UC Berkeley Health System Facilities (8340)	16,421	0	16,421	1	1
Health System: Conference Room Donations Health System Facilities (8340)	40,450	0	40,450	45	622
Health System: Donations - Broader Health System Facilities (8340)	84,777	0	84,777	224	12
Laboratory: Donations Laboratory (7500)	22,041	0	22,041	5	1
Laboratory: Health Career Support Lab Services Education (8744)	18,075	0	18,075	2,400	40
Neurosciences: Board Participation Neurosciences (8759)	3,003	0	3,003	1	1
Neurosciences: Community Health Fairs Neurosciences (8759)	1,246	0	1,246	1	1
Neurosciences: Community Presentations & Outreach Neurosciences (8759)	6,231	0	6,231	446	7
Neurosciences: Information and Referral Assistance Neurosciences (8759)	3,115	0	3,115	1	1
Nursing Education: Nursing Students Education & Training - CC Nursing Education - JMCC (8741)	895,205	0	895,205	215	30
Nursing Education: Nursing Students Education & Training - WC Nursing Education - JMWC (8742)	1,218,650	0	1,218,650	414	1
Nutrition Services: Community Presentations Nutrition Services (8341)	336	0	336	45	12
Orthopedics: Community Outreach Orthopedics Rehabilitation (8754)	3,829	0	3,829	1	1

**John Muir Health**  
**Programs Targeted For...Broader Community**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs	
	Expenses	Offsets	Benefit	Persons	Encounters
Orthopedics: Physician Education Orthopedics Rehabilitation (8754)	62,739	26,895	35,844	400	1
Osteoporosis Center: Osteoporosis Lectures Osteoporosis Center (6009)	373	0	373	30	1
Pharmacy: Medication Presentations (JMCC) Pharmacy - JMCC (8390)	2,792	0	2,792	40	11
Pharmacy: Student Rotations (JMCC) Pharmacy - JMCC (8390)	54,714	0	54,714	9	2
Pharmacy: Student Rotations (JMWC) Pharmacy - JMWC (8391)	35,540	0	35,540	6	1
Physicians Network: Community Education and Seminars John Muir Physician Network (8966)	3,609	0	3,609	30	6
Pulmonary Rehabilitation: Clinical Rotations Pulmonary Rehabilitation (7088)	11,300	0	11,300	150	1
Pulmonary Rehabilitation: Community Health Fairs Pulmonary Rehabilitation (7088)	4,607	0	4,607	2	2
Pulmonary Rehabilitation: Support Groups Pulmonary Rehabilitation (7088)	7,794	0	7,794	95	48
Pulmonary Rehabilitation: Workforce Development Pulmonary Rehabilitation (7088)	1,948	0	1,948	100	15
Rehab-Inpatient: Clinical Internships (CC) Inpatient Rehabilitation (7770)	157,750	0	157,750	8	236
Rehab-Inpatient: High School Presentations and Job Shadowing Inpatient Rehabilitation (7770)	2,807	0	2,807	52	3
Rehab-Outpatient: Clinical Internships Outpatient Rehab (7772)	7,169	0	7,169	15	1
Rehab-Outpatient: Community Caregiver Training Brentwood Rehabilitation (7208)	156	0	156	15	1
Rehab-Outpatient: Community Outreach Outpatient Rehab (7772)	18,784	0	18,784	246	153
Rossmoor: Meeting Room Space Rossmoor Outpatient Center (8972)	837	0	837	12	333
Senior Services: AARP Driving Safety Training Senior Services (8792)	21,271	0	21,271	788	38
Senior Services: Blood Pressure Screening Senior Services (8792)	32,101	0	32,101	2,695	176
Senior Services: Community Education Seminars Senior Services (8792)	23,309	0	23,309	1,301	67
Senior Services: Fall Prevention (Broader) Senior Services (8792)	18,154	0	18,154	75	6
Senior Services: Health Fairs Senior Services (8792)	12,088	0	12,088	3,428	22
Senior Services: Health Insurance Counseling and Advocacy Program Senior Services (8792)	10,675	0	10,675	61	11

5/10/2012

John Muir Health

Programs Targeted For...Broader Community

For period from 1/1/2011 through 12/31/2011

<u>Title / Department</u>	<u>Monetary Inputs</u>			<u>Outputs</u>	
	<u>Expenses</u>	<u>Offsets</u>	<u>Benefit</u>	<u>Persons</u>	<u>Encounters</u>
Senior Services: Information and Referral Assistance Senior Services (8792)	235,400	0	235,400	14,443	14,252
Senior Services: Memory Screening Senior Services (8792)	22,998	0	22,998	255	50
Senior Services: Newsletter Senior Services (8792)	86,094	0	86,094	42,499	3
Senior Services: Outreach/Public Speaking Senior Services (8792)	10,053	0	10,053	260	15
Senior Services: Patient Navigator Program Senior Services (8792)	120,146	0	120,146	1,052	2,065
Senior Services: Senior Health Focus Days Senior Services (8792)	10,675	0	10,675	95	3
Social Services: ACMA Board Member Social Services (8361)	1,871	0	1,871	1	12
Social Services: American Cancer Society Breast Cancer Walk Social Services (8361)	311	0	311	1	1
Social Services: Field Supervisor Social Services (8361)	134,678	0	134,678	2	2
Spiritual Care: Bereavement Correspondence Spiritual Care (8680)	6,220	0	6,220	339	1
Spiritual Care: Clinical Pastoral Education Spiritual Care (8680)	231,477	0	231,477	20	1
Spiritual Care: Grief Support Groups Spiritual Care (8680)	10,463	0	10,463	120	24
Trauma: Bikes for Tykes Helmet Distribution Trauma (7016)	1,325	0	1,325	317	1
Trauma: Car Seat Fitting Station Trauma (7016)	133,006	0	133,006	2,115	1,270
Trauma: Car Seat Safety Coalition Trauma (7016)	6,516	0	6,516	25	2
Trauma: Car Seat Safety Technician Certification Training Trauma (7016)	27,196	0	27,196	72	4
Trauma: Every 15 Minutes Trauma (7016)	31,010	0	31,010	6	6
Volunteer Services: School Tours for Students Volunteer Services (8671)	4,304	0	4,304	423	18
Women's Health Center: Community Based Clinical Services Women's Health Center (7405)	152,057	350	151,707	288	50
Women's Health Center: Community Health Education Women's Health Center (7405)	2,940,657	414,500	2,526,157	29,545	1
Women's Health Center: Health Care Support Services Women's Health Center (7405)	20,657	16,605	4,052	640	1
Women's Health Center: In Kind Donations Women's Health Center (7405)	6,575	0	6,575	10	1

**John Muir Health**  
**Programs Targeted For...Broader Community**  
**For period from 1/1/2011 through 12/31/2011**

<u>Title / Department</u>	Monetary Inputs			Outputs		
	Expenses	Offsets	Benefit	Persons	Encounters	
Workforce Development: Coalition Building Workforce Development (8654)	4,129	0	4,129	14	15	
Workforce Development: Donations for Health Career Promotion Workforce Development (8654)	39,600	0	39,600	7,351	19	
Workforce Development: Health Career Student Support Workforce Development (8654)	101,553	0	101,553	9,076	276	
Workforce Development: In-Kind Donations Workforce Development (8654)	72,528	0	72,528	2,153	110	
Workforce Development: Leadership Development and Training Workforce Development (8654)	7,932	0	7,932	30	2	
Workforce Development: Mentorships and Internships Workforce Development (8654)	331,902	0	331,902	144	17	
<b>Number of Programs 94</b>	<b>Grand Totals</b>	<b>10,120,146</b>	<b>607,536</b>	<b>9,512,610</b>	<b>132,050</b>	<b>20,607</b>

***Attachment H – Economic Valuation Tables***  
***3. Community Partner Organizations***

John Muir Health collaborates with the following organizations:

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

- San Ramon Valley High School
- Senior Alternatives
- St. Francis of Assisi Catholic Church, Concord
- St. John Vianney Catholic Church, Walnut Creek
- STAND! for Families Free of Violence
- Sycamore Place (HUD housing)
- The Williams Group
- Tice Valley Oaks (HUD housing)
- Trader Joe's
- Walnut Creek Senior Club
- We Care Services
- Welcome Home Baby
- Women, Infants and Children (WIC) Pittsburg
- Women's Initiative, Concord
- Ygnancio Pathology Medical Group
- Youth Intervention Network, Antioch

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



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

**Purpose:**

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Policy:**

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

## **Procedures**

### ***Scope of Policy***

#### Services Eligible Under This Policy

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

John Muir Health does not **provide patient assistance for the professional fees charged by physicians and other providers for their services,** even if those services were rendered at a **John Muir Health facility. In accordance with California Health and Safety Code, emergency physicians who provide emergency medical care at John Muir Health are required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the Federal Poverty Guideline (FPG). Detailed policies for emergency physician discounts shall be maintained by the individual physicians or their representative networks.**

### **Community Benefit**

**The John Muir Health Patient Financial Assistance Program is intended to assist members of the local community in paying for necessary healthcare services. This**

policy shall not apply to patients outside of the community except on a case-by-case basis to be determined by JMH Business Office management.

### *Communication of Patient Financial Assistance Options*

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

### *Patient Financial Assistance - Patient Application*

#### Financially Qualified Patients

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

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

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

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

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

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

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

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

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

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

#### Patient Responsibility for **Patient Financial Assistance**

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

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

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

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

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

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

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

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

#### ***Under-insured Patients***

**For patients with high deductibles or non-covered services, John Muir Health will investigate the patient's health plan to determine if Patient Financial Assistance discounts are allowed. The patient may be required to submit a financial assistance application in order to receive a discount. Per California Health and Safety Code, a patient is eligible to apply for a discount if his or her income is at or below 350% of the FPG and his or her annual out-of-pocket costs for medical expenses exceed 10% of his or her household income in the prior 12 months. Exception-based discounts may be issued on a sliding scale from 0-100% at the discretion of JMH Business Office staff and management.**

##### **1. Eligibility Period**

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

##### **2. Refund of Amounts Previously Paid**

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

3. Appeal Regarding Application of this Policy  
In the event any patient believes his or her application for **Patient Financial Assistance** was not properly considered in accordance with this Policy, or he or she otherwise disagrees with the application of this Policy in his or her case, a patient may submit a written request for reconsideration to the Vice-President, Revenue Cycle, and then to the Chief Financial Officer of John Muir Health, who shall be the final level of appeal.
4. Non-Discriminatory Application of this Policy  
Any decisions made under this Policy, including the decision to grant or deny financial assistance under this Policy, shall be based on an individualized determination of financial need, and shall not take into account race, **color, national origin, citizenship, religion, creed**, gender, sexual preference, age, or **disability**.
5. Application by the Patient
  - a. Financial Counselors, upon discovery of the patient's financial circumstances during the patient interview, will advise the patient of the Patient **Financial Assistance** Program and the availability of financial assistance under this Policy
  - b. Patients will be informed of available assistance through a standard message placed on the patient's bill, as well as through a handout available at the Medical Centers, **through the Business Office and/or through the John Muir Health Internet site**.
  - c. The Patient **Financial Assistance** Program's availability and referral numbers will be placed within any notification on John Muir Health's internet site, the patient's bill, or the available handout.
  - d. Notice of availability of financial assistance and instructions for patient screening will be posted in the Emergency Room, and the main Admitting Department lobby of the Medical Centers, as well as in the offsite business office and other outpatient sites, as appropriate.
  - e. Other venues may be **used** to educate and inform the patient and/or physician population of the availability of the Patient **Financial Assistance** Program as deemed appropriate
  - f. Patient, or a patient's guardian or legal conservator, may apply to the Patient **Financial Assistance** Program by calling the **JMH Business Office** and requesting an application from a program representative, or by requesting an application from a financial counselor on site at the Medical Centers
  - g. A patient may apply for multiple outstanding balances on the same application.
  - h. Applications may not be submitted more than six (6) months following the first patient statement date.**
  - i. John Muir Health will review Patient Financial Assistance applications monthly for approval.** Balances approved will be submitted for write-off to a transaction code assigned to Patient **Financial Assistance**, and will follow the signature authority of the John Muir Health Write-Off Guidelines.
  - j. Any recoveries to an account which has qualified and was absorbed under the Health System's Patient Assistance Program will have the amount of the recovery reversed from the Patient **Financial Assistance** adjustment code to ensure the diminished Charity Care is reflected appropriately in the general ledger.

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

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

**OR**

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

**OR**

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

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

**Documentation: Patient Financial Assistance Application**

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

*Attachment I- Community Assessment*

## 2010 Community Assessment Summary

### **How Do We Define Our Community?**

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

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

### **How is the Triennial Assessment Conducted?**

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

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

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

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

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

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

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

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

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

#### **What are the needs in the service area?**

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

#### **Where are the needs greatest?**

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

- Cancer deaths in Antioch, Concord, Oakley, Pittsburg and Brentwood
- Heart disease deaths in Antioch, Oakley, Pittsburg, Concord and Martinez
- Stroke deaths in Antioch, Pittsburg, Concord and Oakley
- Breast Cancer deaths in Brentwood, Antioch, Pittsburg and Concord
- Lung Cancer deaths in Oakley, Antioch, Pittsburg and Concord
- Teen birth rates in Antioch, Concord, Bay Point and Brentwood
- Overweight 5<sup>th</sup> graders in Antioch and Pittsburg
- Diabetes death in Antioch and Pittsburg
- Non-fatal assault hospitalizations in Antioch, Pittsburg, Richmond and Concord
- Homicide deaths in Antioch and Pittsburg
- Hospitalization due to fall age 65+ in Antioch, Pleasant Hill, Martinez, Concord and Walnut Creek
- African Americans are most significantly impacted by health disparities and have a shorter life expectancy

## **Implementation Strategy/Community Benefit Plan**

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

### **Where Is John Muir Focusing Its Efforts?**

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

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

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

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

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

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

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

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

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

1. Incidence/Prevalence (How many people are affected?)
  - a. Growing need
  - b. Worsening trend
  - c. Affects vulnerable populations
  - d. There are health disparities

- e. The problem adversely impacts the individual, his/her family and community
2. There are few resources targeting this issue
  - a. There are gaps in service
  - b. This issue has experienced reduced funding
3. JMH is well-positioned to address this issue
4. If we were to address this issue, we will have a visible impact
5. Leveraging partnerships and community resources

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

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

Our Community Benefit goals for 2012-14 are as follows:

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

Strategies for 2012-2014:

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

### **How are John Muir Health community benefit programs delivered?**

Programs are delivered through two organizations:

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

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

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

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

## Community Needs Not Addressed

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

John Muir Health is also committed to supporting and complementing effective community programs with staff expertise, technical assistance or financial resources in order to avoid duplication or undertaking programs for which other organizations are better suited to succeed and make a difference. In selecting community benefit programs, John Muir Health matches the community needs with its internal skills, resources, and community partnership expertise.

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

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

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

Central and East Contra Costa County health care providers include:

- John Muir Health with medical centers in Concord and Walnut Creek and outpatient centers in Brentwood, Concord and Walnut Creek
- Kaiser Permanente with medical centers in Antioch, Walnut Creek and Richmond
- Sutter Delta Medical Center, Antioch
- Contra Costa Regional Medical Center with outpatient clinics in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg and Richmond
- La Clinica de la Raza, Inc., a federally qualified health center (FQHC) with clinics in the Monument area of Concord and Pittsburg. An additional clinic site in Oakley will open in fall 2011
- Brookside Community Health Center, a FQHC, with clinics in San Pablo and Richmond (all in West County and out of the John Muir Health primary service area)
- RotaCare Free Clinics, Concord and Pittsburg
- Planned Parenthood offering with sites in Concord, Antioch
- San Ramon Medical Center, San Ramon

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

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

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