MARIN HEALTHCARE DISTRICT

100-B Drake's Landing Road, Suite 250, Greenbrae, CA 94904 **Telephone: 415-464-2090** **Fax: 415-464-2094**
Website: www.marinhealthcare.org ***Email:*** info@marinhealthcare.org

LEASE & BUILDING COMMITTEE, REGULAR MEETING
MONDAY, MARCH 30, 2015 AT 5:30 P.M.

Committee:
Chair: Ann Sparkman, JD
Member: Jennifer Rienks, PhD
Staff: Jon Friedenberg, Chief Administrative Officer
Support: Louis Weiner, Executive Assistant

Location:
Marin Healthcare District
100-B Drake's Landing Road, #250
Greenbrae, CA 94904

AGENDA

			ATTACHMENTS
1.	**Call to Order / Approval of the Agenda**	Sparkman	
2.	**Approval of the Minutes of February 4, 2015**	Sparkman	#1
3.	**Public Comment** Any member of the audience may make statements regarding any item NOT on the agenda. Statements are limited to a maximum of three (3) minutes. Please state and spell your name if you wish it to be recorded in the minutes.	Sparkman	
4.	**Grant Review and Recommended Next Steps (Action)**	Sparkman	
	(a) Canal Alliance		#2
	(b) Jewish Family and Children's Services		#3
	(c) Love is the Answer (LITA Marin)		#4
	(d) Marin Villages		#5
	(e) The Redwoods		#6
	(f) Marin Senior Coordinating Council, "Whistlestop"		#7
5.	**Other Business**	Sparkman	
6.	**Monthly Meeting Schedule for 2015**	Sparkman	
7.	**Adjournment**	Sparkman	

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.

American Sign Language Interpreters may be requested by calling (415) 464-2090 (voice) or (415) 464-2094 (fax) at least 48 hours in advance of this meeting.

Tab 1

MARIN HEALTHCARE DISTRICT

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LEASE AND BUILDING COMMITTEE
REGULAR MEETING
WEDNESDAY, FEBRUARY 4, 2015
MINUTES

1. **Call to Order**
   Chair Ann Sparkman, JD, called the meeting to order at 5:31 p.m.

2. **Roll Call**
   Committee Members Present: Chair Ann Sparkman, JD; Member Jennifer Rienks (arrived 5:40 pm)
   Board Members Present: Harris Simmonds, MD; Jennifer Hershon, RN, MSN
   Staff Members Present: Jon Friedenberg; Louis Weiner
   Public Present: Nischit Hegde (CNA)

3. **Minutes Approval**
   It was moved, seconded and carried to approve the minutes of the meeting of November 19, 2014.

4. **Public Comment**
   No public comment.

5. **Bylaws: Purpose and Goal of the Committee**
   Chair Sparkman reviewed the Committee's charge and obligation as stated in the District Bylaws, Article V, Section 4, "Lease and Building Committee." She and Jon Friedenberg noted that topics not covered by the other District Board Standing Committee, the Finance and Audit Committee, are to come to this Committee. An example would be the proposal for marketing materials supporting a District public relations campaign.

   There was discussion of the process of revising Bylaws, Article V, Section 1(c) regarding the inclusion of Community Members on the Board Standing Committees. Such revision would refine requirements regarding Community Members. This will be discussed at the next full Board meeting.

6. **Support of the Hospital Replacement Project**
   Chair Sparkman referred to the Bylaws' charge that this Committee is to "Oversee the District's performance, in coordination with the MGH Corporation, of facility and campus design, planning and construction projects." Director Simmonds described the necessity for MHD and MGH to better integrate with each other in the Hospital Replacement Project process, including using this Committee more. Jon Friedenberg explained that, due to the scope, size, aspect and core purpose of this project, it has been argued that it may be better served to present all

information and recommendations to the entire District Board as a whole at each step, rather than presenting to this Committee first and repeating those presentations subsequently to the Board. The Design Team is presenting full details to the full MHD Board, and the question remains whether there are elements of the details better served to be presented only to this Committee for discussion and recommendation. Jon reiterated that the Design Team's presentations to the MHD Board will all be done in Open Session.

Member Rienks urged consideration of using both the MHD Board and this Committee to help support publicity and philanthropy for the project, and to use the meetings to invite and encourage public input on the project, and the Committee shared this perspective

7. MHD-MGH Lease

The new lease takes effect December 2, 2015. This Committee will monitor and exercise oversight of the Lease. Before the lease takes effect, a regular meeting of this Committee in the fall will include the presence of Counsel Don Bouey (represented the MHD with the lease renewal) for discussion on specifics, as well as general custodial oversight, of the lease. Mr. Bouey, or like counsel, may be called upon for a proposal for periodic lease monitoring.

8. NEXT MEETING

The next meeting will be in March, TBA.

9. ADJOURMENT

Chair Sparkman adjourned the meeting at 6:02 p.m.

Tab 2

Grant Application

Submission Date	2014-12-31 13:50:32
Full Name	Maria Vierra
Phone Number	(415) 306-0418
Fax Number	(415) 454-3967
E-mail	mariav@canalalliance.org
Relationship/Position in Organization	Grants Manager
Name	Canal Alliance
Address	Street Address: 91 Larkspur Street City: San Rafael State / Province: CA Postal / Zip Code: 94901 Country: United States
Website	www.canalalliance.org
Tax Status	exempt
Tax ID #	94-2832648
Brief Organization Description (including mission, goals and communities served)	For more than three decades, Canal Alliance has been the leading service provider and community advocate for Marin's low-income, Spanish-speaking immigrants. The organization annually reaches more than 3,500 young people, families and individuals who face multiple challenges. By effectively collaborating with at least 40 other agencies and 500 volunteers, Canal Alliance delivers youth and adult education services, improves access to community resources, offers immigration legal services and provides business training and job-seeking support. Programs are successful in moving vulnerable immigrants, who fled their home countries to escape poverty and/or persecution, from crisis to stability and finally to thriving.
Project Title	Behavioral Health Program for Low-Income Latino Immigrants
Start Date	1/1/15
End Date	12/31/15
Summary	The community we serve is in great need of accessible bilingual and bicultural behavioral health services. Many immigrants have come to Marin to escape armed conflict, civil unrest, domestic violence and or extreme poverty. Frequently, they have experienced traumatic events in their country of origin, and may incur further trauma from their immigration experience. Once in the US, they face multiple

stressors such as poverty, unemployment, racism, and immigration issues. Many live in overcrowded apartments where an entire family might share a single room to help make ends meet. Family discord and domestic violence are triggered as families struggle to survive, acculturate and learn a new language. Additionally, many families struggle with difficulties experienced as a result of extended separation and eventual reunification between parents and children as part of the immigration process. As a result, many experience and ongoing, elevated level of stress which can affect both mental and physical health. According to the Mayo Clinic:

Stress symptoms can affect your body, your thoughts and feelings, and your behavior. Being able to recognize common stress symptoms can give you a jump on managing them. Stress that's left unchecked can contribute to health problems, such as high blood pressure, heart disease, obesity and diabetes.

The Canal Alliance Behavioral Health Program helps clients to address and reduce causes of stress, learn stress management techniques and receive group and individual support and connection to community resources to improve clients' behavioral and physical health.

Canal Alliance provides community-based, culturally and linguistically competent behavior health services for the Latino community in Marin County. Our unique Behavioral Health program provides a continuum of community defined, best-practices-based services including a Spanish speaking Behavioral Health Specialist who provides brief interventions and group support, Family Advocates/Coaches who provide para-professional behavioral health support and community health workers (promotoras) working in the community to educate the community about behavioral health issues and help people access resources.

All of our work is highly trauma-informed and all the staff are certified in Motivational Interviewing with more than 20 hours of training. The service design reflects the cultural norms of the Latino community we serve. Most clients can be seen quickly, sometimes even immediately. We are located in the heart of the Canal neighborhood, we are highly trusted and have been serving the community for over thirty years, and all of our behavioral health services are offered completely free of charge. The community based multi- service agency prevents fear of stigma, as people receive many types of services at this location. When community members are facing issues of domestic violence, parenting concerns, relationship difficulties or other emotional stress, Canal Alliance is the place they come to for help.

Objectives/Goals (please be as specific and measurable as possible)

1. 80 clients receive brief interventions with Behavioral Health Coordinator; resulting in improved mental health status for 75% as measured by an assessment tool

2. 170 clients will receive one-to-one paraprofessional behavioral health case management, resiliency support and referrals from Canal Alliance Family Resource Advocates

3. 300 immigrant community members will receive education

	outreach about behavioral health and stress management from trained Community Health Advocates
Project Budget (total budget must be submitted with this application)	$624,520
Amount of funding you are requesting from Marin Healthcare District (MHD)	$50,000
What line items would MHD funding go towards and in what time frame would it be used?	A grant of $50,000 would enable Canal Alliance to fully fund the Behavioral Health Coordinator position (budget line item 23) and hire a much-needed half-time assistant to help with support groups and case management services. (line item 27). Please Note: attached project budget is for the total Family Resources Program, which provides our Behavioral Health Services.
Other sources of funding (including already secured and pending)	Secured funding for Family Resources includes grants from Marin Community Foundation ($233k), County government contracts ($231k), and a small number of other foundation grants $64k).
Insurance	Uninsured
Gender	Both
Age Group	18 - 40 years old 40 - 65 years old 65 + years old
Ethnicity	Hispanic or Latino
Other Populations	Low Income Non-English Speaking
Number of people expected to reach/serve:	550+
Other partners involved in the project	Canal Alliance partners with several other community agencies, including the Center for Domestic Peace (home of Marin Abused Women's Services) and the UCSF Childhood Trauma Research Team, led by psychologist Vilma Reyes.
How will progress in achieving each objective/goal be measured?	All client interactions are entered and tracked in Canal Alliance's client services database.
How will outcomes be measured?	Outcome 1 is measured by administering pre and post assessment tests such as the GAINS adapted. Outcome 2 is measured by case notes entered and tracked in client database. Outcome 3 is measured by an Activity Log maintained by Community Health Advocates (Promotoras).

Please upload the total budget for your project	Canal Alliance Project budget for Marin Healthcare Community Grant.pdf
Please upload the total budget for your organization	Canal Alliance FY14-15 Org Budget.pdf

Tab 3

Grant Application

Submission Date	2014-12-23 15:06:18
Full Name	Nancy Masters
Phone Number	(415) 491-3602
Fax Number	(415) 491-7958
E-mail	nancym@jfcs.org
Relationship/Position in Organization	Director, Marin Region
Name	Jewish Family and Children's Services
Address	Street Address: 600 Fifth Avenue City: San Rafael State / Province: CA Postal / Zip Code: 94901-3348 Country: United States
Website	www.jfcs.org
Tax Status	501(c)(3)
Tax ID #	94-1156528
Brief Organization Description (including mission, goals and communities served)	Jewish Family and Children's Services (JFCS), founded in 1850 in Gold Rush San Francisco, today operates more than forty different programs that annually serve 78,000 individuals and families of all ages, faiths, ethnicities, and income levels throughout our five-county West Bay service area stretching from Sonoma County south to Santa Clara County. The JFCS mission is to alleviate suffering and help people of all ages develop and maintain their highest potential by providing comprehensive professional and volunteer services. Our Marin County office, opened in 1972, last year served over 11,000 Marin County residents with a range of supportive services, including emergency assistance; individual and family counseling and care management; our menu of Seniors At Home services to help seniors and people with disabilities maintain their independence and the highest possible quality of life; Parents Place Family Resource Center offering parenting education, consultation, and clinical services for children, youth, and families; YouthFirst youth development activities; Adoption Connection; and extensive volunteer outreach to the ill and isolated. JFCS is committed to serving the entire community. More than 60% of our clients have low- to moderate-incomes that qualify them for subsidies according to our income-based sliding fee scale, which ensures that no one is turned away for inability to pay the full cost of the help that they need to

	overcome challenges and live the best life possible.
Project Title	Seniors At Home - Aging in Place
Start Date	1/1/2015
End Date	12/31/2015
Summary	JFCS' Seniors At Home division (SAH) offers a continuum of care for frail elderly that is both comprehensive and substantive. The menu of SAH services supports older adults in achieving the highest possible quality of life while remaining living safely in their own homes. Care management remains our core service. JFCS geriatric care managers conduct an in-depth assessment to identify physical, mental, and emotional needs. They engage seniors and their families to obtain assistance, and coordinate the delivery of professional and volunteer services to successfully ameliorate many of the barriers to independence that seniors face, decrease social isolation, and increase community in order to improve health and well being. All services are delivered in partnership with the older adult and his/her family or other support system, with particular attention to providing services in a culturally competent manner, respecting the values and beliefs of each individual and family. SAH clients represent a broad cross section of the population, from individuals on MediCal with no assets and resources to older adults with means to pay the full cost of private care, and everyone in between. Clients with greater means are charged for services according to a competitive fee structure established by JFCS for all senior services. JFCS staff is continuously exploring opportunities to raise funds to help underwrite the cost of specialized SAH services and thereby subsidize the cost of needed care for low-income older adults. Those older adults most challenged to age in place with adequate supports are often those with cognitive decline, mental health issues, clients at end of life, and elders with other specialized needs that require significant expertise to address. Seniors who fall between federal poverty and the Older Adult Economic Security Index which was established for Marin County based on actual costs of living for older adults in our county present the greatest challenge as they are ineligible for public services but often unable to afford needed care. This past fall, the County of Marin Department of Aging and Adult Services convened several workgroups in response to its identification of four key areas of need for Marin's aging population. This Aging Action Initiative, which several staff of JFCS SAH assisted with in a leadership capacity, has prioritized the following areas as needing increased focus in order to meet the expanding needs of Marin's rapidly aging population: Care Coordination, Mental Health, Dementia, and Nutrition. In addition, the County of Marin is currently studying the needs of those older adults who are "economically insecure" per the index previously described. Over the past five years, Seniors At Home has been recognizing and responding to the complex needs of

individuals most at risk as they age by developing specialized services that can augment the care management model of care in order to address those most prevalent challenges that impede an individual's ability to age in place. SAH's expanded care management model responds to many of the challenges identified by the community needs assessments and the County of Marin in their recent Aging Initiative described above.

Support from the Marin Healthcare District is requested for an enhanced, comprehensive care management model for low and moderate income Marin older adults which, in addition to providing geriatric care management for older adults with the greatest need in our county, will enable us to access and bring in a team of specialists to consult with seniors and their families and caregivers in order to more expertly address the multi-faceted needs of older adults. Our interdisciplinary consultation team includes a care manager, dementia specialist, palliative care specialist, geriatric psychologist, and chaplain. This team is supported by trained volunteers supervised by the various specialists and managed by our Volunteer Coordinator.

• Program Components

Seniors At Home conducts regular outreach throughout Marin County, and referrals come to our agency through hospital discharge planners, home health social workers, county social workers, 911 emergency responders, physicians, concerned neighbors and family members, and many others who have contact with seniors in great need. SAH's professionally staffed intake department helps callers identify needs. An experienced geriatric social worker makes home visits to conduct a comprehensive biopsychosocial assessment and works with the client and family members, if appropriate, to develop a comprehensive plan of care. The care manager helps clients to implement the care plan, including accessing all needed services available from SAH as well as other Marin non-profits, businesses, health care providers, and public agencies with which SAH enjoys strong collaborative relationships.

The SAH consultative team provides expert resources to the care manager, seniors, family members, and other caregivers and health providers in order to address challenging circumstances that impede the senior's ability to implement aspects of their care plan. Once the care manager has identified a need for additional support, referrals are made to the appropriate team members to mobilize additional resources and expertise for clients and families. The interdisciplinary collaborative team is strengthened through monthly case conferences at which specific clients are discussed and training opportunities are provided to enhance knowledge of all staff in key program areas.

• Mental health screening and intervention by our geriatric psychologist/therapists with short term treatment as needed.

Older adults, particularly those 75 and over, generally are less likely to access mental health services due to perceived stigma of mental health diagnoses, reluctance to

engage in a counseling relationship with a therapist, and difficulty with access, as few mental health practitioners accept Medicare payment due to low reimbursement rates. Geriatric psychiatry services are particularly difficult to access in Marin. In addition, many of the life challenges and stresses experienced by older adults, including declines in health, social networks, independence, and other life changes, can exacerbate previous underlying mental health conditions or trigger onset of depression or anxiety symptoms. The link between chronic disease and depression is well established; in addition, mental health issues often impact seniors' willingness to receive needed medical care and follow physician recommendations. It has been our experience over the past several years that when older adults are identified early regarding risk and are engaged in a non-threatening manner with effective services provided by specially trained practitioners, they are very willing to engage in short-term treatment with successful outcomes.

Our mental health consultants are brought in on those cases where mild to moderate mental health issues are affecting the client's ability to age in place. Our consultants provide professional psychological screening, in-home assessment, and early intervention and linkages to service for underserved older adults with onset of mild to moderate mental health difficulties, often secondary to life transitions such as changes in health status, grief and loss, relocation, social isolation, and other factors. We address barriers to care by providing services in clients' homes within a care management model that reduces the stigma of seeking mental health services. The goal is to increase access to and acceptance of intervention services, offer evidence-based short-term effective treatment as needed, including an evidence-based behavioral activation protocol, and track and improve mental health outcomes. Short term family caregiver counseling is also provided to assist caregivers with mental health issues that arise from the burdens of the care-giving role.

• Dementia consultation for client and family, on-going support provided by our dementia specialist

One in three older adults over 65 have been diagnosed with some form of dementia; the percentage leaps to one in two for adults over age 85. Yet most families and caregivers feel helpless when faced with dementia in their loved one. They are desperate for practical help in easing anxiety, addressing behavioral issues, and ensuring the highest possible quality of life for both the senior and his/her loved ones.

SAH offers individualized, in-person consultation and hands-on training from a dementia specialist for family members and caregivers of adults with dementia. Our dementia specialist, a social worker with ten years of experience in dementia care and direct behavioral intervention and support, is a resource brought in by our SAH care manager as one component of the client's care plan. The goal is to provide tangible tools to help facilitate meaningful interactions between the person with memory loss and their caregiver and/or family members, and to provide caregivers with the education and skill set needed to support the client with dementia with routine care needs.

By meeting with each family in person, she can model the behavioral intervention(s) that address issues of the specific client. She is also available to consult with caregivers by phone, providing real time advice as to how to respond to challenging behaviors in order to enhance client cooperation and avoid a violent outburst.

Our dementia specialist can provide families with a tool kit with guidance on structuring time and supporting reminiscence and sensory stimulation. She has a collection of activities, such as games and crafts that she can choose from to match each client's interests and abilities. Older adults with cognitive impairments are often anxious because they can no longer structure their own time. Our dementia specialist trains caregivers and family members on how to help the senior structure their time, reducing anxiety that can otherwise lead to behavioral outbursts. She can also help caregivers/families make adaptations to create a more comfortable environment for seniors who may be resistant to carrying out activities of daily living (ADL's).

• Palliative and End of Life Support, including palliative care nurse consultant and spiritual consultation by chaplain

Responding to a gap in home-based end of life services in the Bay Area, in 2007 we established our Palliative and End of Life Care (PEOL) service. The PEOL program creates a bridge between hospitals, home, and hospice by collaborating with our community healthcare partners. SAH Palliative and End of Life Care services are offered at the request of the care manager at no cost to any client who is receiving SAH care management. Quality care, comfort, and relief from physical, emotional and spiritual pain are the focus of our palliative care consultant team, which includes an RN with over 20 years of experience in palliative and end of life care and our rabbi/spiritual counselor. As opposed to hospice eligibility, the client does not require a terminal six-month prognosis for program eligibility, so the Palliative Care team can begin caring for clients who are in decline but not dying. The Palliative Care team dialogues with the client about end of life choices, and closely collaborates with all of the client's healthcare providers to ensure the client's choices are honored, including accessing hospice services when appropriate on physician referral. Pain and symptom management consultations regarding treatment options and choices for quality of life, healthcare advocacy, skilled nursing visits, emotional and spiritual support, companionship and family respite, and bereavement support are program components.

• Enhanced community support through volunteer services

Our Seniors At Home program offers extensive volunteer services to our client population that play a key role in helping seniors live safer, healthier, more independent lives in their own homes. Given Marin's topography and housing options, aging in place in Marin can often result in social isolation. Aging in community can coincide with aging in place if community is built into the service delivery model. Aging in community promotes a sense of social connectedness and interdependence, enhanced over time through positive interactions and collaboration in shared interests and pursuits. JFCS builds community through the

volunteer components of its programs, assigning well trained and supervised volunteers to regularly visit and support isolated older adults at risk.

Clients of the agency are screened for their needs and interest in volunteer support. Volunteer outreach offered by our cadre of specially trained and supervised Marin County volunteers include Senior Companions, trained Palliative Care volunteers, “Special Delivery” personal grocery shoppers who shop for seniors at Safeway and, for seniors unable to afford groceries, who stock JFCS pantries and deliver food to seniors, Chicken Souper program volunteers who cook and deliver meals to seniors, and youth and families who volunteer to visit seniors at the holidays or provide tangible assistance. Currently JFCS has volunteer training programs in place for Senior Companions and Palliative/End of Life Care volunteers. We are seeking funding to add two new volunteer programs during the current year: trained mental health peer support volunteers and trained Dementia Program volunteers.

After a referral is made by the care manager or one of our specialist team members, our Marin Volunteer Coordinator makes a home visit to each client to assess how volunteers can best help them, to introduce clients to their volunteers, and to help problem-solve, as needed. After their initial screening interview, volunteers receive a 2-3 hour general orientation. This may be followed by project-specific training such as the 30-hour intensive training for Palliative/End of Life Care volunteers or our proposed 12-hour training for mental health support volunteers. Our Volunteer Coordinator also arranges additional optional training workshops that address specific topics such as elder abuse, LGBT aging issues, supporting clients during the holidays, and understanding the special needs of Holocaust survivors and other victims of trauma. Volunteer Coordinators check in with active volunteers daily to monthly by telephone and/or email. They also regularly phone clients and are in regular contact with JFCS care managers.

Objectives/Goals (please be as specific and measurable as possible)

Objectives --

• During the project year, 150 seniors will be assessed for risk factors that would impede successfully aging in place, include administering established screening tools for dementia, depression, anxiety, and assessing severity of risks along 14 dimensions.

• During the project year, at least 30 seniors will receive specialist consults and interventions designed to increase success of aging in place.

• During the project year, at least 30 seniors will receive support to age in community through assignment of a volunteer visitor trained to help support their goals.

Outcomes --

The program’s success will be measured by the ability of clients receiving care management and other services to continue living successfully in their own homes, safely and with the greatest level of independence possible. While sometimes placement is necessary for the well-being of the

	client and can be a positive outcome if the client is not safe at home, generally the client's goal is to remain in independent living. Client disposition forms are kept on all clients, and each client's status can be tracked and reported Other outcome measures, which will vary according to the identified needs and risk factors of each client, include whether the client is assessed to have made progress in one or more dimensions toward one or more standardized outcomes, improvements in health or mental health functioning, and self-reported satisfaction with services received. We will track the following outcome goals: • At least 90% of SAH care management consumers will avoid institutionalization as evidenced by an annual report that 90% or more of clients still remain in their homes at termination. • 80% of older adults receiving services who complete a satisfaction survey will report being satisfied with services provided • 80% of older adults receiving services will be assessed as having met or made progress toward two or more of the goals identified in their care management plan. Methods used to measure outcomes are discussed under "Evaluation," below.
Project Budget (total budget must be submitted with this application)	$262,374
Amount of funding you are requesting from Marin Healthcare District (MHD)	$50,000
What line items would MHD funding go towards and in what time frame would it be used?	The one year budget detailing how funds will be spent includes a small portion of the salaries of the geriatric specialist team members, care manager, director, and volunteer coordinator, and related operating, facility, and indirect administrative expenses.
Other sources of funding (including already secured and pending)	Marin Community Foundation senior care management and home care: $85,000, May 1, 2014-April 30, 2015; continued funding to be requested based on newly established priorities of the foundation. County of Marin Mental Health Services Act Prevention and Early Intervention initiative: $100,000, July 1, 2014-June 30, 2015; three years grant cycle through June 30, 2017. County of Marin Department of Aging and Adult Services: $18,000 annually; will reapply in July 2015.
Insurance	Insured
Gender	Both
Age Group	65 + years old

Ethnicity	African American Asian Caucasian Hispanic or Latino
Other Populations	Low Income Mentally Ill
Number of people expected to reach/serve:	150
Other partners involved in the project	Seniors At Home collaborates with an extensive network of community agencies to ensure that all client needs are addressed. These include Whistlestop Wheels and Marin Transit; Meals on Wheels program; County of Marin Department of Aging and Adult Services, in particular its In Home Support Services division; County of Marin Mental Health and Substance Abuse; Marin Center for Independent Living; Marin Legal Aid; Fair Housing of Marin; the Alzheimer's Association; and many other community agencies. In addition, Seniors At Home works closely with the local hospital discharge planners, home health agency social workers, and other health care professionals.
How will progress in achieving each objective/goal be measured?	Our intake department collects information on all seniors, family members, and referral sources that contact our agency, as well as referrals made to programs and services within the agency. All clients registered and service units provided by staff are tracked in our management information system. Progress in achieving our objectives of serving clients with the proposed service model will be measured through meeting targets for numbers served and types of services provided. Service utilization is monitored on a monthly basis. In addition, the effectiveness of integrating consultants into case plans will be assessed through numbers of successful referrals, and additions or changes to the care plan that reflect the expertise of the consultants. Our ongoing outreach efforts will be fine tuned in real time in order to reach the target of number served and services to be delivered. Number of volunteers recruited, trained, and successfully placed will be tracked. Volunteers for programs involving intensive training are asked to complete a Volunteer Evaluation Form at the conclusion of their training so that we can continuously monitor and strive to improve this aspect of the program.
How will outcomes be measured?	Since June of 2012, JFCS has been using an outcomes tracking tool developed by LFA Group Consultant Steven LeFrance (generously funded by Marin Community Foundation). This tool assists us in evaluating client outcomes in a standardized manner across agency programs serving both adults and seniors. The care manager-administered tool is used to assess problem severity across standardized problem areas including housing, physical health, daily functioning and safety, mental

	health, substance use, behavior, cognitive functioning, nutrition, social support, and financial, legal, and other concerns. It is also administered at case closing to determine improvements in each identified problem area. This JFCS outcomes tracking tool developed by LFA Group will be integrated into the new agency-wide electronic health record system that JFCS is in the process of implementing. The electronic health record will be able to track more descriptive data on our clients and utilize a more automated variation of this method of measuring impact. Clinical measures are collected as appropriate using standardized assessment tools. A PHQ-9 (or Geriatric Depression Scale if more clinically appropriate), and, if any anxiety symptoms are present, the GAD-7 for anxiety are also used. These screening tools establish a baseline for each client. At set intervals or at the conclusion of our interventions, clients are reassessed to determine if progress has been made in mental health utilizing these established tools. In addition, a determination is made as to whether each client's goals have been met, and the client's progress in addressing the issues identified as part of the initial assessment in the 14 identified categories is determined. In this way, we are able to track the client's experience of progress, the clinician's assessment of the client's progress, and use of established screening tools to obtain a post treatment score that can be compared to the pre-treatment score to determine if improvement has occurred. Client satisfaction with services is also measured through a yearly questionnaire that is sent by mail to all clinical and care management clients of Seniors At Home in Marin. Surveys are mailed to the senior, or occasionally to caregivers if seniors are not able to complete the evaluation form. Follow-up phone calls are made to encourage survey completion. Volunteers also receive satisfaction surveys on a biannual basis.
Please upload the total budget for your project	Marin Healthcare District proposal budget 12-2014.xlsx
Please upload the total budget for your organization	2014-2015 Agency Budget.pdf

Tab 4

Grant Application

Submission Date	2014-11-21 17:36:40
Full Name	Richard Jensen
Phone Number	(415) 472-5482
Fax Number	(415) 472-4965
E-mail	litamarin@sbcglobal.net
Relationship/Position in Organization	Executive Director
Name	Love is the Answer (LITA Marin)
Address	Street Address: 4340 Redwood Highway Building F Street Address Line 2: Suite 101 City: San Rafael State / Province: California Postal / Zip Code: 94903 Country: United States
Website	www.litamarin.org
Tax Status	501(c)3
Tax ID #	95-3295831
Brief Organization Description (including mission, goals and communities served)	Since 1975, LITA Marin has provided friendship and support to the elderly of Marin County, California. As a nonprofit we have more than 300 volunteers of every age that bring a tender heart and a listening ear to long-term care facility residents. LITA establishes friendships for someone who may be alone or does not receive regular visitors. The mission of LITA is to improve the quality of life for persons living in 38 skilled nursing facilities, residential care facilities, and retirement residences throughout Marin County by providing volunteer visitors. LITA promotes friendships that lessen isolation and loneliness, and increase public awareness of the needs of residents of long-term care facilities.
Project Title	LITA Volunteer Recruitment and Placement
Start Date	1/1/2015
End Date	12/31/2015
Summary	We propose that the Marin Healthcare District partner with LITA on the recruiting, processing and placing of adult volunteers with elders in Marin's assisted living, skilled nursing and retirement residences. The grant proceeds would offset LITA's general operating expenses in creating these volunteer positions. Volunteers are sourced in the community through outreach and recruitment

	communications requiring time and effort with other service organizations such as Rotaries, service clubs, senior centers, small and large businesses with Community Development goals.
Objectives/Goals (please be as specific and measurable as possible)	1) With this grant allocation LITA would recruit, process and successfully place 15 adult volunteers in 2015. 2) LITA conducts volunteer satisfaction surveys annually to determine satisfaction among the volunteers and the halo effect on the elders in the visits. We have determined that both the volunteers and the elders benefit mentally. Volunteers are engaged and elders have less loneliness.
Project Budget (total budget must be submitted with this application)	10,100
Amount of funding you are requesting from Marin Healthcare District (MHD)	10,000
What line items would MHD funding go towards and in what time frame would it be used?	Time Frame = 1/1/2015-12/12/2015 Personnel Expenses $8,500 Rent/Utilities $ 930 Gen. Office Exp. $ 670 Insurance $ 148 Travel $ 114 Volunteer Appreciation Event $ 537
Other sources of funding (including already secured and pending)	$100 from LITA's Wallbridge Trust (to cover the cost of preparing this grant request).
Insurance	Insured Uninsured Payer Mix
Gender	Both
Age Group	40 - 65 years old 65 + years old
Ethnicity	African American Asian Caucasian Hispanic or Latino
Other Populations	Low Income Mentally Ill Non-English Speaking
Number of people expected to reach/serve:	15-20 elders served by 15 volunteers
Other partners involved in the project	Wallbridge Trust

How will progress in achieving each objective/goal be measured?	1) Measurement of volunteers recruited, processed and placed by this request 2) Annual volunteer satisfaction survey results
How will outcomes be measured?	1) Measurement of volunteers recruited, processed and placed by this request 2) Annual volunteer satisfaction survey results
Please upload the total budget for your project	MarinHealthCareDistrictProject Request.xlsx
Please upload the total budget for your organization	2014 LITA Budget.pdf

Tab 5

Grant Application

Submission Date	2014-12-17 16:50:27
Full Name	Lisa Brinkmann
Phone Number	(415) 457-4633
Fax Number	(415) 457-4633
E-mail	lbrinkmann@marinvillages.org
Relationship/Position in Organization	Executive Director
Name	Marin Villages
Address	Street Address: 930 Tamalpais Ave City: San Rafael State / Province: CA Postal / Zip Code: 94901 Country: United States
Website	www.marinvillages.org
Tax Status	501(c)(3)
Tax ID #	27-0281669
Brief Organization Description (including mission, goals and communities served)	Marin Villages' mission is to help older adults in Marin County remain in their homes and communities independently, with dignity and grace. We are a grassroots, nonprofit organization fueled by a network of volunteers, mainly seniors, who assist each other with the challenges of remaining healthy, socially engaged, mentally stimulated and independent in the homes and communities they love. Our services range from transportation to medical appointments; from opportunities to engage in social activities to assistance with health management issues and access to vetted agencies and services providers. In a very short time Marin Villages has grown to include over 450 members and volunteers with five active local Villages in Homestead Valley, Mill Valley, North San Rafael, Ross Valley, the Tiburon Peninsula. We are planning to launch new Villages in Central San Rafael and Novato in 2015. Last year we completed over 2,400 requests for service, of which 1,700 were rides and 1000 of those were for medical appointments. In addition to this transportation need, many of our members requested volunteer assistance for grocery shopping, companionship, walks and help around the home. We project this demand for 'neighborly' assistance to continue to grow as our County ages, the demand to "age in place" increases and the availability for alternative housing options narrows.

	The 2014 Marin Civil Grand Jury Report cited MARIN VILLAGES as a promising concept to alleviate some of the problems among seniors “especially low to middle income older adults” in our community. Through our services, we are also able to contribute new resources to the community thus reducing demand on county services. There is now evidence that the Village model promotes a number of salutary outcomes including better health and well-being, and enhanced recovery from illness. Below is a quote from a 92 year-old member, who is once again an active volunteer. After returning home from the hospital, our volunteers paid her daily visits, assisted with preparing dinner, picked up groceries and let her know that she was not alone: “Yes, I came to the Village first as a "volunteer". I was not in need of your services, I was independent -I just wanted to help. Then, in one split minute everything changed. When a sudden stroke set my knees to shaking, I had to sit down fast, - and face a different future. Independence gone, I would now be totally dependent on the assistance of others. It was then I recognized what a truly wondrous resource the Village was with its myriad services available by just a call. So I thank you warmly for all those services, - irreplaceable drivers and household helpers, - and the ability of maintaining some "dignity and grace" in demoralizing circumstances. For all of these things and especially for the warmth and skills of your leaders, I am endlessly grateful."
Project Title	Transition Home
Start Date	January 1, 2015
End Date	December 31, 2015
Summary	Transition Home will be a program offered to members, volunteers, families and friends. We plan to provide a menu of key social services that aim to reduce recidivism after hospitalization or outplacement procedures and to help increase the likelihood of remaining healthy and independent at home. Transition Home will be a combination of educational forums and materials, assess to direct services and a roadmap to successful outplacement back into the home.
Objectives/Goals (please be as specific and measurable as possible)	Through our Transition Home program, we aim to develop repeatable, scalable, and sustainable program to assist seniors in transitioning home after hospitalization and/or outpatient procedures; Transition Home program would offer the following (this is not an exhaustive list): • Educational forums and materials pertaining to key elements of planning for hospitalization and/or outpatient procedures, overview of types of home care organizations, tools/checklists for ‘getting ready’; • Direct volunteer services, including but not limited to: o Prior to hospitalization - pre-planning for personal needs during and after hospital stay using a Transition Home

	checklist and in-take form o While in the hospital – help with pet care, trash removal, bringing in the mail, providing reading material, watering plants o Prior to discharge – assistance with grocery shopping, picking up prescriptions, and other tasks and errands o After discharge - transportation for follow-up appointments, neighborly check-in and visits, assistance with grocery shopping, picking up prescriptions, laundry and minor household tasks; • Follow-up surveys to determine effectiveness of program and satisfaction of participants.
Project Budget (total budget must be submitted with this application)	20,000
Amount of funding you are requesting from Marin Healthcare District (MHD)	20,000
What line items would MHD funding go towards and in what time frame would it be used?	While we are currently performing many of the services that would fall under the Transition Home program, they are not structured or combined into a formal program with a specific goal in mind. Although approximately 85% of our budget ($237,000) goes to member services, we would be unable to specifically develop a new formalized program such as Transition Home with current resources. Consequently, we would use funding from Marin Healthcare District to specifically formalize and implement this Transition Home program. In addition, we will track participation, monitor impact and better understand the impact of neighborly help on recidivism. This funding would be applied to the following line items: 1. staff and consultants to develop, communicate and recruit for the program as well as track, monitor and report on success of program. Jan – December 2015 2. developing marketing collateral, identifying partnerships and promoting the program throughout the Villages and surrounding communities April – August 2015
Other sources of funding (including already secured and pending)	None of our other sources of income will be allocated to this specific program. Our sources of funding come from membership fees, donations and grants including Marin Community Foundation, the County of Marin and Marin Transit.
Insurance	Insured Uninsured Payer Mix
Gender	Both
Age Group	65 + years old
Ethnicity	African American Asian Caucasian Hispanic or Latino

	Other
Other Populations	Low Income
Number of people expected to reach/serve:	We aim to reach/serve our members and volunteers, which currently number 450. In addition, we will open our educational forum to the public (including family and friends). We hope to capture the real number of people services, as the indirect impact of avoiding recidivism through the Transition Home program may be a multiple of those direct (family, friends, social services, etc.) affected.
Other partners involved in the project	We plan to work with Marin General and Marin County Human and Health Services in securing resources and educational materials for this project, as well as other services as appropriate.
How will progress in achieving each objective/goal be measured?	We would measure our success based on: 1. Our ability to publish and distribute collateral, promotions and outreach communicating the Transition Home program by August 2015 2. # of members and volunteers participating in Transition Home programs/events 3. # of members released from the hospital requesting Transition Home services.
How will outcomes be measured?	1. Availability of a 'Transition Home' communication toolkit with communications, educational materials and publications; 2. A 25% participation rate of volunteers and 40% participation rate of members in the Transition Homes educational forum in first year; 3. A 50% participation rate of members released from the hospital, returning home, requesting Transition home services, in first year.
Please upload the total budget for your project	Project budget.xlsx
Please upload the total budget for your organization	BUDGET SUMMARY 2014-2015.pdf

Tab 6

Grant Application

Submission Date	2014-12-19 14:39:04
Full Name	Barbara Solomon
Phone Number	(415) 383-2741
Fax Number	(415) 383-0115
E-mail	bsolomon@theredwoods.org
Relationship/Position in Organization	Chief Executive Officer
Name	The Redwoods
Address	Street Address: 40 Camino Alto City: Mill Valley State / Province: CA Postal / Zip Code: 94941 Country: United States
Website	www.theredwoods.org
Tax Status	501(c)3
Tax ID #	23-7085414
Brief Organization Description (including mission, goals and communities served)	Since 1972, The Redwoods has been a hub of social, physical, spiritual and intellectual activity for Marin County seniors. Our mission is to promote good health, emotional well-being and housing security to a diverse group of seniors, with an emphasis on serving those who are low and moderate income. On our 10-acre Mill Valley campus we provide affordable rental housing, superb services and outstanding care for up to 340 seniors. The age range of our residents is 72 to 104 and the average age is 87. We offer three levels of care: Independent Living, Assisted Living and the Health Care Center, a state-licensed Skilled Nursing Facility. Designed to meet the varying health needs of our residents, these care levels also enable seniors to continue living here even if their capacity for independence diminishes. Our supportive environment promotes active, healthy aging and contributes to a dynamic community spirit. The Redwoods provides a rich array of more than 100 classes, programs and activities. These include a robust daily schedule of yoga, dance, tai chi, outdoor walking and other wellness/fitness classes and a strong network of social services and mental health support groups, as well as organic gardening, arts and crafts classes, political lectures, music groups and more. The excellence of our care and programs has led The Redwoods to be named the best senior living facility by the Pacific Sun's 2014 Best of Marin list. Our Health Care Center recently received a 5-star rating for overall quality from the Centers for Medicare & Medicaid

	Services. We have a long-standing commitment to affordability. Unlike a continuing care retirement community, which typically has high buy-in costs, seniors pay a modest fee ($7,500), which can be waived if it proves to be a financial hardship, to move into The Redwoods. In addition, a full 40% of our 149 Independent Living Apartments have HUD Section 8 subsidies and 30% of Health Care Center residents are on Medi-Cal. The Redwoods also provides rent assistance for low- and moderate-income residents facing financial challenges to remain living at our community, and helps them with health-related costs such as eye glasses, dentures and hearing aids.
Project Title	John L. Levinsohn Center for Dynamic Aging
Start Date	3/26/2015
End Date	3/31/2016
Summary	The Redwoods respectfully requests grant funding for a project that will enhance our existing wellness program for residents, and enable us to extend the program's benefits to seniors from the general Marin community. MHD funds will be used towards our new Center for Dynamic Aging (named the John L. Levinsohn Center for Dynamic Aging), a key feature of our current "Revitalizing the Redwoods" campaign. Marin is the fastest aging county in California, currently a population with one in four residents over the age of 60. And the number of seniors in the county is expected to grow substantially in the immediate future. By 2030, older adults are projected to comprise more than 30% of Marin's population. As a non-profit agency providing affordable rental housing and care for older adults, The Redwoods has an important role to play in helping Marin meet the increased demand for senior housing and services, especially programs that support their physical and mental health. However, after 42 years of providing a high quality of life to seniors, our campus has been in need of major revamping. This is why "Revitalizing The Redwoods," a project to upgrade and modernize much of our 10-acre campus, was launched in December 2013. Among the major components is the construction of the new Center for Dynamic Aging. Complementing The Redwoods commitment to supporting residents' well-being in body, mind and spirit, the Center will include a dedicated exercise studio, space for strength training and fitness classes, massage/therapy rooms, an aqua therapy facility and health resource library. Besides the Center, the project also includes the revitalization of our Independent Living Apartments, the construction of a new kitchen and renovation of the existing dining room, the renovation of our entry and lobby areas and the "greening" of our campus grounds. Given the limited availability of affordable senior rental housing in Marin and projected increase in the senior population, these improvements will strengthen The Redwoods capacity to provide a supportive retirement community that meets the health, wellness and care needs of seniors today and well into the future.
Objectives/Goals (please be as specific and measurable as	Objectives/Goals 1. Construct the new Center for Dynamic Aging, an important

possible)	new hub around which The Redwoods' culture of active living revolves. To be opened in March 2016, the Center will feature: *an aqua therapy area which will include a pool with multi-functionality, such as a chair lift, built-in underwater treadmill, resistance jets and varying floor depths, to support accessibility and a variety of physical therapies, and a hot pool, also with chair lift, for pain relief and soaking. While The Redwoods offers a wide array of exercise classes, this brand new area will enable us to offer water-based fitness and therapy, which allows a person to move more freely than on land, for the first time. *an exercise studio outfitted with HUR circuit training machines, which are designed to meet the specific mobility needs of seniors, improve incontinence and prevent falls: *space for fitness and wellness classes, including yoga, strength training, programs to improve balance, dancing and more. At present, fitness and exercise classes are held in The Redwoods' auditorium and other spaces throughout our campus. The new Center will house all of these activities in a single area wholly dedicated to health and wellness; and, *dedicated rooms for massage and physical therapy for residents, the majority of whom are frail and/or live with chronic pain. 2. Support seniors' positive mental health by integrating a resource library into the Center for Dynamic Aging. This library will feature a computer work station where residents can engage in brain fitness activities that help sharpen their cognitive function. The resource library will also include a wealth of exercise, health and nutritional reference materials to help seniors make informed lifestyle choices. 3. Hire a full-time (1.0 FTE) Program Director, prior to the center opening, to plan and manage all aspects of the Center for Dynamic Aging by December 2015. This person's primary duties will be to: design fitness classes and other activities that benefit seniors' health and well-being, provide instruction to seniors on use of the Center's equipment and therapy pool, coordinate scheduling and use of therapeutic areas and conduct outreach to the residents of The Redwoods and senior residents in the southern Marin community about the Center's programs and to encourage participation. 4. Develop an operations and outreach plan by the end of 2015 to expand access to the Center for Dynamic Aging to seniors in southern Marin County and Mill Valley. Our intention with the Center is to create a resource that attracts residents of The Redwoods and older adults in the community at large who are at a wide variety of fitness levels. Although this region is home to many fitness clubs and gyms, these existing ones primarily cater to younger adults who are already reasonably physically fit and/or enjoy regular exercise. The Center will feature a number of amenities, including chair lifts for the aqua therapy area, rooms for physical therapy and exercise machines designed for seniors with limited mobility, that make it easier for frail or disabled older adults and those contending with chronic pain to take advantage of fitness and wellness activities. The Center will also house, in a building completely dedicated to healthy aging, an array of cardiovascular and

	strength classes and programs that appeal to more active and fit residents and seniors. Outcomes Within the first year of the Center for Dynamic Aging's operation, The Redwoods expects to meet the following outcomes: 1. At least 125 residents of The Redwoods will participate in at least one fitness class or other physical activity. Of this total, at least 50 residents will be regular users of the Center. 2. 60% of residents who use the Center will report reduction in their chronic pain symptoms. More than 70% of seniors living at The Redwoods confront chronic pain. They will benefit from having access to a facility with equipment, instruction and classes designed to maintain and improve physical strength, reduce the incidence of falls, demonstrate techniques to attain better balance, increase flexibility and manage pain. 3. 60% of residents who use the Center will report improved physical fitness, greater levels of energy, enhanced mental function and a more positive outlook on life.
Project Budget (total budget must be submitted with this application)	$3,880,320
Amount of funding you are requesting from Marin Healthcare District (MHD)	$50,000
What line items would MHD funding go towards and in what time frame would it be used?	MHD funding would be used to support essential fixtures and equipment for the Center for Dynamic Aging's aqua therapy area including benches, spa equipment and the two chair lifts for the multi-functional pool and the hot pool. This new facility will enable The Redwoods to bring the benefits of water-based therapy, which is one of the most effective and accessible modalities for healing injuries, restoring patient confidence and increasing mobility, to our residents and seniors in the community at large. MHD funds will also enable us to purchase massage tables for the therapy treatment rooms and fitness equipment for the fitness studio and training room. The Redwoods estimates these items would be purchased and installed from November 2015 to February 2016.
Other sources of funding (including already secured and pending)	The Redwoods has secured lead support for the Center for Dynamic Aging from a trio of major donors. Through their collective gift, the Center will be named in honor of John L. Levinsohn, a long-time supporter and past President of The Redwoods' Board of Directors. Given the significant costs associated with the construction and furnishing of such a health and wellness facility, we are seeking additional funding from foundations, individuals and other entities for this vital component in our Revitalization project. In addition to these earmarked dollars for the Center, The Redwoods' overall "Revitalization" project has strong momentum and is closing in on its goal. The total cost for

	the project is $32.8 million with funding from the following sources: bond financing ($28.2 million), reserves ($2 million) and a capital campaign ($2.6 million). As of December 1, the campaign has raised more than $2,265,000 million from foundations, corporations and individuals, leaving us with $335,000 left to go.
Insurance	Payer Mix
Gender	Both
Age Group	65 + years old
Ethnicity	African American Asian Caucasian Hispanic or Latino
Other Populations	Low Income
Number of people expected to reach/serve:	125
Other partners involved in the project	The Redwoods is exploring potential partnerships to ensure the Center for Dynamic Aging addresses the needs of our residents and seniors from the broader community, specifically those who suffer from chronic pain, limited mobility and declining health as the result of aging. HydroWorx is consulting with us on the design and features of the multi-functional pool and therapeutic hot pool. HUR US, the manufacturer of the circuit training equipment geared for seniors that will be a key feature of the Center, is advising us on both the exercise area layout and machines that will best serve the needs of our senior population. We are in discussions with Impaq, with which we now contract to provide physical therapy to residents, on how best to extend their services within the Center's programs. The Redwoods will also reach out to local area massage schools/centers, such as Massage Envy and National Holistic Institute, about providing massage services, including free and low-cost options for low-income seniors. We regularly partner with Dominican University's Occupational Therapy Department and University of California San Francisco's Nursing program on research-related work, and will explore ways to involve these institutions in the Center's therapeutic- and fitness-related activities.
How will progress in achieving each objective/goal be measured?	Progress on building the Center for Dynamic Aging and integrating a health resource center will be measured through monthly budget reports showing income secured and expenses incurred for the construction and updates on construction progress provided by NOVA Partners, the project manager. Thorough review procedures are already in place for the Revitalization project, which will continue during the construction of the Center, with oversight provided by The Redwoods' Chief Executive Officer, the senior management team and the Board of Directors. The Board meets monthly, the Revitalization Task Force meets quarterly, or more frequently as needed, and fiscal oversight is provided by the bond lender. Staff performance evaluations by The Redwoods'

	management and feedback from residents will help determine the extent to which the new, full-time staff member is successfully managing the Center. Once the Center is operational and being used by residents, The Redwoods will initiate a plan to open up services to the broader community of seniors. This is in keeping with our current practice of keeping our wellness programs open to the public. Progress on the creation of this plan will be measured through meeting notes of the working group, comprising the Center's program director, senior staff, members of the Board of Directors and resident representatives, charged with developing the plan.
How will outcomes be measured?	Users of the Center will be required to sign in electronically, which will track the overall number of residents who are visiting the facility, as well as the frequency of their visits. Changes in the presence of chronic pain, feelings of physical fitness and mental wellness will be measured through a survey that asks residents to self-report on these aspects of their health. Residents will fill out this survey as part of the intake process during their first visit to the Center. It is anticipated that the Program Director will conduct a follow-up survey at six-month intervals to measure progress.
Please upload the total budget for your project	TRWMarinHealthcare14ProjectBudgetFINAL.xls
Please upload the total budget for your organization	TRW FY15 Org Budget.pdf

Tab 7

Grant Application

Submission Date	2014-12-29 19:59:41
Full Name	Yvonne Roberts
Phone Number	(415) 302-9346
Fax Number	(415) 456-2858
E-mail	ruth@seniorscounseling.net
Relationship/Position in Organization	Development & Marketing Director
Name	Marin Senior Coordinating Council
Address	Street Address: 930 Tamalpais Avenue City: San Rafael State / Province: CA Postal / Zip Code: 94901 Country: United States
Website	www.whistlestop.org
Tax Status	CA 501(c) 3
Tax ID #	94-1422463
Brief Organization Description (including mission, goals and communities served)	Since 1954, the Marin Senior Coordinating Council, commonly known as “Whistlestop”, has operated a volunteer-based 501(c)3 nonprofit serving Marin County, CA, by offering a variety of programs for older adults and people with disabilities from its Active Aging Center in downtown San Rafael. Through special needs transportation, nutritious meals, creative social activities and classes, Whistlestop connects friends and families with opportunities to engage in interesting, supportive programs that promote a healthy, better quality of life. Our mission is to ensure that all older adults and people with disabilities in Marin County have the ability to age with independence, dignity and grace. Whistlestop’s Active Aging Center houses its Multicultural Program, a variety of educational, fitness and social classes, a Help Desk which connects individuals to resources and six volunteer-based nutrition programs that include the Jackson Café, Meals on Wheels, Meals of Marin, a brown bag farmers’ market-style free food pantry, a home-delivered grocery service and Supplemental Food Bank program.
Project Title	HEALTHY AGING THROUGH ACCESS TO PROPER NUTRITION
Start Date	July 1, 2015
End Date	June 30, 2016

Summary	Whistlestop's mission seeks to serve those vulnerable older adults and people with disabilities in Marin County who have few opportunities to connect with support services because lack of transportation, limited financial resources or lack of social support. In response to the growing numbers of older adults in Marin in need, Whistlestop has created a number of programs to support these individuals. A key component of healthy aging is proper nutrition and sadly, food insecurity is a growing phenomenon among older adults over sixty years old. It means that those living on fixed incomes in an economy with rising costs of living, simply do not know where they will find enough money to buy food to sustain themselves, much less fresh, nutritious and well-balanced meals. Whistlestop is currently serving 90,000 meals annually to at-risk older adults but must intensify its focus on those suffering from food insecurity by expanding its six nutrition programs in creative ways to fill gaps in food services. The burgeoning growth of the aging population necessitates a hard look at existing services, factoring in dwindling public services and efficient ways to leverage resources. Whistlestop is seeking $15,000 from the Marin Community Healthcare District to support and grow two of its six volunteer-based nutrition programs which connect low-income, at-risk older adults to healthy, well-balanced food resources.
Objectives/Goals (please be as specific and measurable as possible)	Funding from this grant application will be restricted to two of Whistlestop's nutrition programs: the Jackson Café program and the Meals of Marin program. The Jackson Café: Jackson Café began as the lunch meal program in 1972. Today, it is a vibrant, onsite dining room that served 18,373 healthy meals last year with 95% of those served to older adults at subsidized prices. Jackson Café is the result a social enterprise that is a win-win collaboration between two of Marin County's leading and most respected nonprofits: Whistlestop and Homeward Bound of Marin. Nutritious, affordable lunches for older adults are prepared by graduates from Homeward Bound of Marin's culinary academy. Homeward Bound of Marin is Marin County's primary provider of residential and support services for homeless families and individuals in transition. Whistlestop needed a high quality culinary operator to occupy the Jackson Café. In 2010, Homeward Bound had 60 students trained through its Fresh Starts Culinary Academy. Many needed to strengthen their employment skills with hands-on workplace experience. The Jackson Café partnership solved challenges for both organizations. Though the Café was a convenient site for low-cost dining, patronage had dropped as Whistlestop struggled with culinary operations. Homeward Bound leaders had committed to helping culinary students bridge the gap between training and the workplace. The objectives of the Jackson Café program are threefold: • To address the issue of food insecurity among seniors by providing hearty affordable meals; • To provide a warm and inviting environment for more seniors to socialize and avoid isolation; • To provide on-going on-the-job training for people

	overcoming homelessness. Funding will help subsidize food costs to provide nutritious, affordable lunches—a full hot meal with salad and a drink is priced at $4.95 - $5.95 while it costs approximately $8-$9. The Cafe serves lunch Monday through Friday and patronage has steadily increased to 80 seniors per day because customers enjoy the improved menu and atmosphere. We want to grow this number to at least 100 seniors per day. Meals of Marin: For 25 years, Meals of Marin delivered home-cooked meals to those with life-threatening illnesses. In 2013, the organization lost funding and closed its operation. Whistlestop, with the financial support of the County, was asked to continue to deliver to these individuals in desperate need. However, there is no funding for this program moving forward. It costs $2,785 to provide daily meals to a person in great need for one year. Whistlestop is seeking alternative food sources to decrease the cost of the food. For example, Whistlestop has partnered with Kaiser to accept unused meals at the end of the day. These hospital meals are prepared to high quality standards and provide very sick people with nourishment. We would be happy to discuss a similar arrangement with any of the other local hospitals. With increased funding or food, Whistlestop intends to expand the program to raise the number of meals provided and the number of people who can be supported on the program.
Project Budget (total budget must be submitted with this application)	This past fiscal year, Whistlestop's 2014-15 Nutrition Operating Budget of $568,700 faced an anticipated shortfall of $97,600 without funding support.
Amount of funding you are requesting from Marin Healthcare District (MHD)	From MHD, Whistlestop is seeking $15,000
What line items would MHD funding go towards and in what time frame would it be used?	Whistlestop is seeking funding from the Marin Healthcare District Community Health Grant Application to support the cost of Food and Kitchen Supplies for two nutrition programs.
Other sources of funding (including already secured and pending)	Private Foundation grants – $58,500 Event Fundraising - $25,000 Earned Income - $162,389 Meals on Wheels Federal Funding - $125,000 Meal contributions from recipients or their families - $85,204
Insurance	Payer Mix
Gender	Both
Age Group	40 - 65 years old 65 + years old
Ethnicity	African American Asian Caucasian Hispanic or Latino

	Native American/Russian/Vietnamese/Other
Other Populations	Homeless Low Income Mentally Ill Non-English Speaking
Number of people expected to reach/serve:	1,000
Other partners involved in the project	Homeward Bound Fresh Start Culinary Academy Kaiser Hospital
How will progress in achieving each objective/goal be measured?	Program coordinators track the number of enrollees in each program, the number of meals served, the cost of subsidies at the Jackson Café, the pounds of food distributed, and the number of Homeward Bound graduates involved in the program.
How will outcomes be measured?	Whistlestop will measure success by an increase in the numbers of meals provided in the café and delivered to the Meals of Marin recipients over the previous year. We will measure the comfort of the atmosphere in the café by written and online surveys to all participants with a goal of maintaining our 99% nutrition program approval rating or higher. We will measure success as being able to find more jobs for the Homeward Bound graduates than we found last year. We will measure success as being able to reach more people in need than last year and thereby increase the number of individuals served.
Please upload the total budget for your project	Nutrition Budget FYE 14-15.xlsx
Please upload the total budget for your organization	Operating Budget 2015.pdf