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Adventist Health Overview

Adventist Health Clear Lake is an affiliate of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii.

Adventist Health entities include:

- 20 hospitals with more than 3,200 beds
- More than 280 clinics (hospital-based, rural health and physician clinics)
- 13 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Compassionate and talented team of 35,000 associates, medical staff physicians, allied health professionals and volunteers

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the “radical” concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.
In 1968 community members of Clearlake and local doctors established Redbud Community Hospital with the singular purpose: “to provide excellent healthcare for Lake County California.” In November 2008 Redbud Community Hospital was renamed and joined the Adventist Health family. Today, more than 50 years after receiving its first patients, Adventist Health Clear Lake Medical Center is building on that legacy by transforming the health status of our community.

Living our out mission: **To Live God’s Love by Inspiring Health, Wholeness and Hope** is the inspiration that has resulted in awards for best rural critical access hospital in the western United States for patient safety, low mortality, quality and value. We are committed to leading innovative, results-driven initiatives that make a difference in the lives of our patients and community members.

At Adventist Health Clear Lake, we believe community health improvement is enhanced through strategic community collaboration. Together with local agency partners, our Community Integration team is aligning efforts and strategic planning to address the priorities of our Community Health Needs Assessment. In 2019, we are focusing our entire team of associates and caregivers to show that “Love Matters” in every interaction every day through the best employee engagement, patient experience, quality care, and community impact.

As we look back on the past 50 years of growth and service to our community we are inspired to work even more strategically to create the bright future our community deserves.

Sincerely,

David Santos
President and CEO
**Adventist Health Clearlake**

25-bed Critical Access hospital

15630 18th Avenue, Clearlake, CA 95422

Contact: David Santos, President & CEO (707) 995-5820

**Existing healthcare facilities that can respond to the health needs of the community:**

- Adventist Health Clear Lake Medical Center, 15630 18th Avenue, Clearlake, CA 95422
- Adventist Health Clear Lake Medical Office, 15320 Lakeshore Drive, Clearlake, CA 95422
- Adventist Health Live Well, 15320 Lakeshore Drive, Clearlake, CA 95422
- Adventist Health Clear Lake Medical Office Hidden Valley, 18990 Coyote Valley Drive, Hidden Valley Lake, CA 95467
- Adventist Health Clear Lake Medical Office Kelseyville, 52960 State Street, Kelseyville, CA 95451
- Adventist Health Clear Lake Konocti Wellness Center, 9340 C Lake Street, Lower Lake, CA 95457
- Adventist Health Clear Lake Medical Office Middletown, 21337 Bush Street, Middletown, CA 95461
- Adventist Health Clear Lake General Surgery, 15322 Lakeshore Drive, Suite 101, Clearlake, CA 95422
- Adventist Health Clear Lake Rehabilitation Services, 14855 Olympic Drive, Clearlake, CA 95422
- Sutter Lakeside Hospital, 5176 Hill Road East, Lakeport, CA 95453
- Lakeview Health Center, 5335 Lakeshore Drive, Lakeport, CA 95453
- Lake County Tribal Health Consortium, 925 Bevins Street, Lakeport, CA 95453
- Clearlake Veterans Affairs Medical Clinic, 15145 Lakeshore Drive, Clearlake, CA 95422
Community Integration Task Force

David Santos  
President, CEO

Russ Perdock  
Director  
Community Integration

Colleen Assavapisitkul  
RN, BSPA, HACP  
Vice President of Patient Care

Brent Dupper  
Administrative Director  
Physician Outpatient Services

Justin Ammon  
MBA  
Project Coordinator/Associate Analyst  
Community Integration

Shannon Kimbell-Auth  
MSW, MDiv  
Manager Restoration House  
Community Integration

Marc Shapiro, MD  
Chief of Staff

Angelique Cole  
Director  
Outpatient Operations

Carlton Jacobson  
Regional Vice President  
Finance

Conrad Colbrandt  
Executive Director  
Redbud Health Care District

Marylin Wakefield  
PhD, MSW  
Care Management Manager  
Capitation Management

William F. Murray  
EdD, RN  
Wellness Consultant

CHNA/CHP contact:  
Russ Perdock: Director, Community Integration; PerdocRE@ah.org  
15630 18th Avenue, P.O. Box 6710 Clearlake, CA 95422  
To request a copy, provide comments or view electronic copies of current and previous community health needs assessments:  
https://www.adventisthealth.org/about-us/community-benefit/
Invitation to a Healthier Community

Fulfilling Adventist Health’s Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinant of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Plan (Implementation Strategy) marks the second phase in a collaborative effort to systematically investigate and identify our community’s most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, “to share God’s love by providing physical, mental and spiritual healing.”

Identified Community Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, Adventist Health Clear Lake have adopted the following priority areas for our community health investments for 2017-2019:

- Healthy Behaviors
- Clinical Care
- Social & Economic Factors
- Physical Environment

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Do our interventions make a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population’s health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.
Community Profile

How our community is defined

Lake County is located in Northern California just two hours by car from the San Francisco Bay Area, the Sacramento Valley, or the Pacific Coast. The county’s economy is based largely on tourism and recreation, due to the accessibility and popularity of its lakes and accompanying recreational areas. It is predominantly rural, about 100 miles long by about 50 miles wide, and includes the largest natural lake entirely within California borders. Lake County is mostly agricultural, with tourist facilities and some light industry. Major crops include pears, walnuts and, increasingly, wine grapes. Dotted with vineyards and wineries, orchards and farm stands, and small towns, the county is home to Clear Lake, California’s largest natural freshwater lake, known as "The Bass Capital of the West," and Mt. Konocti, which towers over Clear Lake.

Within Lake County there are two incorporated cities, the county seat of Lakeport and the City of Clearlake, the largest city, and the communities of Blue Lakes, Clearlake Oaks, Cobb, Finley, Glenhaven, Hidden Valley Lake, Kelseyville, Loch Lomond, Lower Lake, Lucerne, Nice, Middletown, Spring Valley, Anderson Springs, Upper Lake, and Witter Springs as displayed on the map below.

Lake County is bordered by Mendocino and Sonoma Counties on the west; Glenn, Colusa and Yolo Counties on the east; and Napa County on the south. The two main transportation corridors through the county are State Routes 29 and 20. State Route 29 connects Napa County with Lakeport and State Route 20 traverses California and provides connections to Highway 101 and Interstate 5.

According to California labor market data about county-to-county commute patterns (which have not been updated since 2000), the total workers that live and work in Lake County is 15,566 persons. The total workers commuting in was 1,046, and 4,320 total workers commuted out. About 67% of people who live in Lake County also work within the county. While the population size of Lake County was estimated as 64,918 residents in January 2015, the population can swell with daytime work commuters and seasonal tourists.

Demographics of the community

Approximately 30% of all Lake County residents live in the cities of Clearlake and Lakeport while the remainder lives in unincorporated areas. The population of Lake County has increased modestly overall since the 2000 Census, with most of the growth occurring outside of the two cities (Table 3).
Table 3. Population Estimates of Lake County Cities

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Clearlake</td>
<td>15,250</td>
<td>15,186</td>
<td>15,104</td>
<td>15,087</td>
<td>15,0</td>
<td>14,977</td>
</tr>
<tr>
<td>Lakeport</td>
<td>4,753</td>
<td>4,711</td>
<td>4,673</td>
<td>4,664</td>
<td>4,728</td>
<td>4,699</td>
</tr>
<tr>
<td>Balance of County</td>
<td>44,662</td>
<td>44,486</td>
<td>44,527</td>
<td>44,753</td>
<td>44,995</td>
<td>45,242</td>
</tr>
<tr>
<td>Unincorporated</td>
<td>20,003</td>
<td>19,897</td>
<td>19,777</td>
<td>19,751</td>
<td>19,764</td>
<td>19,676</td>
</tr>
<tr>
<td>County Total</td>
<td>64,665</td>
<td>64,383</td>
<td>64,304</td>
<td>64,504</td>
<td>64,759</td>
<td>64,918</td>
</tr>
</tbody>
</table>


City/county population estimates with annual percent change between January 2014 and January 2015 show slight growth for the county overall. The two cities, however, saw a slight decline in population between the two time periods.

In 2010 three-quarters of Lake County’s population identified themselves as non-Hispanic White, 17.2% as Hispanic, 3.1% as multi-race, 2.4% as American Indian, 1.9% Black, 1.1% Asian and 0.2% as Native Hawaiian/Pacific Islander; less diverse than the state as a whole.

Lake County’s population is projected to become increasingly culturally diverse in coming years with significant growth among Hispanics, Asians and multi-race individuals. The Hispanic population is projected to more than double, Asians to increase four-fold, and persons identifying as multi-race to almost double from 2010 to 2060. Conversely, the proportion of non-Hispanic Whites, African Americans, and American Indians will decline. The shift in Lake County population groups has implications for designing and delivering needed services in ways that are culturally and linguistically appropriate.

Lake County’s senior population is projected to grow at a disproportionate rate, while its proportion of young and working age people declines. The working age population (age 25-64) is expected to shrink by 10% by 2060. In 2010, 17.8% of the county’s population was 65 or older compared to 11.5% statewide. It is predicted to nearly double and comprise almost one-third of the county’s population by 2060. California’s senior population is also expected to double, but to only comprise about one-quarter of the total population. In Lake County, the proportion of people age 75-84 is projected to double, and for people 85 and over to almost triple. The anticipated significant growth in this age group will put a larger burden on the health care system and local economy, which may not have sufficient community services or tax base to support it.
2016 Community Health Needs Assessment Priority Areas

Priority Area 1: Mental Health

While risk and protective factors vary, individuals, families and communities are impacted by mental disorders in endless ways—health status, income, family stability, suicide risk, to name the more important ones. People have different ways of coping with mental and emotional distress—some healthy (exercise, worship), some not (drug use)—and different extents of support systems. Social and economic determinants of mental health demand public health and population-based strategies to prevent and manage common mental disorders in the community.

Priority Area #2: Substance Use Disorders

Experts indicate that an optimal mix of prevention interventions, as well as treatment resources, are required to address substance use issues in communities, because they are among the most difficult social problems to prevent or reduce.

Priority Area #3: Access to Programs and Services

This priority area addresses a range of access concerns ranging from inadequacies in infrastructure to lack of community awareness. It was clear from the community input to the CHNA that so many people in Lake County were unaware of the many health, educational, and social services and programs that are already available (though not always affordable or convenient).

Priority Area #4: Housing and Homelessness

The vast majority of homeless individuals and families fall into homelessness after a housing or personal crisis. These households may require only short-term assistance to find permanent housing quickly and without conditions. Others fall into homelessness after release from institutions, including jail and the foster care system. Still others come to homelessness from mental health programs and other medical care facilities. Early intervention to prevent homelessness is a critical component in treating mental illness before it can cause serious results like unemployment and chronic homelessness.

Information gaps

While no notable gaps in information became evident in the development of the County’s Community Health Needs Assessment, it is anticipated that information gaps will be identified and addressed as initiatives are designed and implemented.

Adventist Health Clear Lake Clear Lake approved the 2016 CHNA in September 2016 and made it publicly available on the Adventist Health Clear Lake Clear Lake website in October 2016. Click here to view the 2016 Community Health Needs Assessment.
2018 Community Benefit Update

In 2016 Adventist Health Clear Lake conducted a community health needs assessment and was followed by a 2017 Community Health Plan (Implementation Strategy) that identified the priority needs listed below. The prioritized needs were chosen based on community health data and the voices of our community. Working together with our community is key to achieving the necessary health improvements to create the communities that allow each member to have safe and healthy places to live, learn, work, play, and pray. Below you will find an inventory of additional interventions supporting the health of our communities.

Priority Need 1 – Healthy Behaviors (Access to Services, Housing and Homelessness, Substance Use Disorders)

Intervention: LIVING NICOTINE FREE with LIVE WELL is a primary intervention which targets high tobacco use in Lake County. This intensive offering lasts for three months and is geared for individuals having a desire to quit using tobacco products. On-on-one telephone support, group meetings, a targeted cell phone app, weekly reminders via text, the use of nicotine replacement products and a referral to the Live Well Program to implement a holistic approach to cessation are included.

- Number of Community Members Served: 28

Intervention: LIVE WELL originated as a pain management program. Over the past decade, Live Well has become a fully integrated multi-disciplinary intervention that is designed to improve the quality of life for all patients enrolled. Program components include: behavioral health, addiction and pain management, dietary counseling, and health coaching. While pain and addiction management remain the primary focus of Live Well, services provided will aid the healing of many chronic diseases.

- Number of Community Members Served: 2653

Intervention: SEPSIS PROTOCOL systematically changed the workflow for laboratory, nursing, and medical staff in order to improve patient outcomes for sepsis. ‘Door to treatment’ time for septic patients, was improved by more than 30 minutes.

- Number of Community Members Served: 22,700 (approximately, every ED visit)

Intervention: SAFE SLEEPING FOR BABY AND MOTHER is an infant safe sleeping campaign designed to reduce infant deaths and injuries related to suffocation and S.I.D.S. Any Lake County family who is expecting and completes the safe sleeping training will receive a baby bundle gift including a Pack n’ Play and baby essentials that support safe infant care. The SAFE SLEEPING FOR BABY & MOTHER workshop launched fully on September 18, 2018 with 6 new mothers attending the first meeting.

- Number of Community Members Served: 16 (4 months)
## Partners

- Health Leadership Network
- Lake County Public Health
- First 5 Lake County
- Sutter Lakeside Hospital
- Medline Industries Inc.
- Mother-Wise
- Lake Family Resource Center
- Lake County Breastfeeding Coalition
- Redbud Health Care District
- North Cost Opportunities
- Easter Seals

## Evaluation Metrics and Impact 2018

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of Lake County residents that have access and engage in healthy behavior programming</td>
<td>Assess the number of members enrolled in healthy behavior programming in 2017 (e.g. smoking cessation; Live Well)</td>
<td>10% improvement</td>
<td># attending classes:</td>
<td>Clinic, hospital, and class records</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- 28 Live Nicotine Free</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- # Attending support groups:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- 2653 Program Attendees for all Live Well programs.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Health Ranking in adult obesity improved 10% from 21 to 19/100,000 people.</td>
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<td></td>
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<td>- Added Mental Health services improving provider/patient ratio.</td>
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<td></td>
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<td></td>
<td>- Reduced teen births by 10%</td>
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<tr>
<td><strong>Decrease substance abuse &amp; adult smoking rate</strong></td>
<td>2017 substance abuse &amp; adult smoking rate</td>
<td>10% reduction</td>
<td><strong>Deaths due to lung cancer ranking increased from 46.5/100k -to- 46.7/100k, ranking fell from 55th to 57th.</strong></td>
<td>CDPH county health status profile 2019.</td>
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</tbody>
</table>
| **Decrease in years of potential life lost before age 75** | 2017 years of potential life lost before age 75 | 10% reduction | **Death rate/Mortality Cancer Mortality Rate**  
- **Heart Disease** improved from 115.7/100k -to- 105.7/100k.  
- **Cerebrovascular Disease** increased from 42.6/100k -to- 45.7/100k.  
- **Chronic Lower Respiratory Disease** improved from 67.3/100k -to- 58.6/100k. | RWJ Foundation Rankings & Roadmaps.  
CDPH county health status profile 2019.  
CHNA. |
| **Improved Quality of Life** | 2017 poor physical/mental health days rate | 10% improvement | **Poor Physical Health Days did not increase.**  
**No increase in Poor Mental Health Days.** | RWJ Foundation Rankings & Roadmaps |
Priority Need 2—Clinical Care (Access to Services, Substance use Disorders, Housing and Homelessness and Mental Health)

Intervention: SAFE RX has already proven its success as an opioid reduction program. The program was established to support a healthier and safer community by improving the quality and functionality of life for individuals experiencing pain. SAFE RX has also shown the ability to reduce harm from prescription drug abuse through celebrative partnerships that focus on prevention, treatment, and recovery. Emphasis is placed on adhering to county-wide opioid prescribing guidelines.

- Number of Community Members Served: 2627

Intervention: PROJECT RESTORATION plays a vital role with the entire population health strategy for Adventist Health Clear Lake Hospital. Its development is based on the evidence-based theories of the Camden Coalition. Its primary purpose is data analysis, solution identification, and countywide collaborative systems design. Project Restoration focuses on: high utilizer identification, readmission prevention, streamlined access to services for vulnerable populations, homelessness alternatives, intensive case management, mental health options, and substance abuse support.

- Number of Community Members Served: 32

Intervention: RESTORATION HOUSE RESPITE BEDS provides an additional link to housing and healing for our most vulnerable clients. Patients ready for discharge without proper housing or without home care available can continue their medical healing in the confines of Restoration House until able to conduct self-care in a permanent housing situation.

- Number of Community Members Served: 8

Intervention: LIVE WELL INTENSIVE (IOPCM) is an enhanced version of Live Well. This intervention is geared to provide case management/disease management services to individuals who have been identified as being at high risk of becoming or are high utilizers of the system. Individuals who enroll in this program often have comorbidities and are frequent users of the hospital's ED. This intervention also helps patients to gain access to provider appointments and provides broad support to improve the social determinants of health and effectively linking to the community resources.

- Number of Community Members Served: 149

Intervention: SEPSIS PROTOCOL is an effort to reduce the time it takes to diagnose and start treatment of sepsis in a patient. Individuals presenting at the ED or inpatient are assessed for elevated lactate with specialized lab equipment that allows readings within seconds instead of the 90 minutes or longer it takes using typical lab equipment. The elevated lactate is a baseline measurement for suspicion of sepsis in patients. In addition to elevated lactate, the protocol takes the sepsis work even further. If a patient’s lactate is elevated there is an automatic reflex to obtain other bloodwork info such as procalcitonin, which is an additional indication of sepsis if elevated. This key systematic change to the workflow for laboratory, nursing, and medical staff reduces ‘Door to treatment’ time for septic patients, by more than 30 min.
Intervention: **CAPITATED MEMBER COMMUNICATION STRATEGTY** is a pilot program designed to engage each member of the AHCL system and motivate each to connect with a personalized care team. The program disseminates information about all available services, helping patients navigate the system while building a relationship and helps guide patients through the financial process. Additionally, the program provides support in health literacy, healthy behaviors, and helps to schedule new patient appointments. This in-person navigator is available during clinic hours and by phone.

- Number of Community Members Served: 0 (counted in Priority Need #1)

Intervention: **More Than Wheels** is a patient shuttle & shuttle voucher program that provides supplemental transportation for patients who need a ride to Adventist Health Clearlake Hospital or our clinic to meet their scheduled appointment. Many residents of Lake County do not have adequate transportation and AHCL hospital shuttle program has shown to improve health outcomes by reducing missed appointments for patients by providing transportation for patients to our clinics and hospital.

- Number of Community Members Served: 400 (6 months of operation)

Intervention: **Empathy in Action, ‘in their shoes’** gives all AHCL hospital employees the tools and the freedom to bring their heart to work by encouraging all to show empathy for patients and for each other. The Empathy in Auction program was developed by our sister hospital Adventist Health Castle in Hawaii and has show to help create a happier more caring work environment and has positive effect on how patients feel about their hospital experience. In 2018 340 AHCL staff completed the Empathy in Auction workshop.

- Number of Community Members Served: 340

**Partners**

- Lake County Public Health
- Lake Health Center – Mendocino Community Health Clinic
- Partnership Health Plan of California
- Sutter Lakeside Hospital
- Clearlake Police Department
- North Coast Opportunities
- Lake County Fire Protection District EMT
- Lake Transit
- Hospice Services of Lake County
- Lake County Behavioral Health
### Evaluation Metrics and Impact 2018.

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th><strong>Baseline Measurement</strong></th>
<th><strong>Performance Target</strong></th>
<th><strong>Indicator</strong></th>
<th><strong>Data Source</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish county-wide opioid prescribing guidelines</td>
<td>Guideline adoption</td>
<td>10% Reduction in new opioid prescriptions</td>
<td>▪ Reduced new prescriptions by 12%&lt;br&gt;▪ 3 new Suboxone prescribers increase of 37%</td>
<td>Partnership Health Plan, CURES data; Safe RX dashboard</td>
</tr>
<tr>
<td>Identify patients at risk for increased health issues</td>
<td>Live Well program enrollments</td>
<td>10% increase</td>
<td>▪ 2653 Total patients enrolled in Live Well.&lt;br&gt;▪ 149 in Live Well Intensive (IOPCM)</td>
<td>Live Well, Partnership Health Plan</td>
</tr>
<tr>
<td>Reduce opioid prescriptions and taper off patients on long term use</td>
<td>Opioid Prescriptions</td>
<td>10% reduction</td>
<td>▪ Reduced opioid prescriptions by 13% from 1206 to 1,064 per 1,000 persons.&lt;br&gt;▪ 2016 to 2018 shows 70% reduction in prescriptions for all doses.&lt;br&gt;▪ High Dose user apts down 85%</td>
<td>Partnership Health Plan, CURES data; Safe RX dashboard</td>
</tr>
<tr>
<td>Reduce E.D. visits</td>
<td>ED visits</td>
<td>10% reduction</td>
<td>▪ 12 recurring ED visits for enrolled patients&lt;br&gt;▪ 77% fewer ED visits (48 fewer vists).&lt;br&gt;▪ 86% less Respite patient ED visits by Restoration Respite members.&lt;br&gt;▪ 86% fewer hospital Days (-197 days, Length Of Stay) by Restoration House members.</td>
<td>Partnership Health Plan, hospital records, Restoration House Records, &amp; data prepped for RWJ.</td>
</tr>
<tr>
<td>Increase Diabetes monitoring</td>
<td>Diabetes monitoring</td>
<td>10% reduction in diabetes ED visits/hospital admissions</td>
<td>▪ 67 Patients enrolled in Diabetes Track&lt;br&gt;▪ Only 9 members visited the ED</td>
<td>Live Well Data, Partnership Health plan</td>
</tr>
<tr>
<td><strong>Reduce Premature Death</strong></td>
<td><strong>Years of life lost</strong></td>
<td><strong>10% reduction</strong></td>
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<tr>
<td><strong>Increase in Premature Death</strong></td>
<td><strong>Ranking from 57/58 to 58/58</strong></td>
<td></td>
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<tr>
<td><strong>Overall County ranking fell from 57/58 to 58/58.</strong></td>
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<tr>
<td><strong>Heart Disease dropped from 115.7 deaths to 105.7 deaths per 100k citizens (rank 45/58).</strong></td>
<td></td>
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<tr>
<td><strong>Strokes increased from 42.6 to 45.7/100k (rank 51/58).</strong></td>
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<tr>
<td><strong>Chronic Lower Respiratory disease raised slightly from 58 to 58.6/100k (rank 51/58).</strong></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>More Than Wheels</strong></th>
<th><strong>Patient Transportation/Access to care</strong></th>
<th><strong>Reduce missed appointments by 5%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Each month 17% fewer patients miss appointments by taking AHCL provided transportation.</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>4496 patients received bus vouchers and did not miss their appointments in 2018.</strong></td>
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<tr>
<td><strong>3560 patients received AHCL shuttle rides in 2018.</strong></td>
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</table>

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<thead>
<tr>
<th><strong>Empathy In Action</strong></th>
<th><strong>Employee empathy training workshop</strong></th>
<th><strong>Increase patient satisfaction by 10%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improved patient interview response “Would Recommend Hospital” 42.3% from 48.9 to 69.6.</strong></td>
<td></td>
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<tr>
<td><strong>Patient interview question “Responsiveness of Hospital Staff” improved 10.2% from 65.5 to 72.2.</strong></td>
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</tbody>
</table>

**Annual health Rankings CDPH 2019 report**
Project Restoration Financial Impact 2018

<table>
<thead>
<tr>
<th>Department Utilization</th>
<th>6 months pre-enrollment</th>
<th>6 months post-enrollment</th>
<th>Savings Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED visits</td>
<td>62</td>
<td>14</td>
<td>$426,000</td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>37</td>
<td>8</td>
<td>$180,000</td>
</tr>
<tr>
<td>Days in Hospital (LOS)</td>
<td>229</td>
<td>32</td>
<td>$788,000</td>
</tr>
<tr>
<td>SUB-TOTAL HOSPITAL</td>
<td>328</td>
<td>56</td>
<td>$1,394,000</td>
</tr>
</tbody>
</table>

| 911 calls/EMS transports     | 41                      | 3                        | $22,382          |
| Police Encounters            | 80                      | 10                       | $24,710          |
| Days in Jail                 | 172                     | 0                        | $84,280          |
| SUB-TOTAL Public Service     | 384                     | 13                       | $131,372         |

TOTAL SAVINGS 2018

$1,525,372

Program Highlight

Restoration House Client Story

“God, I want to seek and find,” muttered 18-year-old Carson Weiss as he hopped on his motorcycle and road out of Nevada. This quiet prayer shaped decades of difficult roads, hard work and service to others. Carson did not know the trajectory of his life that day on the motorcycle. Yet as I sit across from him in the Restoration House office, he projects the calm, focused demeanor of a man who knows his purpose. “So, Carson,” I say, smiling in anticipation of the narrative ahead, “tell me your story.”

Robert Carson Weiss was born in Detroit, Michigan in the summer of 1951. The middle child to parents who both struggled with their own addictions and a complex relationship- Carson embraced his eccentric attitude from a young age. His parents migrated west to Nevada, and Carson recalls this as an opportunity for him to spend time alone, going on walks and fishing. When he was eight the conflict in his home reached a breaking point and his parents divorced.

Carson pauses at this point of his story. As if digging up a painful past memory his face tightens a bit as he explained the cost that this time in his life had on what he wanted his future to be. He told me about 6th grade, the excitement of making the swim team, the enthusiasm of starting practice and feeling confident in the water; until he found out he had to pay dues. “This is when my life really took a turn” Carson recalls, “I did not even have the heart to ask, I knew we did not have the money, so I walked in the next day and quit. It was devastating. I was never quite the same after that, I started making poor decisions, I started smoking. It was really hard.”

Isolation became a healing mechanism for Carson in these early adolescent years, he was shy and spent most of his time alone. School was difficult until he moved in with his dad his junior year of High School. As his academic success increased Carson could see graduation in the distance.
He had just asked his step-mom if he could get a class ring for graduation, something he had worked hard to achieve. The “no, we don’t have the money” response had become more than Carson could handle that day, and when his friends pulled up and asked if he wanted to go to North Carolina he did not think much of jumping in the truck. “Honestly, I did not really think they were serious, then we started driving”. This three-month adventure led to years of traveling, living off the land, finding side jobs in new places, and forming new relationships and included time in, Ohio, California, Texas, and Nevada.

This time on the road marked another season in Carson’s life. While he had taken his first sip of alcohol around seven, he was not a heavy drinker, but when he got to Nevada things changed. “The beer was free, and it was really easy to drink.” Beer turned to hard liquor and Carson developed an addiction to alcohol. Jail time and hospitalization followed in the years to come and in 1999 Carson took the first step to turn his life around, he went to a meeting. Meeting turned to detox, detox, to rehab, rehab to a position as a live-in peer counselor. Fifteen years of working and participating in sobriety programs solidified for Carson the call on his heart to help others who are wrestling with addiction.

After taking some time away from the program, Carson again began to battle the clutch of alcohol. Relapse gave way to homelessness and hospitalization. A referral came to Project Restoration and Carson joined the program, his leadership and commitment to bettering himself and others setting the groundwork for the impact that he has made here. “I feel it is in my blood to serve, like that is what I was put on earth to do,” Carson says as we wind down our interview. A smile crosses his face when I ask him what Restoration House has done for him, “There is real love here, not phony put on or greedy love, there is genuine desire to heal. This is a place where I can still ask God to seek and find.”

Whether it be telling his story, offering strength and hope, or accompanying others to the meetings helped save his life; there is no doubt in my mind that Carson will continue to inspire, serve, and heal where ever he goes.
Priority Need 3 – Social and Economic (Access to Services, Substance use Disorders, Housing and Homelessness and Mental Health)

Intervention: **Hope Rising** (formerly Healthy Clear Lake Collaborative) Adventist Health Clear Lake Medical Center provides the backbone leadership and support to build and strengthen the community collaboration committed to mobilizing and inspiring community partnerships and actions that support individual, collective, and community health and wellness across Lake County. The Accountable Community For Health provides support and cohesive communication to the broad range of work throughout the community, supports leadership development in service providers & community members, shared data collection and analysis, and provides leadership for signature projects including SafeRx, and anchor activities including countywide wellness publications and resource guides, events, and evaluations.

- Number of Community Members Served: Entire County Population (65000)

Intervention: **SAFE RX** has already proven its success as an opioid reduction program. The program was established to support a healthier and safer community by improving the quality and functionality of life for individuals experiencing pain. SAFE RX has also shown the ability to reduce harm from prescription drug abuse through celebrative partnerships that focus on prevention, treatment, and recovery. Emphasis is placed on adhering to county-wide opioid prescribing guidelines.

- Number of Community Members Served: 0 (previously counted in Need #2)

Intervention: **RESTORATION HOUSE PROJECT** plays a vital role with the entire population health strategy for Adventist Health Clear Lake Medical Center. Its development is based on the evidence-based theories of the Camden Coalition. Its primary purpose is data analysis, solution identification, and countywide collaborative systems design. Project Restoration focuses on: high utilizer identification, readmission prevention, streamlined access to services for vulnerable populations, homelessness alternatives, intensive case management, mental health options, and substance abuse support.

- Number of Community Members Served: 0 (previously counted in Need #2)

Intervention: **HOPE CENTER FOR TRANSFORMATION** provides a program of intensive case management for individual transformation. The program will augment the county’s transitional housing and provide a range of support to facilitate access to and retention of permanent housing. The project, based on operational and successful housing models is embedded with services from county agencies, nonprofits, and health care systems, to create a powerful tool for individual and community transformation.

- Number of Community Members to be Served: 400
**Partners:**

- Sutter Lakeside Hospital
- Lake County Public Health
- Lake Health Center
- Mendocino Community Health Clinic
- Partnership Health Plan of California
- Sutter Lakeside Hospital
- Clearlake Police Department
- North Coast Opportunities
- Lake County Fire Protection District (EMT)
- Lake Transit
- Hospice Services of Lake County
- Lake County Behavioral Health
- County of Lake Board of Supervisors
- Woodland Community College
- Lake County Department of Social Services
- Hospice Services of Lake County

## Evaluation Metrics 2018

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
</table>
| Create community partnerships           | Collaboration to develop joint initiatives                                             | Buy in of major county organizations                                                | - 17 organizations partnered to form “Hope Rising Coalition”.  
- Over $4.4 Million in grants raised.                                                                                                             | Self-reporting              |
| Community buy-in                        | Participation                                                                         | 10% improvement in health                                                            | - 17 partners in Hope Rising help improve outcomes for Restoration House members.  
- 2627 SafeRx members with reduced opioid prescriptions.  
- 174 Live Well Intensive (IOPCM) patients with improved outcomes and reduced hospital visits.                                              | Hospital and clinic records |
Partnerships contributed to reduced cost, fewer hospitalizations and improved health outcomes for 32 Restoration House patients.

<table>
<thead>
<tr>
<th>Long term indicators</th>
<th>Participation</th>
<th>10% improvement in health rankings</th>
<th>Total of 2833 program participants experienced improved health outcomes as a direct result of community partnerships, Hope Rising, and hospital programs.</th>
</tr>
</thead>
</table>

Program Highlight: Live Well intensive (IOPCM)

Example of Whole Person Care

We had a patient who has Partnership Health and is capitated to our hospital (AHCL). We had been working with her for several months. She had serious skin infections from bedbugs and scratching the sores. She ended up being admitted to the hospital as an in-patient twice for her skin rash and infection and was admitted into the Intensive Care Unit (ICU). When the patient presented in our Emergency Department with new bites, we discussed options as a team, and determined that the only way to prevent readmission was to have the patient’s home fumigated. We (AHCL Hospital) contracted with a local company who did a fantastic job of eliminating all the bed bugs at the patient’s home. The patient has not had any new bites since that time. We spent $850.00 to have her home fumigated which cost far less than 1 day’s stay in the hospital and, most importantly, the patient’s needs were met – emotionally, spiritually and physically.

Program Highlight: Restoration House

Stories By the Numbers

Our first client walked out of jail and into transitional housing on June 6th, 2017. Since then we have worked with an additional thirty-nine men and women. Our clients include veterans, former business owners, retired civil servants, people with mental health issues, drug addiction and complex medical needs. Some have wrestled with poverty their entire lives and others were brought to it by an emergent health crisis. They include Americans of Caucasian, Latin and African descent. There is no single expression that can fully describe the diverse paths
that led these vulnerable members of our community to Project Restoration, but when they arrive, however they arrive, Hope Starts Here.

Fourteen of our clients have been sustainably housed; one of them was able to purchase a manufactured home in Clearlake and two of them were able to reconnect and move in with family members. Another is waiting to move into his new home which is in the process of being remodeled to allow safe access and mobility for his wheelchair.

Ten men and women currently reside at Restoration House. There are three people waiting for the next open bed.

Three of our clients came to us in the hopes of attaining health but became Hospice patients; their focus changed to pursuing a different kind of wholeness—reunification with family or a safe place to die among friends. The first of them passed in June 2018 surrounded by her son, daughter in-law and grandchildren. The second passed in a skilled nursing facility where her pain was managed, and she could rest in a comfortable bed. The third asked to be allowed to pass at Restoration House where in his final week he was surrounded by friends who read to him, sang with him, prayed for him or sat with him in silent vigil.

In addition to our residential clients, we are able to work with a few non-residential clients. One is in a Domestic Violence Shelter and we are assisting her with medical needs and appointments. Another will graduate from a three-month alcohol recovery program next week. Another is not ready for change, but we meet him where he is at and help as we are able. Among all of our clients, eight left the program before being sustainably housed and in stable health; of these two were able to return when they were ready, and we could welcome them back, one as a non-residential client and one in residence.

We are privileged to be part of each story and journey represented by the above numbers. – Rev. Shannon Kimbell-Auth, Project Restoration Coordinator
Priority Need 4 – Physical Environment (Access to Services, Mental Health)

Intervention: RESTORATION HOUSE PROJECT plays a key role in addressing this priority. Housing for the homeless is wrapped under this initiative. While the ultimate goal is permanent housing for patients experiencing homelessness, the initial phase of this project is transitional housing. Individual who have the greatest need are identified by both IOPCM hospital staff & by Restoration House staff for entry into the program and granted this living arrangement. The Camden Coalition with their ability to assess county-wide data and services used by homeless assists and support this project.

- Number of Community Members Served: 0 (previously counted in Need #2)

Intervention: WARMING CENTER & TEMPORARY SHELTER named “Hope Harbor” is on the front line of Lake County’s effort to provide care and access for people experiencing homelessness. Volunteers operate the shelter and screenings, along with many other social services, are available during Hope Harbor’s seasonal operation. Hope Harbor operates during the coldest months of the year and provides overnight sleeping arrangements for up to 26 homeless per night in the winter months, dinner and a packed breakfast in the morning.

- Number of Community Members Served: 240

Intervention: NUTRITIONAL SERVICES is seeking to impact the health and wellness attitudes of patients, employees, and community members through healthful food options at AHCL hospital. A comprehensive revitalization project was implemented which is focused on creating a vibrant and integral space focusing on health, wellness and healthy eating habits. This is accomplished through innovative menu offerings, added resources, and a visually appealing environment. Above all, emphasis is placed on fresh healthy food items. Through this revitalization program Adventist Health Clear Lake Medical Center models healthy choices to patients, residents of our community, and hospital employees through the Nutritional Services department.

- Number of Community Members Served: 2500

Intervention: HOPE CENTER FOR TRANSFORMATION A facility owned by Adventist Health Clear Lake and operated through community partnerships and the Hope Rising coalition will be the flagship facility to offer intensive case management, transitional housing, substance use disorder treatment, and job skill training with work experience for up to 200 program members per year. Hope Center graduates will be supported through aftercare groups and access to permanent housing options throughout the county. The program is designed to augment existing transitional housing programs and to provide a range of support to facilitate access to and retention of permanent housing. Hope Center is based on operational and successful housing models and is embedded with services from county agencies, nonprofit, and healthcare systems, to create a powerful tool for individual and community transformation.

- Number of Community Members to be Served: 0 (previously counted in Need #3)
## Partners

- Sutter Lakeside Hospital
- Lake County Public Health
- Lake Health Center
- Mendocino Community Health Clinic
- Partnership Health Plan of California
- Sutter Lakeside Hospital
- Clearlake Police Department
- North Coast Opportunities
- Lake County Fire Protection District (EMT)
- Lake Transit
- Hospice Services of Lake County
- Lake County Behavioral Health
- County of Lake Board of Supervisors
- Woodland Community College
- Lake County Department of Social Services
- Hospice Services of Lake County
- Redwood Community Services
- Lake County Continuum of Care
- Donald Miller & Associates

## Evaluation Metrics 2018

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Café Remodel</td>
<td>Completed remodel</td>
<td>Healthier food options and health inspiring environment</td>
<td>▪ Improved patient experience and satisfaction scores.</td>
<td>Self-reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Lifted employee morale and increased satisfaction scores.</td>
<td></td>
</tr>
<tr>
<td>Room Service</td>
<td>Implementation</td>
<td>All patient rooms</td>
<td>▪ 25 rooms receiving room service daily.</td>
<td>Self Reporting</td>
</tr>
<tr>
<td>Community Garden</td>
<td>Harvested produce</td>
<td>Harvest used in nutrition services</td>
<td>▪ Menu options</td>
<td>Self Reporting</td>
</tr>
<tr>
<td><strong>Kitchen Remodel</strong></td>
<td><strong>Completed Construction</strong></td>
<td><strong>Kitchen reopened with new equipment, new chef hired with restaurant training.</strong></td>
<td><strong>Self Reporting</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improved patient experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Raised employee engagement and satisfaction scores.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Decrease in food waste</strong></th>
<th><strong>More fresh vegetable food consumption</strong></th>
<th><strong>20% reduction in waste</strong></th>
<th><strong>Improved patient experience scores. Increased employee engagement &amp; satisfaction scores.</strong></th>
</tr>
</thead>
</table>

**Program Highlight: Safe Rx**

In December 2018, SafeRx Lake County established a partnership with The Clearlake Youth Center to fund an ongoing youth group program focused on prevention and wellness. The program, called Hope, is geared toward high school ages and offers:

- Peer Support and Feedback
- Opportunity to Socialize & Build Friendships
- Group and Individual Support
- Encouraging Atmosphere
- Promote Spiritual Strength and Personal Empowerment
- Free Dinner Served
- Promote Positive Attitude
- Increase Personal Responsibility
- Positive Reinforcement
- Adults Available to Listen/Share
- Life Topic Discussion
- Worship, Meditation, Prayer Time Available
• Opportunities to participate in community events
• Share possible solutions to our daily stress factors
• Build Self-Worth
• Gain knowledge to make healthy choices
• A place to feel safe, accepted, heard
• Learn important life skills
• Gain tools and resources to make positive choices.
• Build resiliency against peer pressure
• Connect with supportive people
• Help others grow and succeed
• Share and discuss personal questions and concerns
• Discover steps to a healthier life
• A place where people become friends and friends become family
Other Community Benefits

Intervention: Population Health Analysis and Strategy Development Project
  - Number of Community Members Served: Entire County Population (65000).

Intervention: ECAT Catastrophic Fund for assistance in case of disaster.
  - Number of Community Members Served: 6

Intervention: CPR/First Aid/BLS/ACLS/PALS Courses.
  - Number of Community Members Served: 200

Intervention: Economic Development Council Participation.
  - Number of Community Members Served: Population of Clearlake (15500).

Intervention: Education in Healthcare including Physical Therapy, Nursing education.
  - Number of Community Members Served: 1135.

Intervention: Training for Healthcare Professionals including PT/OT, Empathy, Medical Imaging Internship, Highschool Shadowing program, CEP & other training.
  - Number of Community Members Served: 602.

Intervention: Social Services Enrollment Assistance:
  - Number of Community Members Served: 1600

Intervention: Workshops and Support for New & Growing Families:
  - Number of Community Members Served: 42

Intervention: Fitness and Exercise, Annual Turkey Trot Fun Run:
  - Number of Community Members Served: 165

Intervention: Use of Hospital Facilities for Community Groups:
  - Number of Community Members Served: 1200

Intervention: Leadership Training, Empathy in Action Cultural Sensitivity:
  - Number of Community Members Served: 340

Intervention: Nutrition & Weight Management, Operation Christmas Joy:
Intervention: Dental Screenings:
  - Number of Community Members Served: 400

Intervention: Weight Watchers meetings:
  - Number of Community Members Served: 80

Intervention: Support Group, Death in the Family “Circle of Life”:
  - Number of Community Members Served: 164

Intervention: Mental Health Support Groups
  - Number of Community Members Served: 724

Intervention: Patient Shuttle and Transportation, made available to all Clearlake patients.
  - Number of Community Members Served: 6,000

Intervention: Women’s and Children’s services OB, classes and education including “Mommy to Be”, “Bright Start”, High Risk Management, Childbirth classes.
  - Number of Community Members Served: 80

Intervention: Workforce Development - Health Professional Recruitment for MUA’s, Physician Recruitment:
  - Number of Community Members Served: Health service area 22,000 lives

Partners

- Lake Transit
- Redwood Community Services
- Pacific Union College
- North Coast Opportunities
- County of Lake Department of Social Services
- Partnership Health Plan of California
Changes in 2018

The Robert Wood Johnson Foundation and The CDPH Health Rankings continue to rank Lake County in last place, 58/58 counties in California for health and years of potential life lost before age 75. Despite the ranked and weighted outcomes, the county wide collaboration and AHCL CHP initiatives are beginning to drive changes that will begin to improve the health rankings for Lake County. Our work and collaboration with agencies around Lake County is driving positive change. The best example of that change is the collaboration and contribution of 17 agencies including healthcare systems to form the Hope Rising Accountable Community for Health coalition and appoint a director charged with managing the creation of the new 2019 CHNA for Lake County.

Disaster Relief, Fire and the Mendocino Complex fire.

Lake County has endured devastating wild fires for the past 3 years consecutively. On July 27, 2018 the Ranch and River Fires started miles apart in the northern part of the county. Overnight both fires grew dramatically eventually causing the evacuation of all 19,000 northern county residents of Kelseyville, Lakeport, Upper Lake, Blue Lakes, Potter Valley, Nice, Lucerne, Clearlake Oaks and other unincorporated areas. On July 31 mandatory evacuations closed Sutter Lakeside Hospital, the largest of the two hospitals serving the 65,000 residents of Lake County. Sutter Lakeside Hospital would remain closed for the next 11 days until reopening on August 11, 2018. Lake County tribal Health Consortium and Lakeview Medical Center were closed to out-patient services as were numerous pharmacies.

Adventist Health Clear Lake Medical Center was the only operating hospital in the county for more than a week as firefighters battled to save the city of Lakeport. Patients at Sutter Lakeside were transferred to Adventist Health Clear Lake Medical Center and other out-of-county hospitals with beds available. AHCL brought in additional staff, many who lived in evacuated areas of the community, to provide medical care to our 65,000 Lake County citizens.

Working closely with County EOC and Lake County Public Health, AHCL staff was able to provide needed medical treatment to both evacuated and non-evacuated patients. N95 masks were widely distributed to anyone in need. Evacuees who did not get their medications before leaving home were assisted in getting refills to bridge the gap until they returned home. Oxygen and necessary medical aids were procured as needed. The Emergency Department saw an increased number of patients for breathing treatments due to the poor air quality.

AHCL finance department records show an increase in charity medical care provided during the month of August 2018 due primarily to the closure of Sutter Lakeside Hospital and the increased need in the county for medical care due to the fire disaster.
https://vimeo.com/289021679

Mendocino Complex Fire Perimeter
Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1) The distribution of specific health statuses and outcomes within a population;
2) Factors that cause the present outcomes distribution; and
3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
2) Improve care quality and patient safety and
3) Advance care coordination across the health care continuum.

Our mission as a health system is to Live God’s love by inspiring health, wholeness and health and we believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.
Glossary of terms

Medical Care Services (Charity Care and Un-reimbursed Medi-Cal and Other Means Tested Government Programs)

Free or discounted health services provided to persons who meet the organization’s criteria for financial assistance and are thereby deemed unable to pay for all or portion of the services. Charity Care does not include: a) bad debt or uncollectible charges that the hospital recorded as revenue but wrote-off due to failure to pay by patients, or the cost of providing care to such patients; b) the difference between the cost of care provided under Medicaid or other means-tested government programs, and the revenue derived there from; or c) contractual adjustments with any third-party payers. Clinical services are provided, despite a financial loss to the organization; measured after removing losses, and by cost associated with, Charity Care, Medicaid, and other means-tested government programs.

Community Health Improvement

Interventions carried out or supported and are subsidized by the health care organizations, for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services. Community Health Improvement – These activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Helps fund vital health improvement activities such as free and low-cost health screenings, community health education, support groups, and other community health initiatives targeting identified community needs.

Subsidized Health Services – Clinical and social services that meet an identified community need and are provided despite a financial loss. These services are provided because they meet an identified community need and if were not available in the area they would fall to the responsibility of government or another not-for-profit organization.

Financial and In-Kind Contributions – Contributions that include donations and the cost of hours donated by staff to the community while on the organization’s payroll, the indirect cost of space donated to tax-exempt companies (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies. Financial and in-kind contributions are given to community organizations committed to improving community health who are not affiliated with the health system.

Community Building Activities – Community-building activities include interventions the social determinants of health such as poverty, homelessness, and environmental problems.
Health Professions Education and Research

Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual’s health profession specialty. It does not include education or training programs available exclusively to the organization’s employees and medical staff, or scholarships provided to those individuals. Costs for medical residents and interns may be included.

Any study or investigation in which the goal is to generate generalized knowledge made available to the public, such as underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal)
Community Health Needs Assessment and Community Health Plan Coordination Policy

Entity:

System-wide Corporate Policy  Standard Policy  Model Policy

Corporate Policy  Department: Administrative Services
Category/Section: Planning

POLICY SUMMARY/INTENT:

This policy is to clarify the general requirements, processes and procedures to be followed by each Adventist Health hospital. Adventist Health promotes effective, sustainable community benefit programming in support of our mission and tax-exempt status.

DEFINITIONS

1. Community Health Needs Assessment (CHNA): A CHNA is a dynamic and ongoing process that is undertaken to identify the health strengths and needs of the respective community of each Adventist Health hospital. The CHNA will include a two-document process, the first being a detailed document highlighting the health related data within each hospital community and the second document (Community Health Plan or CHP) containing the identified health priorities and action plans aimed at improving the identified needs and health status of that community.

   A CHNA relies on the collection and analysis of health data relevant to each hospital’s community, the identification of priorities and resultant objectives and the development of measurable action steps that will enable the objectives to be measured and tracked over time.

2. Community Health Plan: The CHP is the second component of the CHNA and represents the response to the data collection process and identified priority areas. For each health need, the CHP must either: a) describe how the hospital plans to meet the identified health need, or b) identify the health need as one the hospital does not intend to specifically address and provide an explanation as to why the hospital does not intend to address that health need.

3. Community Benefit: A community benefit is a program, activity or other intervention that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of these objectives:

   - Improve access to health care services
   - Enhance the health of the community
   - Advance medical or health care knowledge
   - Relieve or reduce the burden of government or other community efforts
Community benefits include charity care and the unreimbursed costs of Medicaid and other means-tested government programs for the indigent, as well as health professions’ education, research, community health improvement, subsidized health services and cash and in-kind contributions for community benefit.

**AFFECTED DEPARTMENTS/SERVICES:**
Adventist Health hospitals

**POLICY: COMPLIANCE – KEY ELEMENTS**

**PURPOSE:**
The provision of community benefit is central to Adventist Health’s mission of service and compassion. Restoring and promoting the health and quality of life of those in the communities served, is a function of our mission “To share God’s love by providing physical, mental and spiritual healing.” The purpose of this policy is: a) to establish a system to capture and report the costs of services provided to the underprivileged and broader community; b) to clarify community benefit management roles; c) to standardize planning and reporting procedures; and d) to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals. As a charitable organization, Adventist Health will, at all times, meet the requirements to qualify for federal income tax exemption under Internal Revenue Code (IRC) §501(c)(3). The purpose of this document is to:

1. Set forth Adventist Health’s policy on compliance with IRC §501(r) and the Patient Protection and Affordable Care Act with respect to CHNAs;
2. Set forth Adventist Health’s policy on compliance with California (SB 697), Oregon (HB 3290), Washington (HB 2431) and Hawaii State legislation on community benefit;
3. Ensure the standardization and institutionalization of Adventist Health’s community benefit practices with all Adventist Health hospitals; and
4. Describe the core principles that Adventist Health uses to ensure a strategic approach to community benefit program planning, implementation and evaluation.

**A. General Requirements**

1. Each licensed Adventist Health hospital will conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through such assessment.

2. The Adventist Health *Community Health Planning & Reporting Guidelines* will be the standard for CHNAs and CHPs in all Adventist Health hospitals.

3. Accordingly, the CHNA and associated implementation strategy (also called the Community Health Plan) will initially be performed and completed in the calendar year ending December 31, 2013, with implementation to begin in 2014.

4. Thereafter, a CHNA and implementation strategy will be conducted and adopted within every succeeding three-year time period. Each successive three-year period will be known as the Assessment Period.
5. Adventist Health will comply with federal and state mandates in the reporting of community benefit costs and will provide a yearly report on system wide community benefit performance to board of directors. Adventist Health will issue and disseminate to diverse community stakeholders an annual web-based system wide report on its community benefit initiatives and performance.

6. The financial summary of the community benefit report will be approved by the hospital’s chief financial officer.

7. The Adventist Health budget & reimbursement department will monitor community benefit data gathering and reporting for Adventist Health hospitals.

B. **Documentation of Public Community Health Needs Assessment (CHNA)**

1. Adventist Health will implement the use of the Lyon Software CBISA™ product as a tool to uniformly track community benefit costs to be used for consistent state and federal reporting.

2. A written public record of the CHNA process and its outcomes will be created and made available to key stakeholders in the community and to the general public. The written public report must include:
   
   a. A description of the hospital’s community and how it was determined.
   
   b. The process and methods used to conduct the assessment.
   
   c. How the hospital took into account input from persons who represent the broad interests of the community served.
   
   d. All of the community health needs identified through the CHNA and their priorities, as well as a description of the process and criteria used in the prioritization.
   
   e. Existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

3. The CHNA and CHP will be submitted to the Adventist Health corporate office for approval by the board of directors. Each hospital will also review their CHNA and CHP with the local governing board. The Adventist Health government relations department will monitor hospital progress on the CHNA and CHP development and reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals’ community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.

4. The CHNA and CHP will be made available to the public and must be posted on each hospital’s website so that it is readily accessible to the public. The CHNA must remain posted on the hospital’s website until two subsequent CHNA documents have been posted. Adventist Health hospitals may also provide copies of the CHNA to community groups who may be interested in the findings (e.g., county or state health departments, community organizations, etc.).
5. For California hospitals, the CHPs will be compiled and submitted to OSHPD by the Adventist Health government relations department. Hospitals in other states will submit their plans as required by their state.

6. Financial assistance policies for each hospital must be available on each hospital’s website and readily available to the public.

---

Corporate Initiated Policies: (For corporate office use)

References: Replaces Policy: AD-04-002-S

Author: Administration

Approved: SMT 12-9-2013, AH Board 12-16-2013

Review Date:

Revision Date:

Attachments:

Distribution: AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Director
### Restoration House Data:

**Public Services Cost Savings**

<table>
<thead>
<tr>
<th>Prior Consecutive Years of Type of Encounters</th>
<th>Community Utilization Variables</th>
<th>Community Utilization Costs/Variables</th>
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**OUR MISSION:**

Living God’s love by inspiring health, wholeness & Hope.
## Restoration House Data continued:

### Healthcare Cost Savings

<table>
<thead>
<tr>
<th>Visits</th>
<th>Gross Charges</th>
<th>Outpatient Charges</th>
<th>Operating Margin (Estimated)</th>
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<table>
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<tr>
<th>Healthcare Cost/Savings</th>
<th>Total</th>
<th>ED</th>
<th>BP</th>
<th>ED/BP</th>
<th>FEES/ Service</th>
<th>Total</th>
<th>Revenue</th>
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Diabetes Track report:

**AH Clear Lake**

Diabetes Track – pilot results (25 patients who completed program)

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<tr>
<td>Pre HbA1c</td>
<td>9.42%</td>
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<tr>
<td>Post HbA1c</td>
<td>7.83%</td>
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<tr>
<td>Difference</td>
<td>1.59%</td>
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</table>

90% of enrolled patients saw their HbA1c drop

Clinic Bus Vouchers purchased in 2018

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<tr>
<th>SITES</th>
<th>MONTHLY-$40.00</th>
<th>PUNCH-$10.00</th>
<th>BASE FARE-$1.25</th>
<th>TOTAL</th>
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<td>CLEARLAKE CLINIC</td>
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<td>50</td>
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<tr>
<td>PHYSICAL THERAPY</td>
<td>700</td>
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<td>CL HOSPITAL ADMITTING</td>
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<td><strong>Sub Total:</strong></td>
<td>51</td>
<td>95</td>
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<td>4350</td>
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<td><strong>TOTAL</strong></td>
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<td>$8,427.50</td>
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Adventist Health Clear Lake Patient Shuttle Service 2018

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<tr>
<th>Shuttle Bus 1</th>
<th>Month</th>
<th>Patients</th>
<th>Shuttle Bus 2</th>
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<td></td>
<td>November</td>
<td>318</td>
<td>November</td>
<td>80</td>
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<td></td>
<td>December</td>
<td>316</td>
<td>December</td>
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<td></td>
<td><strong>Sub Total</strong></td>
<td>3560</td>
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<td><strong>137</strong></td>
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<td></td>
<td><strong>TOTAL</strong></td>
<td>3697</td>
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Empathy In Action 2018. Post Discharge Interview Reports:

**Picker-IP-A: Would Recommend Hospital**

- Qtr 1 2017: PR=70
- Qtr 1 2018: PR=60
- Qtr 2 2018: PR=60
- Qtr 3 2018: PR=70
- Qtr 4 2018: PR=70

**CAHPS-IP-A: Responsiveness of Hospital Staff**

- Qtr 1 2017: PR=30
- Qtr 1 2018: PR=60
- Qtr 2 2018: PR=70
- Qtr 3 2018: PR=70
- Qtr 4 2018: PR=70

Note: The charts show trends and scores over different quarters.
### SafeRx Data Opioid data for Lake County 2017 – 2018

#### Partnership HealthPlan

<table>
<thead>
<tr>
<th>SafeRx</th>
<th>Target</th>
<th>Qtr 1 Jul - Sep 2015-16</th>
<th>Qtr 2 Oct - Dec 2015-16</th>
<th>Qtr 3 Jan - Mar 2016-16</th>
<th>Qtr 4 Apr - Jun 2016-17</th>
<th>QTR 1 Jul - Sep 2016-17</th>
<th>QTR 2 Oct-Dec 2016-17</th>
<th>QTR 3 Jan-Mar 2016-17</th>
<th>QTR 4 Apr-June 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg MED per PHC user per Qtr (target = Plan Ave., current Qtr.)</td>
<td>55</td>
<td>59</td>
<td>56</td>
<td>54</td>
<td>54</td>
<td>54</td>
<td>52</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Ave. PHC users/100PMP (target = Plan Ave., current Qtr.)</td>
<td>9</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>7</td>
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<tr>
<td>All Opioid Users/Qtr.</td>
<td>1,745</td>
<td>1,702</td>
<td>1,692</td>
<td>1,463</td>
<td>1,345</td>
<td>1,204</td>
<td>1,209</td>
<td>1,158</td>
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<tr>
<td>Unsafe Dose Users (&gt;120 MED)</td>
<td>163</td>
<td>155</td>
<td>137</td>
<td>117</td>
<td>112</td>
<td>100</td>
<td>98</td>
<td>80</td>
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<tr>
<td>Total Prescriptions/100PMP (target = 75% reduction)</td>
<td>8</td>
<td>17</td>
<td>16</td>
<td>15</td>
<td>12</td>
<td>11</td>
<td>9.4</td>
<td>9.5</td>
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<tr>
<td>Initial Prescriptions P100PMP (target = 50% reduction)</td>
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<td>2.9</td>
<td>2.8</td>
<td>3.1</td>
<td>2.3</td>
<td>2.5</td>
<td>2.1</td>
<td>2.1</td>
<td>2.4</td>
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<tr>
<td>Dose Escalations (target= 90% reduction)</td>
<td>3%</td>
<td>25%</td>
<td>22%</td>
<td>22%</td>
<td>17%</td>
<td>15%</td>
<td>16%</td>
<td>15%</td>
<td>14%</td>
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<tr>
<td>Ave. Percent Users on Unsafe Dose (&gt;120 mg. MED) (target = 75% red.)</td>
<td>4.8%</td>
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<td>7%</td>
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#### Quarterly Statistics

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</thead>
<tbody>
<tr>
<td>Avg MED per PHC user per Qtr (target = Plan Ave., current Qtr.)</td>
<td>55</td>
<td>59</td>
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<tr>
<td>Ave. PHC users/100PMP (target = Plan Ave., current Qtr.)</td>
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<td>16.5</td>
<td>12.4</td>
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<td>All Opioid Users/Qtr.</td>
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<td>Unsafe Dose Users (&gt;120 MED)</td>
<td>269</td>
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<td>36</td>
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<td>MED per 100PMP</td>
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<td>401</td>
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<tr>
<td>Total Prescriptions/100PMP (target = 75% reduction)</td>
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<td>24</td>
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<td>Initial Prescriptions/100PMP (target = 50% reduction)</td>
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<td>Ave. Percent Users on Unsafe Dose (&gt;120 mg. MED) (target = 75% reduction)</td>
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