2018 Community Benefit Report

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

Prepared May 2019

JOHN MUIR HEALTH

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Executive Summary

John Muir Health is a community-based, not-for-profit, health system that is governed locally in Contra Costa County. John Muir Health's mission to *improve the health of the communities we serve with quality and compassion* accurately reflects our community health efforts as a corporate leader and community partner.

Community Benefit is a term used to describe the many health programs and medical services supported totally or in part by John Muir Health that provide tangible benefits to the community and improve the health of its residents. Community Benefit contributions include activities at John Muir Medical Center, Walnut Creek, John Muir Medical Center, Concord, John Muir Health Behavioral Health Center, John Muir/Mt. Diablo Community Health Fund and John Muir Physician Network.

We are equally proud of our diverse programs, collaborations and contributions that help to improve access to health care and the overall health of the most vulnerable residents in our community. As a not-for-profit, community-based health system, addressing community needs is rooted in our values. Many of our physicians, nurses, staff and volunteers serve the community well beyond their time at work. Our support and many partnerships are woven into the fabric of the communities we serve.

Overall, in 2018, we contributed over $129 million to our Community Benefit activities, with 89% going specifically towards those facing barriers to health and wellness. These are much more than numbers. We are continually assessing the effectiveness of our programs to ensure they are having the intended impact. Each program provides direct benefits to individuals and families, and leads to a healthier community.

John Muir Health develops collaborative partnerships with local organizations in order to be responsive to the needs of the most vulnerable and underserved populations in our community. We conduct a comprehensive Community Health Needs Assessment and Community Health Improvement Plan every three years in order to guide our community benefit investments and measure community health improvement. For comprehensive details on our community programs for vulnerable populations, refer to attachment D.

In addition to these community benefit programs, John Muir Health contributes $1 million a year to the John Muir/Mt. Diablo Community Health Fund, whose goal is to foster systemic change to improve the health of people in Central and East Contra Costa County who are most likely to experience health care disparities.

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

Who is John Muir Health?

About John Muir Health

John Muir Health includes two of the largest medical centers in Contra Costa County: John Muir Medical Center, Walnut Creek, a 554-licensed bed medical center that serves as Contra Costa County's only designated trauma center; and John Muir Medical Center, Concord, a 245-licensed bed medical center in Concord. Together, they are recognized as preeminent centers for neurosciences, orthopedics, cancer care, cardiovascular care and high-risk obstetrics. John Muir Health also offers complete inpatient and outpatient behavioral health programs and services at our Behavioral Health Center, a fully accredited, 73-bed psychiatric hospital located in Concord.

Other areas of specialty include general surgery, robotic surgery, weight-loss surgery, rehabilitation and critical care. All hospitals are accredited by The Joint Commission, a national surveyor of quality patient care. In addition, John Muir Health provides a number of primary care and outpatient services throughout the community and urgent care centers in Brentwood, Concord, San Ramon and Walnut Creek.

The John Muir Physician Network is a not-for-profit medical foundation with more 1,000 primary care and specialist physicians. The physicians associated with the John Muir Physician Network belong to John Muir Medical Group, John Muir Health Multispecialty Medical Group, John Muir Health Cardiovascular Medical Group or are independent physicians practicing in our community. These physicians accept all HMO and most PPO insurance plans, as well as Medicare.

The Physician Network owns and operates practices staffed by foundation physicians in locations from Brentwood to Livermore to Oakland, including outpatient centers in Brentwood, Concord, Pleasanton, Tice Valley/Rossmoor and Walnut Creek. The Physician Network also provides hospitalists (in-patient medical services) at John Muir Health’s two hospitals and partner hospital, San Ramon Regional Medical Center.

John Muir Medical Group's 350 clinician members work within the John Muir Health System’s hospitals, urgent care and outpatient clinics in multiple specialties, mostly in primary care.

John Muir Health partners with other leading health care organizations, including UCSF Health, Tenet/San Ramon Regional Medical Center and Stanford Children’s Health to expand its capabilities, increase access to services and better serve patients. For more information, visit www.johnmuirhealth.com.

Mission, Vision, Values

The John Muir Health mission serves as the foundation for directing the organization's Community Benefit activities.

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

John Muir Health's vision is to exceed our patients' expectations for seamless, consistently positive experiences with all aspects of John Muir Health. We will distinguish ourselves by:

- Providing quality health care services and an exceptional experience to our communities, and creating value- driven, regional centers of excellence.
- Delivering pre-eminent tertiary services and advanced medical technology.
- Delivering on our brand promise: We listen. We explain. We work together as a team.
- Providing highly reliable health care services that promote safety and the prevention of error.
- Attracting and retaining quality physicians and employees to deliver excellent medical care.
- Fostering an organizational culture that respects employees, supports them in developing their skills and talents, and encourages superior performance.
- Providing stewardship of resources and maintaining a strong financial position consistent with our mission.
- Partnering with physicians to strengthen both John Muir Health and physicians in our unified purpose to improve the delivery of care.
- Building alliances that create healthier communities.
- Ensuring locally-controlled health care.

John Muir Health's ten core values that guide the Board of Directors, management and employees in their efforts are: *Excellence; High Reliability; Honesty and Integrity; Mutual Respect and Teamwork; Listening, Explaining and Working together as a team; Caring and Compassion; Commitment to Patient Safety; Continuous Improvement; Stewardship of Resources;* and *Access to Care.*

Community Commitment

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

John Muir Health views its commitment to community service initiatives as core to our mission. This commitment is seen through every facet of the organization from volunteers to physicians, in our emergency departments, and in our outpatient centers.

Most clinical service lines lead and operate a community service initiative. For example, our Trauma Department leads the hospital-based violence intervention program, Beyond Violence. John Muir Health's Magnet® recognized nurses, the highest recognition in nursing, are leaders in community services through their initiatives to promote health and wellness outside the hospital. Employees contribute when they participate in departmental programs, when they volunteer for John Muir Health-sponsored community events, and when they volunteer in their own communities to make them better places to live and work.

About Community Benefit at John Muir Health

The Community Health Improvement department serves as the steward for John Muir Health's charitable purposes by assisting the community in achieving optimal health through education, collaboration, and health and wellness programs and services. Community Health Improvement works in partnership with local communities, other health systems, public health providers, community clinics, community-based organizations and school districts to identify and address unmet health needs among vulnerable populations. Community Health Improvement's main roles are to coordinate the John Muir Health community benefit planning process and to act as the liaison to the community-at-large, which enables John Muir Health to align resources and strategies to better impact its goal of creating healthy communities.

The Community Benefit Oversight Committee (CBOC) provides governance for all community benefit activities. CBOC is comprised of executive leaders from across the health system and key community leaders. Additionally, John Muir Health administration and the John Muir Health Board of Directors oversee community benefit through frequent reporting.

How Do We Define Our Community?

John Muir Health's primary and secondary service areas extend from Solano County into Contra Costa County to San Ramon in southern Contra Costa County and into the Tri-Valley area, which includes northern Alameda County. John Muir Health's Trauma Center serves all of Contra Costa County, as well as southern Solano County and is the backup Trauma Center for Alameda County. The map of the John Muir Health service area is included in attachment C.

The primary focus of our Community Benefit programs is on the needs of vulnerable populations. We define vulnerable populations as those with evidenced-based disparities in health outcomes, significant barriers to care and the economically disadvantaged.

What Are the Needs of Our Community?

Community Health Needs Assessment

John Muir Health has long valued a systematic approach for identifying community health needs in order to guide thoughtful and effective Community Benefit investment for years to come. In 2016, John Muir Health conducted another triennial Community Health Needs Assessment (CHNA) in response to the federal requirements described in section 501(r)(3) of the Internal Revenue Code and the requirements of California Senate Bill 697, enacted in 1994. This 2016 CHNA guides our implementation strategy of programming from 2018-2019. The 2016 CHNA continues John Muir Health's long-standing commitment to the communities we serve by understanding their needs and assets in order to define where and how John Muir Health community investments can have the greatest impact.

All John Muir Health entities collaborated with Kaiser Permanente Diablo Area and East Bay Area, St. Rose Hospital, San Ramon Regional Medical Center, Stanford Health Care ValleyCare, UCSF Benioff Children's Hospital Oakland, and Washington Hospital Healthcare System. The process included comprehensive review of secondary data on health outcomes, drivers, conditions and behaviors in addition to the collection and analysis of primary data through community conversations with members of vulnerable populations in our service area. We gathered input on the identified community health needs and the relative priority among them, through a convening of public and community health leaders, advocates and experts. The resulting prioritized list represents a community understanding informed by both data and experience with particular relevance for vulnerable populations in the John Muir Health service area (listed in priority order).

1. Obesity, diabetes, healthy eating and active living
2. Economic security
3. Healthcare access and delivery, including primary and specialty care
4. Oral/Dental health
5. Mental health
6. Substance abuse, including alcohol, tobacco, and other drugs
7. Unintentional injuries
8. Violence and injury prevention

The CHNA report was approved by the Board of Directors in November 2016.

The 2016 CHNA report is available to the public on John Muir Health's website: http://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html

In 2019, a subsequent CHNA will be conducted to guide programming from 2020-2022.

Ongoing Community Input

John Muir Health stays abreast of current health issues of importance to the community by active participation within the Dental Collaborative of Contra Costa, Access to Care Stakeholders, East Central Contra Costa Access Action Team, Healthy and Active Before 5, Families Coalition for Activity and Nutrition, Mobile Health Clinic Association Northern California Roundtable, and other ongoing collaborations. These sources of information provide current information regarding community health status and also help identify emerging needs in the service area population.

Where Is John Muir Health Focusing Its Efforts?

Community Health Improvement Plan

In 2016, John Muir Health adopted a triennial Community Health Improvement Plan in response the health needs identified in the 2016 CHNA report. The Community Health Improvement Plan serves as the triennial implementation strategy for John Muir Health hospitals: John Muir Health Medical Center, Walnut Creek, John Muir Health Medical Center, Concord and John Muir Health Behavioral Health Center.

In 2016, John Muir Health convened the CHNA Advisory Committee, comprised of John Muir Health leadership and community health experts. The CHNA Advisory Committee reviewed the CHNA report and utilized established criteria to select the community health needs that John Muir Health would address as an organization from 2018-2019:

- Healthcare access and delivery, including primary and specialty care
- Behavioral health, including mental health and substance abuse
- Obesity, diabetes, healthy eating and active living

The Community Health Improvement Plan (attachment D) includes long and short term goals, strategies, anticipated impacts and metrics associated with each John Muir Health selected community health need.

The Board of Directors approved the Community Health Improvement Plan in November 2016.

The Community Health Improvement Plan is available on John Muir Health's website: http://www.johnmuirhealth.com/about-john-muir-health/community-commitment.html
The Community Health Improvement Plan also serves as the foundation for annually evaluating the impact of our Community Benefit investments through measurable annual objectives and time frames. Please see the Community Health Improvement Plan annual update that includes 2018 program year-end results and 2018 program objectives in attachment D.

Community Benefit Guiding Principles

Community Benefit focus area selection is guided by the John Muir Health Community Benefit Oversight Committee. The Committee 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. The Committee annually reviews community assessment data and program evaluations, and makes recommendations for program funding in the annual budget process.

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

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

Economic Valuation of Community Benefit

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

Community Benefit is a term used to describe the many health programs and medical services supported totally or in part by John Muir Health that provide tangible benefits to improve the health of the community.

John Muir Health follows the guidelines developed by the Catholic Healthcare Association for reporting the economic value of its Community Benefit contributions. John Muir Health uses a cost accounting methodology that aligns with Catholic Health Care Association guidelines for community benefit accounting and industry best practices. Program costs are tracked and reported using CBISA, a community benefit database. Indirect costs are applied based on data obtained through the cost accounting system.

The cost of charity care is calculated using annual charity care charges pursuant John Muir Health's financial assistance policy, patients eligible for presumptive charity care, and an annual cost to gross charge ratio that is based on total operating expenses divided by gross charges. The unpaid cost of Medi-Cal is calculated using the total cost of care, as determined by the cost to gross charge ratio, minus the total payment received from the Medi-Cal program.

2018 John Muir Health Community Benefit Contributions

The economic valuation of Community Benefit contributions includes Community Benefit activities provided by all John Muir Health entities: John Muir Medical Centers, Concord and Walnut Creek, the Behavioral Health Center, John Muir Physician Network and John Muir/Mt. Diablo Community Health Fund. Contributions are shown for Fiscal Year 2018 in total and then detailed by program categories. These categories align with the IRS Form 990, Schedule H. A separate 2018 Form 990, Schedule H will be submitted for John Muir Health and for John Muir Health Behavioral Health Center.

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

Community Benefits by Activity Type – Form 990	**Total Benefit**
Charity Care	$5,596,095
Unpaid Costs of Medi-Cal	$99,823,740
Subsidized Health Services	$6,057,263
Community Health Improvement	$6,865,109
Community Building	$393,752
Financial and In-Kind Contributions	$2,674,220
Health Professions Education	$5,689,776
Research	$1,593,548
Community Benefit Operations	$1,268,405
TOTAL COMMUNITY BENEFIT	**$129,961,908**
Unpaid Costs of Medicare (not included in total)	$420,674,252

Community Benefits by Population Served - OSHPD	**Total Benefit**
Charity Care	$5,596,095
Unpaid Costs of Medi-Cal	$99,823,740
Vulnerable Community	$9,957,641
Broader Community	$7,301,108
Health Professions Education & Research	$7,283,324
TOTAL COMMUNITY BENEFIT	**$129,961,908**
Unpaid Costs of Medicare (not included in total)	$420,674,252

Non-Quantifiable Benefits

John Muir Health contributes many non-quantifiable benefits. The health system continually provides leadership in the community, assists with local capacity building and participates in community-wide health planning. John Muir Health staff are actively involved in community organizations as volunteers to address the needs of the vulnerable and underserved. The following are examples of non-quantifiable benefits provided to the community in 2018:

- John Muir Health's commitment to environmental sustainability is evident through many initiatives. John Muir Health maintained forty vehicle charging stations to reduce fuel consumption and carbon dioxide emissions. John Muir Health is installing a photovoltaic solar system on the roof of the Walnut Creek Medical Center's parking garage, producing 580,000 kilowatt hours of power annually.
- John Muir Health nurses are deeply involved in their community through volunteering. John Muir Health encourages nursing volunteerism through Magnet® recognition status where nurses build partnerships with the community. For example, our nurses provide health education at community events and participate as volunteers on our Mobile Health Clinic.
- John Muir Health employees donate backpacks with school supplies to foster youth through the annual Foster a Dream Backpack challenge. In 2018, employees provided over 550 backpacks to Foster a Dream.
- John Muir Health and our employees actively participate in disease awareness events in order to promote health in our community. Events in 2018 included, the Light the Night Leukemia Walk, National Alliance on Mental Illness Walk, Sweep Away Stigma community service, American Heart Association Heart Walk, Go Red community event, and others.

How to Contact Us

Please contact us with feedback regarding John Muir Health's Community Benefit programs and services by emailing Community.Benefit@johnmuirhealth.com.

Attachments

Attachment A – Economic Valuation of Community Benefit – Detailed

PURPOSE	DESCRIPTION	CONTRIBUTION AMOUNT
CHARITY CARE	Charity care is providing health care services for those that have no insurance and are otherwise unable to pay. John Muir Health provides charity care through its Concord and Walnut Creek medical centers for people regardless of their ability to pay. This includes the critical emergency and trauma services at our medical center campuses. The amount listed are costs not charges.	$5,596,095
GOVERNMENT SPONSORED HEALTH CARE (UNPAID COSTS OF MEDI-CAL)	John Muir Health provides care for patients who participate in government-sponsored programs such as Medi-Cal. The payment received from these programs rarely covers the full cost of services provided to these patients. As a Community Benefit, John Muir Health absorbs the difference between the cost (not charges) and the payment. In addition Medicare does not cover all the health care costs for patients over 65 years old. The Medicare costs are not included here.	$99,823,740
SUBSIDIZED HEALTH SERVICES	In some cases John Muir Health provides services at a loss because the service is the only available resource in the community. We consider these losses a community benefit. Subsidized services include the Emergency Medical Services, Behavioral Health Services, ambulance base station for the county at John Muir Medical Center, Walnut Creek.	$6,057,263
COMMUNITY HEALTH IMPROVEMENT	John Muir Health also supports a wide range of activities and resources that promote health and wellness, including health education, libraries, and support groups. John Muir Health provides the community an array of resources including health care professionals, mobile health services, health information and education services.	$6,865,109
COMMUNITY BUILDING	Community Building includes workforce development activities and community collaborative development.	$393,752

FINANCIAL AND IN-KIND CONTRIBUTIONS	Financial and In-kind contributions are donations to community based-organizations and in-kind donations of supplies, facilities and staff time.	$2,674,220
HEALTH PROFESSIONS EDUCATION	Community Benefit also includes health professions education programs in the areas of nursing, physical therapy, ultrasound technology, radiologic technology, rehabilitation, clinical pastoral care, and other health professions.	$5,689,776
RESEARCH	Research includes clinical research funded by government agency or tax-exempt organizations where findings are available to the public.	$1,593,548
COMMUNITY BENEFIT OPERATIONS	In order to coordinate our Community Benefit planning and execution of programs to maximize their impact, John Muir Health also supports a dedicated staff and their office operations.	$1,268,405
TOTAL		**$129,961,908**

Attachment B – Board Lists

John Muir Health
2019 Board of Directors

JOHN MUIR HEALTH
JOHN MUIR PHYSICIAN NETWORK
JOHN MUIR BEHAVIORAL HEALTH
Effective January 1, 2019

Community Members–voting

Robert E. Edmondson, Chair & Treasurer
Kathleen Odne, Vice Chair
John Sayres, Secretary
Roger Bailey
Anne Grodin
Jay Harris
Calvin (Cal) Knight (CEO)
Michael Robinson
Jack Thompson

Physician Members-voting

Taejoon Ahn, M.D.
Ravi Hundal, M.D.
John Merson, M.D.
Mark Musco, M.D.
Chi Perlroth, M.D.
Johannes Peters, M.D.

Ex-Officio non-voting

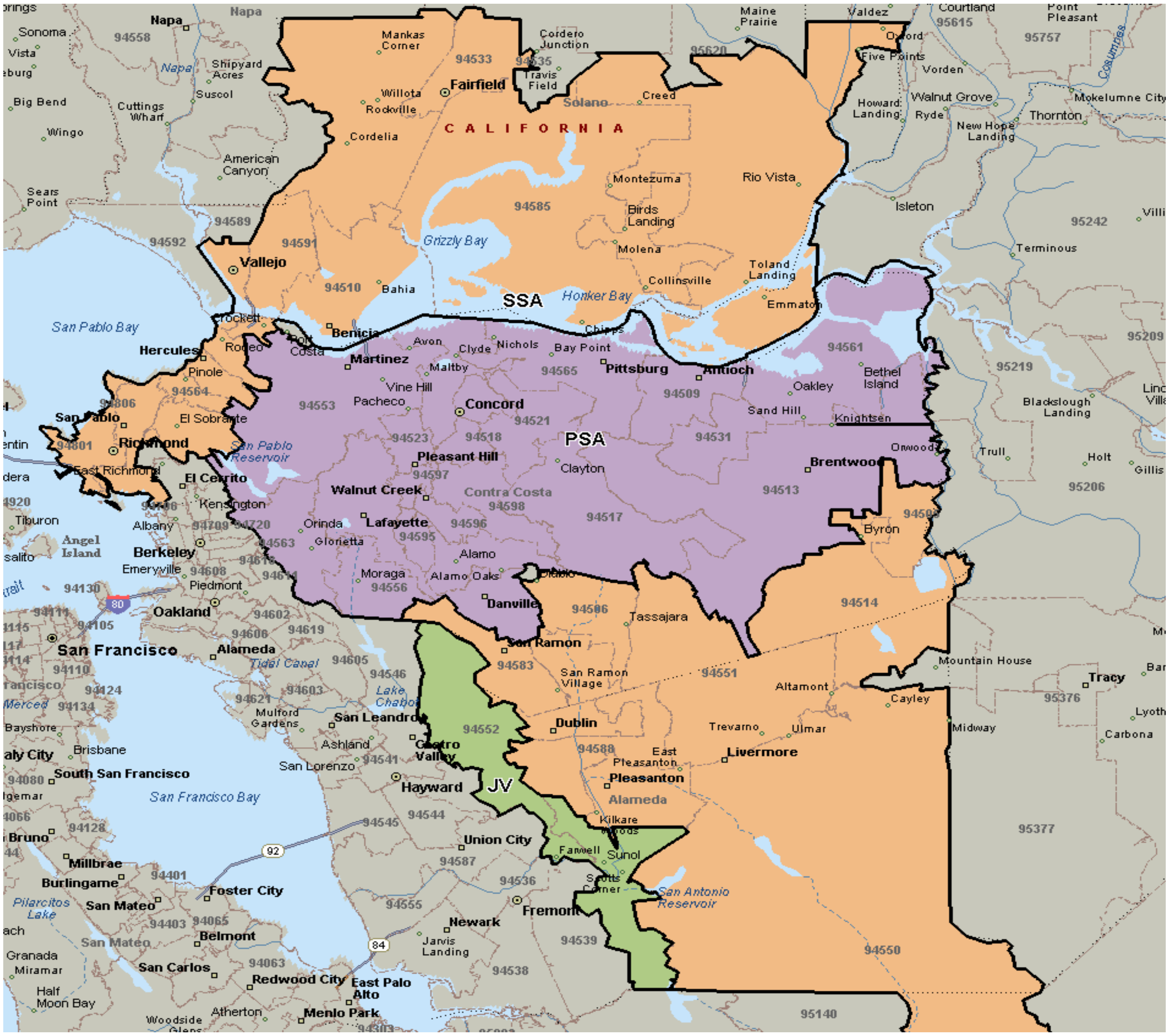
Deborah Arce, M.D.
Yaron Friedman, M.D., Walnut Creek Campus Chief of Staff
Niren Angle, M.D., Concord Campus Chief of Staff
Lee Huskins, President & CAO for JMHPN

John Muir/Mt. Diablo Community Health Fund
2019 Board of Directors

Officers and Directors

Ken Carlson, Chairman
Drew Robinson, Vice Chairman
Ernesto Avila, Treasurer
Arthur Shingleton, Secretary
Dominic Aliano
Edi Birsan
Gail Cristancho
Carolyn Fong, RN, NP, PhD
Rina Shah, MD

Attachment C – Map of Community Benefit Service Area



Attachment D – John Muir Health Community Health Improvement Plan:

2018 Year End Results and 2019 Objectives

John Muir Health Community Health Improvement Plan
2018 Year End Results & 2019 Objectives

The Community Health Improvement Plan includes initiatives and community based programs operated or substantially supported by John Muir Medical Center, Walnut Creek, John Muir Medical Center, Concord and John Muir Health Behavioral Health Center. Programs were developed in response to the 2016 Community Health Needs Assessment, internal data and community partner input.

All programs focus on the following three priority areas:

1. Healthcare access and delivery, including primary and specialty care
2. Behavioral Health, including mental health and substance abuse
3. Obesity, diabetes, healthy eating and active living

The following 2018 year end results and 2019 objectives are outlined by each of three identified community health needs, their associated long term and intermediate goals. Select program outcomes from 2018 are provided in the tables below.

Community Health Need:	**Healthcare access and delivery, including primary and specialty care**
Long Term Goal:	Increase access to appropriate health care and health care support services for low-income children, adults, and seniors.
Intermediate Goals:	1. Increase access to comprehensive primary care for vulnerable adults. 2. Increase access to specialty care services for vulnerable adults. 3. Increase access to health care support services for vulnerable children and adults.

Mobile Health Clinic: Provide comprehensive primary care for vulnerable adults who are unable to access care due to inadequate insurance coverage, availability of services, timeliness of appointments or accessibility.

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

2018 Objectives	Outcomes
1. Mobile Health Clinic will serve 400 people during Saturday Clinic. 2. The Mobile Health Clinic target goal is to serve 2,000 patients through partnership programs.	• Mobile Health Clinic served 407 people during Saturday Clinic. • The Mobile Health Clinic served 2,890 patients through partnership programs (RotaCare and Healthcare for the Homeless).

3. 100% of services will meet the linguistic needs of the population served.	• 76% of patients were non-English speaking and 100% of services met their linguistic needs (primarily Spanish).
4. 95% of patients will be uninsured.	• 96% of patients served were uninsured.
5. 100% of patients who need additional care will be referred to a specialist or other health organization (report on referrals rates).	• 100% of patients who needed additional care were referred to a specialist or other health organization.
6. 50% of referrals will be tracked and monitored by MHC staff and among them, 75% will report follow-through with the referral.	• 100% of referrals were tracked and monitored by MHC staff and among them, 39% reported follow-through with their referral.
7. 90% of patient survey respondents will report high levels of satisfaction on services received.	• 94% of patient survey respondents reported high levels of satisfaction on services received.
8. 90% of patient survey respondents will report high levels of satisfaction on services offered.	• 94% of patient survey respondents reported high levels of satisfaction on services offered.
9. The Mobile Health Clinic will reduce the number of avoidable Emergency Department visits.	• If the Mobile Health Clinic was not available, 24% of patients reported that they would have sought care at the Emergency Department.

2019 Objectives

- All objectives remain the same for 2019.

<u>Community Nurse Program</u>: Provide health care support services for children in schools that serve low-income families.

FY10 Baseline: During the 2009-2010 school year, the Community Nurse received 309 referrals and then referred 220 to external community resources, such as the county health department, community clinics, family and child agencies and physician appointments. 100% of students received mandated screenings.

2018 Objectives	Outcomes
1. Throughout all School Nurse programming, serve a target number of 3,000 individuals (including students, parents and school staff).	• From August 2017 to June 2018, a total of 5,244 students, parents and school staff were served.
2. Provide direct onsite Community Nurse services at 3 schools in Central & East Contra Costa County.	• Onsite community Nurse services were provided at Cambridge, Foothill, and Willow Cove Elementary Schools.
3. Issue referrals to appropriate resources, as needed and address all referrals received.	• 188 referrals were received by the Community Nurse and 39 referrals were then made to external community resources.
4. Conduct at least 20 mass screenings for vision, hearing and lice during the school year to reach at least 2,000 students.	• A total of 19 mass screenings were conducted for vision, hearing and lice, reaching 1,977 students.

5. Provide at least 500 medical interventions, 500 first aid treatments and 50 calls w/ a provider for students throughout the school year. 6. Provide at least 1 form of support assistance to all families after a family consultation.	• Community Nurses performed a total of 139 medical interventions, 2,793 first aid treatments, and 18 calls with student's medical provider. • On average, 1.3 support assistance was provided to families including food, housing, transportation, health insurance, clothing, health education, medication assistance, among others.

2019 Objectives

- All objectives remain the same for 2019.

<u>Mobile Dental Clinic</u>: Provide health care support services for children in schools that serve low-income families through the Dental Collaborative of Contra Costa County.

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

2018 Objectives	Outcomes
1. The Mobile Dental Clinic will provide dental services to 500 children, to include dental education, assessments, fluoride treatment and sealants. 2. The Mobile Dental Clinic will provide enrollment assistance to all patients in need. 3. 95% of patients will be connected to a Dental Home (Lifelong Brookside, La Clínica de la Raza, and Contra Costa Health Services Clinics).	• Mobile Dental Clinic provided oral health services to 10,873 children for a total of 11,575 visits. The Dental Collaborative provided the following in schools: 9,360 dental education encounters; 1,544 assessments; 2,847 fluoride; 302 sealants. • A total of 517 families were provided with insurance enrollment assistance. • 100% of Mobile Dental Clinic patients were connected to a dental home through referral partnerships with Lifelong Brookside, La Clínica de la Raza or Contra Costa Health Services Clinics.

2019 Objectives

- All objectives remain the same for 2019.

<u>La Clínica Specialty Care Program</u>: Provide specialty care services through the La Clínica Specialty Care program for vulnerable adults who are unable to access care due to lack of coverage.

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

2018 Objectives	Outcomes
1. Recruit specialists to participate in the program as needed to meet the needs of the referred patients.	• Providers were recruited to meet the needs of referred patients, which included gynecological oncologist, gynecologist, medical

2. 100% of accepted patients will be uninsured. Provide specialty care as budgeted. 3. 50% of referrals will be accepted to care and among them, 100% will receive program-specific services. (100% of eligible individuals will be accepted). 4. Monitor diagnoses of all procedures and interventions and provide necessary follow-up support for diagnosed patients. 5. 95% of patients will complete treatment or receive/be scheduled for follow-up services.	oncologist, radiation oncologist, diagnostic imaging, gastroenterologist, surgeon, cancer geneticist, and urologist. • 100% of patients were uninsured and 77% of patients referred indicated a non-English language preference and 80% identified as Hispanic/Latino. • In total, 237 patients were referred from La Clínica and among them, 220 were accepted into the Specialty Care Program (acceptance rate of 93%). The top referring health conditions include: gastrointestinal, gynecological, urological, thyroid, and breast. • A total of 2 cancer diagnoses were made. In addition, 628 procedures and interventions were provided throughout the year. The majority of interventions were consultations/follow-up with specialist and imaging. • 97% of patients completed treatment or received/scheduled for follow-up.
2019 Objectives	
• All objectives remain the same for 2019.	

<u>Operation Access</u>: Provide specialty care services through Operation Access for vulnerable adults who are unable to access care due to lack of coverage.

FY 07 Baseline: 16 surgical services provided by John Muir Health. 100% of patients reported improved health after surgical procedure.

2018 Objectives	Outcomes
1. 100% of patients served will be uninsured. 2. 100% of services will meet the linguistic needs of the population served. 3. 35% of all OA services in Contra Costa County will be provided by John Muir Health. 4. Increase the number of surgical services provided by John Muir Health by 5% annually. 5. Decrease surgery wait times by scheduling preliminary physician's appointment within 60-90 days of referral and the subsequent surgical procedure within 90-120 days of referral.	• 100% of Operation Access patients were uninsured. • The linguistic needs were met for 100% of patients, including English, Spanish, Portuguese, Punjab, and Amharic. • 34% of all OA services provided in CCC were provided by John Muir Health. • In 2018, a total of 146 surgical procedures were provided in a John Muir Health operating room. This represents a 170% increase from the previous year. • Average wait time from referral to first appointment was 70 days and the average wait time from referral to surgery was 89 days.

6. Reduce proportion of patients in Contra Costa County who have to travel to other counties for referrals from 57% to 50%. 7. Retain at minimum 75% of active volunteer physicians at John Muir Health. 8. Retain at minimum 50% of active "high volume" volunteer physicians at John Muir Health among total participating physicians. 9. Recruit one new volunteer John Muir Health physician per year (specialty varies per year based on program need). 10. 90% of volunteer physicians, clinic and patient survey respondents will report high levels of satisfaction with OA. 11. 90% of Contra Costa County patient survey respondents will report improvements resulting from their participation with OA in the following five categories: health, quality of life, ability to work, relief in symptoms, and ability to care for home and/or family. 12. OA will reduce Emergency Room utilization. 13. Raise visibility of OA's program and the contributions of John Muir Health through at least two OA newsletters.	• 45% of patient referrals had to travel to counties other than Contra Costa County. • In total, there were 22 active volunteer physicians from John Muir Health who provided at least one surgical service. • 64% of volunteers were "high volume" providers, who provided at least 4 services during the year. • In 2018, 3 new physicians were recruited. • 94% of patients reported high levels of satisfaction with their OA experience. • In 2018, all patient quality of life improvement measures remained high. Resulting from OA services, 95% of patients reported improved health, 95% reported improved quality of life, 91% improved work ability, 91% experienced and relief of symptoms and 91% improved ability to care for home and/or family. • Prior to utilizing OA services, 21% of patients reported that they visited the Emergency Room. • Two stories about John Muir Health volunteer physicians were highlighted and two practices were awarded an honor.
2019 Objectives	
• All objectives will remain the same in 2019.	

<u>Every Woman Counts Program:</u> Provide free breast cancer screening for low-income women who are unable to access care due to lack of coverage.

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.

2018 Objectives	Outcomes
1. Every Woman Counts will continue to have breast cancer screening clinics.	• In 2018, there were 29 Breast Cancer Screening Clinics.

2. 80% of eligible individuals will be accepted to care and among them, 100% will receive program-specific services. Every Woman Counts will continue with a volume of over 450 patient screenings.	• 100% of eligible patients were accepted to care. There were 358 breast cancer patients served in the clinics for a total of 395 encounters. • The majority of women served at the breast cancer clinics (60%) were between ages 40-49. 98% identified as Hispanic and among them, 96% indicated a non-English language preference.
3. Every Woman Counts will continue to support efforts to diversify the demographics of the patient population through expanded service reach.	
4. 100% of individuals will be uninsured (to qualify must be low income or uninsured).	• In 2018, 100% of patients were uninsured.
5. Within 18 months of their initial screening date, 80% of returning breast cancer screening patients will be re-screened.	• 69% of patients were screened within 18 months of their initial screening.
6. Provide 80% of patients with one stop breast services to include breast exams, diagnostic mammograms, ultrasounds, and biopsies that all occur within 1-day.	• 98% of breast cancer patients were provided with same day, “one stop” services, including: breast exams, diagnostic mammograms, ultrasounds and biopsies.
7. Every Woman Counts will provide breast cancer screenings and will connect patients with appropriate referrals for any issues detected. 75% of biopsies will receive results within 2 weeks.	• The program provided 10 breast biopsies and 100% received biopsy results within 2 weeks. 3 women were diagnosed with Breast Cancer and 100% were provided with appropriate follow-up to monitor their diagnosis.
8. Every Woman Counts will enroll diagnosed patients in the Breast and Cervical Cancer Treatment Program and refer to community partners for treatment.	• 100% of diagnoses were enrolled in the Breast and Cervical Cancer Treatment Program.
9. Distribute health education materials to 90% of patients.	• 100% of patients received health education materials.

2019 Objectives

- All objectives will remain the same for 2019.

<u>Lung Cancer Screening Program</u>: Provide screening programs for low-income adults who are unable to access care due to lack of coverage.

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

2018 Objectives	Outcomes
1. 80% of referrals will be accepted to care (among new referrals).	• 59% of new referrals were accepted to receive lung cancer screenings at the clinical trial and others who had insurance coverage were accepted to the Lung Cancer Screening Program.
2. The Lung Cancer Screening Program will perform at least 100 CT screening exams.	• In 2018, a total of 209 screenings were conducted.
3. 20% of individuals served are low income individuals who live 200% below the Federal Poverty Line (FPL).	• Of the total participants receiving screens in 2018, 27% lived in households with incomes less than 200% of the FPL.
4. The Lung Cancer Screening Program will diversify the demographics of the population served through partnership development with community clinics, physicians and expanding the program reach to the low income, underinsured populations.	• Of the total participants who disclosed their demographic information, 54% identified as male and 92% identified White as their race/ethnicity (2% identified as Black/African American, 5% as Asian and 0.5% as Hispanic/Latino).
5. The Lung Cancer Screening Program will provide scan results within 10 working days to 100% of the participants.	• 100% of participants were provided scan results within 10 days.
6. 85% of individuals will report: a. increased knowledge; b. high levels of satisfaction as a participant in a research study.	• 71% of participants rated their experience as a subject in a research study as “excellent” and 7% as “very good.”
7. 85% of the participants will report increased knowledge and engagement in their healthcare as a result of the services provided by the Lung Cancer Screening Program.	• According to the Participant Survey, 79% reported increased knowledge about their health condition and 64% felt more engaged in their healthcare as a result of the services provided.
8. 85% of individuals will report that as a result of their participation, they: a. were more likely to make lifestyle changes; b. felt more proactive and involved in their healthcare.	• According to the Participant Survey, 71% of participants reported that they are more likely to make a lifestyle change as a result of the education and services received and 100% reported that they felt more proactive in their healthcare.
9. Participants of the Lung Cancer Screening program will provide appropriate treatment and follow-up services, which are proxies for lives saved or extended.	• As a result of the screenings provided, 36 participants were recommended for follow-up care, and 3 participants received a biopsy and 36 received treatment. 3 participants were diagnosed with lung cancer and received treatment.

2019 Objectives

- All objectives remain the same for 2019.

<u>Medication Assistance Program</u>: Provide access to health care support and care coordination services for vulnerable adults and seniors that address poor health outcomes, quality and satisfaction while improving efficiency.

FY 09 Baseline: 35 low-income Medicare patients were provided 374 free or low-cost medications, which saved patients a total of $144,209 in medication costs.

2018 Objectives	Outcomes
1. The Medication Assistance Program will serve at least 50 Medicare patients and will track total number of prescriptions provided. 2. The Medication Assistance Program will track the value of medications provided. 3. 75% of seniors served through the Medication Assistance Program have incomes of 200% or less of the Federal Poverty Level (FPL). 4. Medication Assistance Program tracked referral sources for new program participants.	• 152 Medicare patients who have medication costs that exceed their ability to pay were served from Central and East Contra Costa County, and were provided with 785 prescriptions. • Medications provided were valued at $1,072,994. • 47% of people assisted (n=71) in this program had incomes of 200% or less of the FPL. The remainder were below 400% FPL. • In total, the Medication Assistance program completed 191 referrals, primarily to physicians and case management.

2019 Objectives

- All objectives remain the same for 2019.

<u>Geriatric Care Coordination (GCC) and Patient Navigator (PN) Program:</u> Enable older adults, families and caregivers to access all medical, health and community services that may assist in promoting best quality of life.

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

2018 Objectives	Outcomes
1. GCC and PN will assist 3,500 patients and their families in effectively obtaining health care by providing information about services and health education. 2. GCC Case Managers will provide care coordination assistance to 100% of seniors referred. 3. GCC Case Managers will provide assistance to all walk-in seniors inquiring about services.	• In 2018, GCC and PN assisted 2,942 older patients to effectively obtain health care and by providing information about services and health education. • GCC Case Managers received a total of 2,036 referrals and 100% were provided assistance. • GCC Case Managers assisted 592 “walk-in” seniors who inquired about a variety of health and support services.

2019 Objectives

- Epic implemented for Care Coordination in the beginning of 2018.
- Objectives may change pending Epic reporting capabilities.

<u>Fall Prevention Program (FPP):</u> Provide access to health care support and care coordination services for vulnerable adults and seniors that address poor health outcomes, quality and satisfaction while improving efficiency through fall prevention safety trainings, home assessments and modifications, and education through Meals on Wheels of Mt. Diablo Region.

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

2018 Objectives	Outcomes
1. In 2018, convene the Fall Prevention Coalition quarterly.	• 4 coalition meetings were held and on average 25 individuals attended, representing 65 agencies.
2. Among individuals the program serves, 80% have household incomes up to 200% of the Federal Poverty Line.	• In 2018, 83% of individuals had incomes at or below 200% FPL.
3. Among individuals the program serves, 80% are vulnerable individuals who reside in Contra Costa County communities.	• 67 individuals served resided in Community Benefit designated areas, of which 40% were residents of Central Contra Costa County, 44% in East and 30% resided alone.
4. In 2018, programming will be provided in multiple languages, as needed, to meet the linguistic needs of patients seeking services.	• 19% of older adults who received Home Safety Modification services reported a language other than English as their primary language. The majority of these are Spanish speaking. Other languages included Farsi, Tagalog, Punjabi, Russian, and Chinese.
5. Coordinate seniors with referrals to fall prevention services and other internal and external programming, as relevant.	• FPP received 273 referrals and conducted 157 home safety assessments and modifications the homes of older adults. Among these referrals, 47 people are on the waitlist, 69 either declined services or did not qualify for services.
6. 85% of seniors report that they would not have access to fall prevention services had they not participated in the program.	• 94% of seniors reported increased access to fall prevention services.
7. Conduct 20 fall prevention education presentations with a target reach of 400 seniors.	• FPP conducted 20 education presentations, reaching 412 seniors and 26 caregivers.
8. 90% of participating seniors will report increased knowledge about fall prevention, risk factors, fall reduction strategies (e.g., exercise, medication, reducing hazards, maintaining strong bones).	• On average 97% of seniors reported increased knowledge about fall prevention, risk factors, and fall reduction strategies.
9. Conduct at least 140 home assessments and complete home modifications for at least 75% of those assessed.	• FPP conducted 157 home assessments and completed home modifications in 93% of those assessed.

10. 85% of seniors who have received a home modification will report positive changes in their lives.	• 99% of seniors who received a home modification reported positive changes in their lives.
11. Conduct at least 5 exercise sessions each offered in both English and Spanish, as appropriate.	• 15 total exercise sessions were offered with a total of 431 participants. Based on need, the In Home Exercise Program was offered in Spanish.
12. 85% of seniors who attend exercise sessions will report positive changes in their lives.	• 88% of seniors who attended exercise sessions reported positive changes in their lives.
13. 70% of high-risk fallers in the intensive in-home exercise program will report improvements.	• 70% of high-risk fallers in the intensive in-home exercise program reported they feel less likely to fall post-program.
14. Implement *A Matter of Balance Train-the-Trainer Program.* Track number of workshops, number of attendees and number of trained coaches.	• 10 Matter of Balance workshops were completed, with 96 attendees. 17 MOB coaches were trained.
2018 Objectives	
• All objectives remain the same for 2019.	

<u>Caring Hands Volunteer Caregivers & Senior Transportation Program (STP):</u> Provide access to health care support and care coordination services for vulnerable adults and seniors that address poor health outcomes, quality and satisfaction while improving efficiency through transportation assistance.

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

2018 Objectives	Outcomes
1. Caring Hands will serve 325 seniors (includes 1:1 weekly program and STP ad-hoc one-way assisted rides).	• In 2018, a total of 385 seniors benefited from Caring Hands transportation assistance, where 222 participated in the weekly program and 143 participated in the STP ad-hoc program.
2. Caring Hands will provide a minimum of 7000 rides for 8000 hours.	• Caring Hands volunteers provided 6,110 rides for a total of 8,059 hours.
3. Caring Hands will provide 1500 friendly visits for 2500 hours.	• Caring Hands volunteers provided 1,560 friendly visits for a total of 3,402 hours.
4. Caring Hands will provide at least 700 respite visits for 1500 hours.	• Caring Hands volunteers provided 795 respite visits for a total of 1,798 hours.
5. Caring Hands will provide at least 2500 assisted outings for 5000 hours.	• Caring Hands volunteers provided 2,886 assisted outings for a total of 7,749 hours.

6. Caring Hands will provide 35 household tasks for 70 hours.	• Caring Hands volunteers provided 27 household tasks for a total of 39 hours.
7. Caring Hands will be stable with the number of Hispanic seniors served and will not refuse any Spanish speaking seniors.	• A total of 15 Spanish speaking seniors participated in the program.
8. Caring Hands will maintain and manage at least 175 volunteers.	• Caring Hands had a total of 314 volunteers for the entire program and 11 were Latino/Hispanic to meet the linguistic need of the Spanish speaking population.
9. Caring Hands will decrease senior isolation and increase healthcare access to seniors by serving, in total, 100 low income seniors (<200%FPL) and 200 seniors who live alone.	• In total, 178 seniors were low income (<200%FPL) and 223 seniors lived alone.
10. 85% of seniors will report high overall satisfaction with their participation in the Caring Hands program.	• 98% of seniors reported high overall satisfaction with their experience in the program.
2019 Objectives	
• All objectives remain the same for 2019.	

Community Health Need:	**Behavioral Health, including mental health and substance abuse**
Long Term Goal:	Increase access to behavioral health support for vulnerable communities.
Intermediate Goals:	1. Increase access to mental health prevention and intervention support for vulnerable adults. 2. Reduce youth community violence in vulnerable communities.

<u>Beyond Violence Program</u>: Provide intervention and referrals to violence related trauma victims in order to prevent recidivism and retaliation.

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

2018 Objectives	**Outcomes**
1. 60% of eligible individuals (based on violent injury and lives/injured in eligible cities) will be referred to Beyond Violence and 60% will consent to services and will be accepted as Beyond Violence clients.	• In 2018, there was a total client load of 43 individuals. There were a total of 63 violent injuries among which 24 met the eligibility criteria, referred to the program and agreed to participate (59% referral rate). The program also continued to support 19 ongoing clients from the previous year.
2. Signed consents will be obtained from 100% of referred patients.	• 100% of clients consented to services.

3. 70% of clients will complete the program or continue participation in the following year. Maintain a less than 30% dropout rate. 4. 80% of clients will maintain a high or medium level of engagement throughout their participation in the program (excluding dropouts, based on encounter). 5. 95% of clients will avoid re-injury, arrest and retaliation (excluding dropouts, based on encounter). 6. 100% of clients will remain alive. 7. Provide, on average, 4 support services per client throughout the year to include: a. enrolled/re-enrolled in school (including traditional middle/high schools, alternative schools, college, and home school/independent study) b. participated in an educational support program (includes tutoring & GED preparation) c. received employment assistance d. found a new job e. received housing assistance f. received legal advocacy g. received mental health counseling h. received assistance with health care services i. conflict resolution j. family intervention	• 86% of clients either completed the program or continued participation in the following year and 14% dropped out. • 77% of clients maintained a high or medium level of engagement throughout their participation in the program. • 100% of clients avoided re-injury, 100% avoided retaliation and 100% avoided re-arrest. • 100% of clients remained alive. • Intervention Specialists pursued a total of 239 support service interventions for an average of 5.6 interventions per client.
2019 Objectives	
• A new cloud-based data system, QuesGen, was implemented in 2019. • Additional or new objectives may be defined pending reporting capabilities.	

<u>Complex Community Care Coordination (CCCC) Program</u>: Provide comprehensive case management and support services for individuals who frequent the Emergency Department, have excessive hospitalizations and meet criteria related to social determinants of health.

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

2018 Objectives	Outcomes
1. 70% of referrals who meet eligibility criteria will be accepted to the program.	• In 2018 a total of 88 clients participated in the program.
2. Clients will report improvement in access to benefits including Medi-Cal and county programs.	• 100% of patients are enrolled in Medi-Cal, Medicare, Basic Adult Care or are covered by another insurance plan, while 0 patients lacked coverage.
3. Provide intensive case management for each client.	• Provided interventions related to benefits, appointment, care plan, case management, communications, housing, mental health, site visit, transportation or other.
4. 50% of discharged clients will complete goals.	• 75% of clients were considered “resolved cases” and discharged from the program.

2019 Objectives

- Epic implemented for Care Coordination in the beginning of 2018.
- In 2019, objectives may change pending Epic reporting capabilities.

<u>Putnam Clubhouse</u>: Support and/or provide behavioral health intervention services to vulnerable adults with severe mental health illness through education and vocational rehabilitation support services.

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.

2018 Objectives	Outcomes
1. By December 2018, the Clubhouse will have an average daily attendance of 50, a monthly attendance of 145, a yearly attendance of 375 and members will spend 58,000 hours participating in Clubhouse activities.	• In 2018, there was an average daily attendance of 45 members and a monthly attendance of 123 members representing a total of 299 members who participated in program activities, where they spent a total of 53,471 hours participating in Clubhouse activities.
2. By December 2018, increase membership overall by 70 of which 30 will be young adults age 30 and under.	• 69 new members overall joined the Clubhouse in 2018, among them 25 new members under the age of 30 joined.

3. Among those members who indicate education in their career plan, 80% will be referred to appropriate education resources within 14 days.	• 100% of members who indicated education in their career plan were referred to appropriate education resources and 54 members attended school and among them 24 returned to school.
4. Among those members who indicate employment in their career plan, 80% will be referred to appropriate education resources within 14 days.	• 100% of members who indicated employment in their career plan were referred to employment resources and 126 members were employed and among them 49 were placed in employment earning $12.58/hour on average.
5. 60% of total members will participate in Health Watch.	• 66% of members participated in Health Watch (197 members).
6. At least 80% of respondents in the annual member satisfaction survey will report an increase in their independence.	• 79% of members who responded to the survey reported an increase in their independence.
7. At least 80% of respondents in the annual member satisfaction survey will self-report improved quality of life from participation in the Clubhouse program.	• 80% of members who responded to the survey reported an improvement in their emotional wellbeing and 86% reported an improvement in their mental wellbeing.
8. In 2018, there will be a statistically significant decrease in hospitalizations and out-of-home placements (residential treatment) following membership.	• 86% of members who completed the Annual Hospitalization Survey showed decreased hospitalizations and out-of-home placements ($p<.05$).
9. John Muir Health to provide health education materials around top 5 health topics for distribution at the Clubhouse.	• John Muir Health provided health education materials around the following topics: nutrition guidelines, how to manage diabetes, how to effectively quit smoking, exercise to build healthy lifestyles, and understanding antipsychotic medications. These resources were each distributed to 120 individuals.
10. John Muir Health to provide 3 on-site member presentations or workshops.	• John Muir Health provided 12 on-site workshops entitled: smoking cessation, medication management, sleep management, nutrition, storytelling and team building, and a series of Q&A with JMH Resident Physicians. Workshops reached a total of 117 individuals.

2019 Objectives

All objectives remain the same for 2019.

<u>Respite Care Center</u>: Connect homeless patients discharged from hospital to Respite Care Center to provide recuperative care and on-site comprehensive case management and support services to medically fragile homeless adults.

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

2018 Objectives	Outcomes
1. John Muir Health Case Managers/Social Workers will identify patients that meet criteria for respite and refer qualifying patients to the Respite Center.	• In 2018, 199 patients were referred to the Respite Center.
2. 50% of patients referred will be admitted to respite.	• In 2018, 30% of the patients referred were accepted and among them, 37 patients were admitted to respite.
3. Medical diagnoses will be tracked in 100% of individuals at intake and appropriate medical linkages will be provided.	• In 2018, on average, admitted patients were provided with 6.69 medical linkages, with an average of 4.38 medical conditions and stayed in the program for an average of 64 days.
4. Mental health and substance abuse history will be tracked in 100% of individuals with a MH or SA history at intake and appropriate mental health & substance abuse linkages will be provided.	• For patients with a mental health history, they had an average of 1.27 conditions (depression as most common). For patients with a substance abuse history, they were using on average 2.36 substances (alcohol as most common).
5. The Respite Center will save approximately 4 hospital days for every patient admitted to respite.	• In 2018, patients who were admitted to respite from John Muir Health saved 148 hospital days.

2019 Objectives

- All objectives remain the same for 2019.

<u>Mentes Positivas en Accion (Positive Minds in Action) Promotores Program</u>: Support the prevention and/or improvement in the levels of stress and depression in vulnerable communities through the Positive Minds in Action promotores program offered by Monument Impact.

FY 16 Baseline: 2 train the trainer promotores were trained, who then trained 9 new promotores. They then administered the program to 100 community members of the Monument Corridor Area in Concord.

2018 Objectives	Outcomes
1. Train the Trainer: Train two promotores to become trainer of new promotores of Positive Minds in Action.	• New promotores were not trained in 2018 to be a trainer of the Mentes Positivas en Accion Promotores Program. The 14 week training is conducted by Rosa Maria Sternberg PhD, RN. Currently, there are 18 active trained promotores.

2. The new promotores' knowledge will be tested with pre and post knowledge tests administered at the beginning of classes and at the end of the training program. 3. Previously trained promotores will participate in an 8 session Mindfulness course (MPA Part 2). 4. Trained promotores will deliver the MPA Program (Part 1 and 2) in Spanish to people in the community who self-identify as living with high levels of stress, anxiety or depression, and expand geographical areas to deliver MPA1 in East County. 5. Promotores fidelity to the program will be assessed by observing promotores delivering the program, and by completing a fidelity scale.	• A 25-question test was administered to test promotores' knowledge of stress and depression management and cognitive behavioral concepts. • 13 promotores were trained for MPA2 as a continual training opportunity for those who were previously trained in MPA1. • 121 participants enrolled and began the program and 121 graduated (completed at least 5 classes). 12 programs of MPA1 and 5 of MPA 2 were completed for a total of 17 programs delivered in 2018. • Promotores delivered the program with excellent fidelity (mean score 3.85, range 1-4).
2019 Objectives	
All objectives remain the same for 2019.	

Community Health Need:	**Obesity, diabetes, healthy eating and active living**
Long Term Goal:	Decrease the number of residents who suffer from negative health outcomes as a result of obesity, diabetes, poor nutrition and lack of exercise.
Intermediate Goals:	1. Reduce the incidence of diabetes in vulnerable adults. 2. Increase access to healthy food and exercise for low-income families.

Diabetes Services: Provide diabetes prevention programs to vulnerable adults who are identified as pre-diabetic.

2018 Objectives	Outcomes
1. In 2018, train three Diabetes Education Empowerment Program (DEEP) trainers. 2. In 2018, launch a pilot of the 6-week Diabetes Education Empowerment Program (DEEP) in collaboration with La Clínica de la Raza and Monument Impact.	• In 2018, three John Muir Health clinical staff were trained to be DEEP-certified trainers. • In 2018, John Muir Health in collaboration with La Clínica de la Raza and Monument Impact supported the DEEP program with a total participation of 12 people for 6 weeks.

3. Conduct the program entirely in Spanish for monolingual Spanish speakers identified as lacking access to appropriate diabetes education services. 4. 100% of participants will be uninsured. 5. Track weight, blood pressure and blood sugar levels (A1c) for all participants.	• The DEEP program was conducted in Spanish. • 100% of participants were uninsured. • Health metrics were tracked by health clinic staff.
2019 Objectives	
All objectives remain the same for 2019.	

<u>Healthy and Active Before 5 (HAB45)</u>: Support HAB45 to prevent obesity in children age 0 to 5 by addressing barriers to healthy eating and active play.

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

2018 Objectives	Outcomes
1. By December 2018, convene at least 2 collaborative membership meetings to inspire progress in implementing the HAB45 Action Plan and policy agenda among local organizations serving young children in Contra Costa.	• HAB45 convened two Leadership Council meetings in Spring and Fall 2018. 79 Leadership Council Members from Contra Costa agencies attended the Leadership Council meetings.
2. By December 2018, build capacity of collaborative members to advocate for public policy changes that will benefit families with young children, by providing at least 2 leadership development opportunities for collaborative members, as well as by forging 2 new partnerships with key stakeholders.	• During Leadership Council meetings, Advocacy Pledges were signed by attendees. In addition, HAB45 organized an "advocacy field trip" to Concord's November 27th City Council meeting. Two new partnerships included Shelter Inc. and SparkPoint.
3. By December 2018, provide support to 2 agencies to inspire staff at these agencies to adopt at least 2 new policies that establish healthy organizational practices.	• HAB45 supported the adoption of 2 new policies that create healthier environments for children through the Pledge the Practice, Pass the Policy Initiative. These policies reach approximately 608 children and 5,800 adults.
4. By December 2018, provide support to 4 agencies to deepen the implementation of previously passed healthy organizational practices to ensure lasting, positive change to the food and activity environments of these agencies.	• Two organizations committed to deepening the implementation of existing policies in 2018 including Monument Impact and the Concord Junior Giants.

5. By December 2018, provide technical assistance to collaborative park improvement partners in order better advocate for safer, more accessible parks and play spaces for low-income families with young children.	• Following the completion of the Bay Point parks assessment & report in 2017, HAB45 has been working to share the findings and recommendations with Bay Point decision makers and advocate for park improvements. The community's top priority is improved bathrooms at Ambrose Park. In collaboration with HAB45, First 5 Contra Costa, and East County Regional Group, HAB45 has been working on a park strategy. In addition, a Richmond parks assessment was conducted in September. HAB45 is proud to partner with the West County Regional Group and First 5 Contra Costa in this effort.
6. By December 2018, update and disseminate the Healthy & Active Before 5 Mission, Vision, and Priorities to reflect strategic planning decisions in line with a broader health equity focus.	• HAB45's Executive Committee worked in the early months of 2018 to collaboratively review and revise its Mission, Vision, and Priorities.
2019 Objectives	
All objectives remain the same for 2019.	

<u>Food Bank of Contra Costa and Solano County's Community Produce Program</u>: Support the Food Bank to provide access to fresh produce for low-income families in Contra Costa County.

2018 Objectives	Outcomes
1. The Food Bank's Community Produce Program will provide over 3 million pounds of fresh food to families in need. 2. In 2018, the Community Produce Program will serve 25,000 individuals. 3. Families accessing fresh produce will report high consumption of fresh foods.	• In 2018, the Community Produce Program distributed over 3.5 million pounds fresh fruits and vegetables. • In 2018, the Community Produce Program provided fresh fruits and vegetables to over 26,000 people. • In 2018, clients overall reported increased consumption of fresh fruits and vegetables and having more balanced diets since receiving food from the program.
2019 Objectives	
All objectives remain the same for 2019.	

New Program Partnerships for 2019

In addition to the above programs, John Muir Health forged new partnerships with the following organizations for program development in 2019. Outlined below based on priority health need areas:

1. Healthcare access and delivery, including primary and specialty care
    - Independent Living Resources
    - City of Walnut Creek Transportation Program
2. Behavioral Health, including mental health and substance abuse
    - Fred Finch Youth Center
    - Support4Recovery
3. Obesity, diabetes, healthy eating and active living
    - Fresh Approach

The John Muir/Mt. Diablo Community Health Fund

The John Muir/Mt. Diablo Community Health Fund supports the planning and implementation of sustainable health initiatives that address current and emerging health care needs. To do so, they distribute grants and partner with community-based health centers and nonprofit organizations to improve health of vulnerable populations in John Muir Health's service area. In 2018, John Muir/Mt. Diablo Community Health Fund supported the following community health initiatives and nonprofit organizations:

Far East Contra Costa Service Expansion Initiative
- Meals on Wheels Diablo Region and Senior Outreach Services

Resident Empowerment Program
- Contra Costa Senior Legal Services
- Ombudsman Services of Contra Costa & Solano

Contra Costa Data Sharing Initiative
- Contra Costa & Solano Community Clinic Consortium
- La Clínica De La Raza

Contra Costa Care Team Uplift Initiative
- La Clínica De La Raza

Contra Costa Call Center Initiative
- La Clínica De La Raza

Veteran Health and Wellness
- Veterans of Foreign Wars, Post 10789
- East Contra Costa Veteran Health Navigation Partnership

Food Pantries at Colleges in Eastern and Central Contra Costa Initiative
- Food Bank of Contra Costa & Solano
- California State University, East Bay Foundation
- Los Medanos College Foundation

For additional details: https://www.johnmuirhealth.com/about-john-muir-health/community-commitment/community-health-fund.html

Attachment E – Community Partner Organizations

John Muir Health collaborates with the following organizations (the sample below does not represent all organizations):

- AARP
- Alameda Contra Costa Medical Association
- Alzheimer's Association
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Red Cross
- American Stroke Association
- Antioch Unified School District
- Bay Imaging Consultants
- Bike East Bay
- Benicia Unified School District
- Brighter Beginnings
- California State University East Bay
- Cancer Support Committee
- Catholic Charities of the East Bay
- Center for Human Development
- City of Concord
- City of Pleasanton
- City of Walnut Creek
- Community Clinic Consortium
- Concord Chamber of Commerce
- Concord Rotary Club
- Contra Costa County Health Services
- Contra Costa County Office of Education
- Contra Costa Employment and Human Services Department (Head Start)
- Contra Costa Fall Prevention Program
- Contra Costa Health Plan
- Dozier-Libbey Medical High School
- Dublin Chamber of Commerce
- East Bay Leadership Council
- East Bay Healthcare Workforce Partnership
- Family Justice Center
- First Five of Contra Costa County
- Food Bank of Contra Costa and Solano
- Food Bank of Alameda County
- Golden Gate Association of Health Underwriters
- Health Insurance Advocacy and Counseling Program
- Healthy and Active Before Five
- Kaiser Permanente
- La Clínica de la Raza
- Lamorinda Village
- Lifelong Community Health Center
- Livermore Chamber of Commerce
- Livermore Unified School District
- Local Contra Costa County police and fire departments
- Meals on Wheels of Mt. Diablo Region
- Medical Anesthesia Consultants Group
- Monument Impact
- Mothers Against Drunk Driving
- Mt. Diablo Unified School District
- National Alliance on Mental Illness (NAMI) of Contra Costa County
- Oakland Chamber of Commerce
- One Day at a Time
- Operation Access
- Pittsburg Senior Center
- Pittsburg Unified School District
- Planned Parenthood
- Pleasanton Chamber of Commerce
- Project Open Hand
- Putnam Clubhouse
- Rainbow Community Center
- Ronald McDonald House Charities of the Bay Area
- RotaCare Free Clinic, Concord
- RotaCare Free Clinic, Pittsburg
- RYSE Center
- San Ramon Valley Unified School District
- STAND! for Families Free of Violence
- Support 4 Recovery
- Sutter Health
- Village Community Resource Center
- Walnut Creek Chamber of Commerce
- White Pony Express
- Workability

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

Subject: AD - Patient Financial Assistance Program (Discount & Charity Care)				
Applies To:	☒	**John Muir Medical Center – Concord**	☒	**John Muir Medical Center – Walnut Creek**
	☐	**John Muir Physician Network**	☒	**John Muir Behavioral Health Center**
	☐	**John Muir Health and all entities**		

I. Purpose:

The purpose of this Policy is to set forth clear criteria and a fair process for providing financial assistance to patients who (i) require medically-necessary hospital services and (ii) have limited or no means to pay for such care. This Policy is designed to comply with the California Hospital Fair Pricing Law (Health & Safety Code § 127400 et seq.), United States Internal Revenue Code Section 501(r), and guidance from the United States Department of Health and Human Services Office of Inspector General ("OIG") regarding financial assistance to uninsured and underinsured patients.

Definitions:

Designated Languages: The Designated Languages are English, Spanish, and any other language that is spoken by more than 1,000 patients (including inpatients and outpatients) receiving care at a JMH hospital in a twelve-month period as measured in the most recent language survey conducted by the JMH Community Health Improvement Department. Such assessment shall be conducted and documented at least every three years upon request from JMH Finance.

Family: For patients 18 years of age or older, a patient's family is defined as his or her (i) spouse or domestic partner (as defined in Section 297 of the Family Code) and (ii) dependent children under 21 years of age (whether or not living at home). For persons under 18 years of age, a patient's family is defined to include (i) a parent or caretaker relative and (ii) other children under 21 years of age of the parent or caretaker relative.

Hospital Service: A Hospital Service is a service that (i) is furnished by a JMH hospital in an inpatient or hospital-based outpatient setting and (ii) billed by a JMH hospital. The term does not include (i) separately-billable professional services of physicians or allied health professionals or (ii) services furnished by any person or facility outside of a licensed hospital.

Medically-Necessary Hospital Service: A Medically-Necessary Hospital Service is a Hospital Service that (i) is absolutely necessary to treat or diagnose a patient, (ii) could adversely affect the patient's condition if withheld, and (iii) is not considered an elective or cosmetic intervention or treatment.

Reasonable Payment Plan: A Reasonable Payment Plan is one that incorporates monthly payments to the Hospital that are not more than 10 percent of a patient's Family income for a month (after Essential Living Expenses have been deducted from such income) and precludes any interest charge on the unpaid balance. "Essential Living Expenses" means, for purposes of this definition, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Self-Pay Patient: A financially-eligible Self-Pay patient is one who (i) has a Family income at or below 400% FPL and (ii) lacks third-party coverage for the specific services billed. A patient who has third-party coverage for certain hospital services will qualify as self-pay for those services hospital services falling outside the scope of the patient's coverage (including, without limitation, non-covered services, denied days, denied stays, services furnished before a deductible level is reached). By contrast, a patient lacking general health insurance coverage will fail to qualify as Self-Pay if he or she has a specific source of payment for the condition giving rise to hospital care (e.g., worker's compensation, automobile insurance, third-party liability).

Underinsured Patient: A financially-eligible Underinsured Patient is one who meets all of the following requirements: he or she

- Has third-party coverage (i.e., is not a Self-Pay Patient);
- Has a Family income at or below 400% of the Federal Poverty Level (FPL); and
- Has out-of-pocket medical expenses in the prior twelve (12) months (whether incurred or paid in or out of any hospital) exceeding 10% of Family income.

II. Policy:

A. General Scope. This policy is designed to provide assistance to patients who (i) require Medically-Necessary Hospital Services, (ii) have a Family income of 400% or less of the FPL and (iii) are either Self-Pay Patients or Underinsured Patients. This policy and the financial screening criteria must be applied consistently to all cases throughout JMH. Any decisions made under this Policy, including the decision to grant or deny financial assistance, 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.

B. Exclusions. This policy addresses financial assistance only for Medically-Necessary Hospital Services. It explicitly excludes services that are not Medically-Necessary. It also explicitly excludes the following services even when they are medically necessary: (i) separately-billable professional services whether or not furnished in the Hospital or

(ii) services of any person or facility outside of a licensed hospital. Finally, this Policy will not apply if the patient/responsible party provides false information about financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

C. Professional Services.

1. General. As noted above, this Policy does not provide financial assistance for separately-billable services of physicians and allied health professionals who furnish care in the Hospital. Rather, such professionals independently choose whether they wish to offer financial assistance (and, if so, the terms under which such assistance will be offered). JMH will maintain a list of each physician and allied health professional practice that furnishes care in the Hospital ("**Practice List**") and separately indicate for each identified practice whether it has agreed to be bound by the terms of this Policy. The Practice List shall be updated quarterly, indicate the date on which it was last updated, and be made available (i) on line in any location where this Policy is posted and (ii) in hard copy without charge upon request submitted to The Director Patient Financial Services, SBO and the Executive Director Revenue Cycle, 5003 Commercial Circle, Concord CA 94520.

2. It should be noted, however, that an emergency physician who provides emergency medical services in a JMH (or non-JMH) hospital is required to provide discounts to uninsured patients or patients with high medical costs who have a Family income at or below 350% of the Federal Poverty Level. This is true regardless of whether the emergency physician or his or her practice has agreed to specifically be bound by this Policy.

III. Procedure

A. Communication of Financial Assistance PolicyResponsibility: Admitting, Emergency Department, Outpatient Settings, Patient Financial Services.

1. Patients will be provided a brochure describing JMH's Financial Assistance Policy, including information about eligibility, as well as contact information as to where the patient may obtain further information. The brochure will be given to patients at the time of service when such patients (i) are in the Admitting Department, Emergency Department, or other outpatient hospital settings and (ii) do not appear to have third-party coverage. The brochure will also be provided with the initial billing statement. The brochure will be available in each of the Designated Languages.

2. Notice of JMH's Financial Assistance Policy will be posted in conspicuous places throughout the hospital, including the emergency department, admitting, registration, patient financial services and other outpatient departments where patients may be billed for services, even though not admitted. Posted notices will be provided in each of the Designated Languages.

3. Patients shall receive notice in any of the Designated Languages regarding the availability of financial assistance in their billing statements and collection action

letters (with such notice including contact information to include the telephone number and web site address at which to secure more information as well as this Policy, a financial assistance application form and patient brochure summarizing the policy).

4. Information about the availability of financial assistance -- including a copy of this Policy, a financial assistance application form and patient brochure that contains written notice of JMH's Financial Assistance Policy -- shall be available online in each of the Designated Languages at www.johnmuirhealth.com/patients-and visitors/payment-and-insurance/patient-financial-assistance-program. Paper copies of these materials shall be available upon request (without charge) in the Designated Languages by mail and in the Emergency Department and Admissions Department.

5. 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.

6. Any applicant must provide the following in order to be considered for financial assistance under this policy: (i) the most recent income tax return filed by each member of the Family (or certification that no return has been filed for the family member), (ii) wage statements covering the most recent 3 months for each Family member (or certification that such Family member has not received wages during that period), (iii) three most recent statements for each bank account or investment account maintained by a Family member, (iv) evidence of out-of-pocket medical expenditures relevant to determining if a patient is an Under Insured Patient, (v) proof of rent or mortgage payments for the last three months, and (vi) a release permitting JMH or its agents or representatives to contact third parties to validate the accuracy and completeness of documents submitted. Documentation of income and assets submitted to JMH as part of the Patient Financial Assistance Program Such information will not be used for collection activities.

B. Eligibility Procedures

Responsibility: Admitting/Registration, Emergency Department, Outpatient Settings, Patient Financial Services

1. Patients Without Third-Party Coverage.

   a. If the patient does not indicate coverage by a third-party payer, or requests financial assistance, the patient should be provided with an application for the Medi-Cal program, the Healthy Families program, coverage offered through the California Health Benefits Exchange, California Children's Services CCS, or other state or county-funded health coverage program before the patient leaves the hospital, emergency department or other outpatient setting. The patient also shall be provided with a referral to Health Consumer Center, Bay Area Legal Aid, 1735 Telegraph Avenue, Oakland, CA 94612; (855) 693-7285, http://healthconsumer.org/index.php?id=446, or other agency as applicable.

   b. All uninsured patients will be offered an opportunity to complete a Patient Financial Assistance Application. The form is available in each of the Designated

Languages. The Patient Financial Assistance Application will be used to determine a patient's eligibility for local, state and federal governmental programs as well as assistance under this Policy. Applications may not be submitted more than six (6) months following the first patient statement date. The eligibility screening will be performed by JMH or its designee. It is the patient's responsibility to cooperate with the information gathering process. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations.

c. All potentially-eligible patients must apply for assistance through State, County and other programs before JMH financial assistance will be considered under this Policy. Financial assistance will be provided under this policy only upon receipt by JMH of a copy of the denial. If denied, JMH must receive a copy of denial. Failure to comply with the application process or provide required documents can be considered in the determination. Willful failure by the patient to cooperate may result in JMH's inability to provide financial assistance.

d. JMH 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 pursuant to the JMH Write-Off Guidelines.

e. Any recoveries to an account will be identified and steps taken to ensure the diminished assistance is reflected appropriately in the general ledger.

2. Patients With Third-Party Coverage.

a. Patients with third-party coverage who nonetheless have significant out-of-pocket medical costs will be screened to determine whether they qualify as an Underinsured Patient. Upon patient request for financial assistance, the patient will be informed of the criteria to qualify as an Underinsured Patient and the need to provide evidence of payment for any services rendered at other providers in the past twelve months. It is the patient's decision as to whether he or she believes that he or she may be eligible for charity or discounted care and wishes to apply. However, the hospital must insure that all information pertaining to the Charity and Discounted Care Policy was provided to the patient.

b. Applications may not be submitted more than six (6) months following the first patient statement date. The eligibility screening under this policy will be performed by JMH or its designee. It is the patient's responsibility to cooperate with the information gathering process.

c. JMH 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 pursuant to the JMH Write-Off Guidelines.

d. Any recoveries to an account which has qualified and was absorbed under the terms of this Policy will have the amount of the recovery reversed from the Patient Financial Assistance adjustment code to ensure the diminished assistance is reflected appropriately in the general ledger.

C. Eligibility For Free Care

1. A Patient without third-party coverage (and ineligible for coverage under State, County, and other programs) will be entitled to free Medically-Necessary Hospital Care under this Policy if the sum of the following is at or below 400% of the Federal Poverty Level:

    a. Patient's Family income (as validated by its most recent filed Federal tax return and most recent three months of paycheck stubs from each Family member).

    b. Patient's monetary assets (assets that are readily convertible to cash, such as bank accounts and publicly traded stock) after excluding (i) the first $10,000 of monetary assets (liquid assets) and (ii) 50% of a patient's monetary assets (liquid assets) above the first $10,000. Retirement accounts and IRS-defined deferred-compensation plans (both qualified and non-qualified) are not considered monetary assets and are excluded from consideration.

2. JMH will waive any out-of-pocket fees for Medically-Necessary Hospital Services furnished to an Underinsured Patient if the sum of the following is at or below 400% of the Federal Poverty Level:

    a. Patient's Family income (as validated by its most recent filed Federal tax return and most recent three months of paycheck stubs from each Family member).

    b. Patient's monetary assets (assets that are readily convertible to cash, such as bank accounts and publicly traded stock) after excluding (i) the first $10,000 of monetary assets (liquid assets) and (ii) 50% of a patient's monetary assets (liquid assets) above the first $10,000. Retirement accounts and IRS-defined deferred-compensation plans (both qualified and non-qualified) are not considered monetary assets and are excluded from consideration.

3. The JMH Business Office Management may, under unusual circumstances, extend free care to individuals who would not otherwise qualify for free care under this policy. When such an award is made, the unusual circumstances justifying the award of free care will be documented and stored by Patient Financial Services.

D. Eligibility For Partial Discount For Patients With No Third-Party Coverage

1. Patients without third-party coverage (and ineligible for coverage under State, County, and other programs) but who are nonetheless ineligible for free care under this Policy, are eligible for a partial discount if they provide sufficient documentation of a Family income at or below 400% of the FPL.

2. The Patient Financial Assistance Application should be completed for all patients requesting a need-based discount.

3. Family income will be verified with the most recent filed Federal tax return and or recent paycheck stubs.

4. Discounted Payments will be limited to the highest of Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program in which Hospital participates.

5. Patients qualifying for a Partial Discount will be offered an extended payment plan. The terms of the payment plan shall be negotiated by JMH and the patient, and take into consideration the patient's Family income and essential living expenses. If JMH and the patient cannot agree on the payment plan, the JMH shall use the formula described in the Definition Section above under "Reasonable Payment Plan". Extended payment plans will be interest-free. Standard payment plan length will be twelve (12) months. Longer payment plans can be provided on an exception basis.

6. If a patient is deemed presumptively eligible for only a Partial Discount, the patient shall be notified and given the opportunity to submit any additional information to qualify for Free Care.

E. Eligibility For Partial Discount For Underinsured Patients With Third-Party Coverage

1. The Patient Financial Assistance Application should be completed for all patients requesting discounted care. Underinsured Patients need to be evaluated monthly to accurately account for medical cost for the last twelve (12) months. Patient is required to provide proof of payment of medical expenses.

2. Underinsured Patients with third-party coverage who do not qualify under Section III.B.2.A of this Policy but whose Family incomes are at or below 400% of the FPL are eligible for a discount.

3. Discounted Payments will be limited to the highest of Medicare, Medi-Cal, Healthy Families, or any other government-sponsored health program in which Hospital participates.

4. If a non-contracted third-party payer (who has not otherwise negotiated a discount off JMH's standard rates) has paid an amount equal to or more than the maximum governmental program payment, JMH would consider the difference as a partial charity care discount, and write off the difference. If payment received is less than the maximum governmental program payment, JMH can collect from the patient the difference between the third-party payment and the acceptable governmental program payment. However, this policy does not waive or alter any contractual provisions or rates negotiated by and between JMH and a third party payer, and will not provide discounts to a non-contracted third party payer or other entities that are legally responsible to make payment on behalf of a beneficiary, covered person or insured.

5. Patients qualifying as Underinsured Patients will be offered an extended payment plan. The terms of the payment plan shall be negotiated by JMH and the patient, and take into consideration the patient's Family income and essential living expenses. If JMH and the patient cannot agree on the payment plan, then JMH shall use the formula described in

the Definition Section above under “Reasonable Payment Plan”. Extended payment plans will be interest-free. Standard payment plan length will be twelve (12) months. Longer payment plans can be provided on an exception basis.

F. Review Process

Responsibility: Admitting/Registration and Patient Financial Services

1. Requirements above will be reviewed and consistently applied throughout JMH in making a determination on each patient case.

2. Information collected in the Patient Financial Assistance Application may be verified by JMH. A waiver or release may be required authorizing the hospital to obtain account information from a financial or commercial institution or other entity that holds or maintains the monetary assets to verify their value. The patient's signature on the Patient Financial Assistance Application will certify that the information contained in the form is accurate and complete.

3. Any patient, or patient’s legal representative, who requests charity or discounted care under this policy shall make every reasonable effort to provide JMH with documentation of income and all health benefits coverage. Failure to provide information would result in denial of charity or discounted care.

4. Eligibility will be determined based on patient’s Family income including monetary assets as outlined in AB 774 (Health & Safety Code Section 127400 et seq.).

5. In the case of inpatient services, the Patient Financial Assistance Application will be required each time the patient is admitted and is valid for the current admission plus retroactive application for any services up to 6 months prior to the current admission. In the case of outpatient services, the Patient Financial Assistance Application must be submitted every six months.

6. Patients will be notified in writing of approval or reason for denial of charity or discounted care eligibility in languages as determined by JMH pursuant to Federal and state laws and regulations.

7. Specific payment liability for discounts will require the episode of care or treatment plan to be determined and priced to enable accuracy of Federal healthcare program reimbursement reporting. For Underinsured Patients, it may be necessary to wait until a payer has adjudicated the claim to determine patient financial liability.

8. See Section III.H. for Appeals/Reporting Procedures.

G. Patient Billing And Collection Practices

Responsibility: Patient Financial Services

1. Patients who have not provided proof of coverage by a third party at or before care is provided will receive a statement of charges for services rendered at the hospital. Included in that statement will be a request to provide the hospital with health insurance or third-party coverage information. An additional statement will be provided on the bill that informs the patient that if they do not have health insurance coverage, the patient may be eligible for Medi-Cal, Healthy Families Program, coverage offered through the California Health Benefit Exchange, California Children's' Services, other state- or county-funded health coverage, or charity or discounted care under this policy. At the time of initial billing, the brochure summarizing the Patient Financial Assistance Policy will be provided to the patient.

2. Hospital or its contracted collection agencies must send a notice specifying the following at least thirty (30) days before commencing a collection action: (i) collection activities the Hospital or contracted collection agency may take and (ii) the likely timeline within which they would be undertaken. Reasonable efforts must be made (and documented) to orally notify patients of the FAP.

3. Patient's request for information regarding the Patient Financial Assistance Program can be communicated verbally or in writing and a Patient Financial Assistance Application will be given/mailed to patient/guarantor address. Written correspondence to the patient shall also be in the languages as determined by JMH pursuant to Federal and state laws and regulations.

4. If a patient is attempting to qualify for eligibility under the hospital's charity or discounted care policy, and is attempting in good faith to settle the outstanding bill, the hospital shall not send the unpaid bill to any collection agency or other assignee unless that entity has agreed to comply with this policy.

5. Patients are required to report to JMH any change in their financial information promptly.

6. Prior to deferring or denying medically-necessary care due to non-payment of prior bills, JMH must provide written notice that Financial Assistance is available for those who qualify and wait at least 240 days from the date of the post-discharge notice

7. Prior to commencing collection activities against a patient who is eligible for financial assistance under this Policy, the hospital and our contracted collection agencies will provide a notice (i) containing a statement that non-profit credit counseling may be available, and containing a summary of the patient's rights and (ii) a further statement as follows: "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except in under unusual circumstances, debt collectors may not contact you before 8:00 AM or after 9:00 PM, In general a debt collector may not give information about your debt to another person or than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP or online at

www.ftc.gov." The foregoing notices shall also be included in any communication with the patient indicating the commencement of collection activities may occur.

8. Neither JMH nor its contracted collection agencies will impose wage garnishments or liens on primary residences except as provided below. This requirement does not preclude JMH from pursuing reimbursement from third party liability settlements or other legally responsible parties.

9. Agencies that assist the hospital and may send a statement to the patient must sign a written agreement that it will adhere to the hospital's standards and scope of practices.

   The agency must also agree to:

   a) Not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.

   b) Suspend any extraordinary collection efforts if patient has submitted a pending Financial Assistance application.

   c) Not place liens on primary residences.

   d) Adhere to all requirements as identified in Health & Safety Code Section 127400 et seq. and T. Reg. 1.501(r)-6.

   e) Comply with the definition and application of a Reasonable Payment Plan, as defined in the Definition Section above.

10. In the event that a patient is overcharged an amount that is greater than $5.00, the hospital shall reimburse the patient the overcharged amount with 7 % interest (Article XV, Section 1 of the California Constitution) calculated from the date the overpayment is identified.

H. Appeals/Reporting Procedures

Responsibility: Patient Financial Services

1. In the event of a dispute or denial, a patient may seek review from the Director of Patient Financial Services. The Executive Director Revenue Cycle will review a second level appeal.

2. This Patient Financial Assistance Program and the plain language summary and the Patient Financial Assistance Application shall be provided to the Office of Statewide Health Planning and Development (OSHPD) at least biennially on January 1, or with significant revision.

3. If no significant revision has been made by JMH since the policies and financial

information form was previously provided, OSPHD will be notified that there has been no significant revision.

4. In reporting data relating to charity and discounted care, only those write offs and discounts provided under this Policy shall count towards calculation of "community benefit" on the Form 990 filed by JMH.

IV. Patient/Family Education

Provided through publication of this policy on the JMH website, direct education from JMH designees, and posted information as outlined in this Policy.

V. Documentation: N/A

VI. Relevant Hyperlinks: N/A

<table>
<tr><td colspan="5">Reference/Regulations:</td></tr>
<tr><td colspan="5">California Hospital Fair Pricing Law (Health & Safety Code § 127400 et seq.), United States Internal Revenue Code Section 501(r)</td></tr>
<tr><td colspan="4">Sponsor(s) Name & Title:</td><td>Origination Date:</td></tr>
<tr><td colspan="4">Chris Pass
Interim Chief Financial Officer</td><td>December 2006</td></tr>
<tr><td colspan="5">Supersedes: (with last approval date)</td></tr>
<tr><td colspan="5">Previous title: AD - Patient Assistance / Charity Care Program / Uninsured Patient Discount Program (SA-11.04)</td></tr>
<tr><td colspan="5">Record of Review Dates</td></tr>
<tr><td colspan="3">Review Only Dates:</td><td colspan="2">Revision Dates:</td></tr>
<tr><td colspan="3"></td><td colspan="2">10/09; 12/11, 10/15</td></tr>
<tr><td colspan="5">List Committee, Medical Staff, etc. Reviews: (with approval date)</td></tr>
<tr><td colspan="5">Record of Approval Dates</td></tr>
<tr><td>PPRC: 11/5/15</td><td>Admin: 11/13/15</td><td>MEC-WC: N/A</td><td colspan="2">MEC-CC: N/A</td></tr>
<tr><td>Operations Council: 12/4/15</td><td colspan="4">Board: 12/06, 11/09, 2/12, 1/16</td></tr>
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<tr><td colspan="3">Record of Approval Dates (Behavioral Health Center)</td></tr>
<tr><td>Committee (Name):</td><td>MEC-BH:</td><td>Board:</td></tr>
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