



St. John's Regional Medical Center
Community Benefit Report 2012
Community Benefit Implementation Plan 2013

A message from:

Laurie Eberst, Dignity Health Sr. Vice President Southern California West Service Area and CEO of St. John's Hospitals, Martin Shum, Chair of the St. John's Community Board.

St. John's hospitals are committed to the health of the communities we serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment of our communities has always been a key measure of our success in Ventura County and it will continue to be so as we move forward

In January 2012 the system of which we are a member, Dignity Health (formerly Catholic Healthcare West) announced changes in our governance structure and name that will better position the system to welcome new partners in the changing healthcare landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture of healing and clearly describes who we are and that for which we stand. The new Dignity Health governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 St. John's hospitals, like the nation, were significantly impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$64,410,534 in charity care, community benefits and unreimbursed patient care.

At St. John's hospitals we strive to manage our resources and advance our ministry of healing in a manner that benefits the common good now and in the future. Despite today's challenges and uncertainties we see this as a time of great hope and opportunity for the future of health care as we enter our second century of service to Ventura County. We want to acknowledge and thank the women and men who have worked together in the spirit of collaboration and with a Servant's Heart to address the health priorities of our communities through health and wellness programs and services.

In accordance with policy and our commitment to accountability the St. John's hospitals Community Board has reviewed and approved this 2012 Community Benefit report.



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Southern California West Service Area,
CEO of St. John's Hospitals



Martin Shum
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St. John's Community Board

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EXECUTIVE SUMMARY

St. John's Regional Medical Center in Oxnard and St. John's Pleasant Valley Hospital in Camarillo [note--together referred to as "St. John's Hospitals"] are members of Dignity Health (formerly Catholic Healthcare West or CHW)¹, a not-for-profit corporation. Together, St. John's Hospitals represent the largest acute care health organization in Ventura County. With over 1900 employees, and primary service areas of Oxnard, Port Hueneme and Camarillo, St. John's also serves all of Ventura County and beyond, including the cities of Ventura, Moorpark, Thousand Oaks and Somis.

The Sisters of Mercy established St. John's Regional Medical Center (SJPMC), originally called St. John's Hospital, near the coastal plain of Oxnard in 1912. The hospital grew from a six-room wooden structure to today's 265-bed facility on a 48-acre in northeast Oxnard. Located in a community that has a land use mix of residential, agricultural and industrial, including a large Navy base and a vacation harbor area, SJPMC offers comprehensive medical programs and services, including emergency care, acute physical rehabilitation, cardiac care, cancer care, maternity and childbirth services (including a Neonatal Intensive Care Unit staffed by a 24/7 neonatologist), orthopedics, and neurology. It is also home to St. John's Cancer Center of Ventura County, St. John's Regional Spine Center, and St. John's Center for Surgical Weight Loss. SJPMC has the only 24/7 Critical Care Intensivist Physician program in Ventura County.

Further inland, St. John's Pleasant Valley Hospital (SJPVH) was founded in 1974 by a group of Camarillo community leaders and physicians who believed that Camarillo needed a hospital of its own. In 1993 it merged with St. John's Oxnard thus forming one ministry of healing with two hospital campuses.

St. John's hospitals continue the legacy of healing and community service in the Catholic social tradition. Many of the outreach/community benefit programs at St. John's were initiated by the Sisters of Mercy. One of our sister sponsors continues to work in the Community Education Department today. In response to those issues identified in our 2009 Community Health Needs Assessment (which is posted on the St. John's web page), St. John's continues its commitment to meet the health care needs of those who are un/under insured, with foci of: Diabetes Programs, Community Immunizations, Comprehensive Perinatal Services Program (CPSP) called Healthy Beginnings, Senior Health/Wellness, Chronic Disease Self Management Program (CDSMP) and Congestive Heart Failure (CHF) Readmission Reduction program.

CDSMP seeks to prevent people from 'becoming their disease' by use of the Stanford model of evidenced based education and support. It consists of a 2 plus hour workshop, once a week, for six weeks, attended by people with different chronic health problems facilitated by two trained leaders. Topics include: 1) techniques to deal with problems like frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining/improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, and, 6) how to evaluate new treatments. Classes are highly participative, where mutual support and successes are celebrated to build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

¹ For more information on the name change, please visit www.dignityhealth.org

Diabetes Hospital Admission/Readmission Reduction (HARR) program aims at reducing the complications and associated hospital readmissions of community members with type 2-diabetes by identifying, recruiting and enrolling an annual cohort of 50 – 75 community members with type 2 diabetes into the program who are then provided enhanced diabetes-related preventative and screening services.

Diabetes Case Management Outreach is intended to assist community members without financial means or with other barriers to healthcare access and follow-up care, with information, education, treatment, and self-management tools to manage their chronic disease. Designed to benefit those individuals with diabetes who choose not to participate in the Diabetes HARR program and those participants who need additional case management support, this program acts as a “safety net” in providing a variety of free services and connects those in need with various community health resources.

CPSP Care program (named Healthy Beginnings) provides bilingual and multicultural prenatal healthcare services, including screenings and education for low income un/under insured women. Program goals and activities include: avoiding low birth weight, identifying and referring for treatment of gestational diabetes, breast feeding soon after birth, relational issues arising from the pregnancy, hospital pre-registration and referral for state insurance programs as needed. This program is designed to reduce the long term burden on government by reducing the long term results of children born following poor perinatal care.

Community Immunizations in our Primary Service Areas were enhanced through our Shots for Kids and Adults program which is designed to ensure up-to-date immunization compliance for school aged children and their family members.

Senior Health/Wellness through Senior Health Connection consists of several programs that seek to provide seniors with tools to improve their health and wellness. We offer: Energizer's Walking Program, English and Spanish language diabetes support groups, Spanish and English language People with Arthritis Can Exercise (PACE) classes, flu and pneumonia immunizations clinics, mature driver safety classes, Health Insurance Counseling and Advocacy Program, wellness lectures and classes, and screening clinics offered at three county senior centers in Oxnard. Blood pressure and blood glucose screenings are offered during the wellness clinics and at the Energizer's Walking Program. In addition, hemoglobin glucose (HbA1C) screenings are offered to participants who have diabetes as part of the “Know your Numbers” Program.

CHF Readmission/Reduction is a new HARR program utilizing the Congestive Heart Active Management Program (CHAMP®) from Mercy General Hospital's Sacramento Mercy Heart & Valve Institute. This is an evidence based comprehensive program is designed to assist those who have CHF. Through regular phone interaction with a health care professional (in Spanish or English) CHAMP® will help recently discharged patients, and their family members, better understand CHF so as to empower them to manage this condition in order to improve the quality of their lives, increase interactions with their physician and avoid unnecessary hospitalizations.

A full description of these programs may be found at http://www.stjohnshealth.org/Medical_Services/community_education.

In FY2012, SJRMC unsponsored community benefit expense totaled \$27,541,948, which excludes the unpaid costs of Medicare totaling \$17,593,569.

MISSION STATEMENT

ST. JOHN'S HOSPITALS' MISSION

As members of Dignity Health, for St. John's Hospitals our mission sets a clear focus for our work. Our values define how we carry out the mission. Our vision demands that we consistently and effectively live up to both.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Values

Dignity Health is committed to providing high-quality, affordable health care to the communities we serve. Above all else we value:

- **Dignity** - Respecting the inherent value and worth of each person.
- **Collaboration** - Working together with people who support common values and vision to achieve shared goals.
- **Justice** - Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.
- **Stewardship** - Cultivating the resources entrusted to us to promote healing and wholeness.
- **Excellence** - Exceeding expectations through teamwork and innovation.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served.

ORGANIZATIONAL COMMITMENT

Founded as a ministry by the Sisters of Mercy in 1912, St. John's has carried forth its sacred work for 100 years. This century long calling to provide care to patients and the broader community has remained the same for but statutory requirements have added the need to report our community work. In response to the enactment of Medicare and Medicaid legislation in 1965, the Internal Revenue Service (IRS) issued Revenue Ruling 69-545, which shifted how hospitals would qualify as 'not for profit' for federal tax exemption status from reporting just charity care to a broader category called 'community benefits' (which includes charity care). This IRS ruling required nonprofit hospitals to provide "community benefits" to retain federal tax-exemption, which broadened the scope beyond charity care to include activities that benefit the community as a whole."² Because Medicare and Medicaid increased reimbursement coverage, hospitals began caring for fewer uninsured individuals therefore resulting in less uncompensated care (i.e. charity care). IRS Ruling 69-545 (1969) and IRS Ruling 83-157 (1983) called upon not-for-profit hospitals to "promote the health of a class of persons broad enough to benefit the community as a whole, even though not benefiting all persons directly." The reference to a defined community suggests a population health orientation and determining the minimum size for the class of beneficiaries needed in order to produce a benefit for the larger defined community suggests accountability to achieve a measurable impact. Therefore, St. John's Community Benefit programs are planned by examining the health needs of the community residents in Ventura County, and particularly in our areas of service, evaluating the available resources of the hospital and then focus the resources available where there is the greatest need consistent with our resources—adding resources if/when possible. Combining this legal setting with the Dignity Health Statement of Common Values,³ the Ethical Directives for Catholic Health Care Services⁴ and as a matter of justice (one of our core values), we have a special responsibility for persons who are poor and vulnerable based on the notion that "health issues are more prevalent among those who are poor and vulnerable than in other segments of the population."⁵

Despite different beginnings, both St. John's hospitals have held to community service as a guiding principle. Hospital leadership has implemented a vision of offering Loving Care as a Ministry of Healing to our patients and communities. Community wellness with justice and care for all has been at the forefront of Executive planning and Community Board oversight (an Executive staff and Community Board roster is found in Appendix B). St. John's Community Board reviews, approves, and offers broad based support for the community health activities of St. John's. The board, representing a cross-section of the community, has members from a wide spectrum of businesses and community based organizations in the hospitals' service area. Possessing a thorough understanding of the top five healthcare needs that emerged from the 2009 community needs assessment, St. John's Foundation is instrumental in supporting funding to sustain community health improvement initiatives and St. John's Executive Leadership and Community Board are essential in reviewing and approving budgeting decisions, program content, program design,

² The Hilltop Institute, "Hospital Community Benefits after the ACA: The Emerging Federal Framework," January 2011 Issue Brief.

³ See http://www.dignityhealth.org/Who_We_Are/Our_Mission_Vision_And_Values/index.htm

⁴ ERD 3, Ethical and Religious Directives for Catholic Health Care Services, USCCB, see <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>

⁵ California Newsreel, Unnatural Causes, 2008. Accessed online August 2012

http://www.unnaturalcauses.org/series_objectives.php, <http://content.healthaffairs.org/content/12/1/162.abstract>

program targeting, continuation, termination, monitoring and oversight. With quarterly reports to the Community Board, monthly oversight by the Community Board's Community Relations/Community Benefits Committee, regular funding for programs dedicated to those in need from the St. John's Healthcare Foundation, monthly "Mission Moment" reports to the Foundation Board and most importantly, volunteering by dedicated hospital staff at all levels for specific community benefit events, St. John's commitment to providing benefit to the community can be found throughout the organization.

A particular example of community involvement is the active role the Community Relations/Benefit Committee takes in the Dignity Health Grants program through review of all proposals and recommending final grantees and amounts.

The Vice President of Mission Integration is an active member of the Executive team and the executive liaison to the Community and Foundation Boards for community benefits. Additionally, community benefit/outreach activities are an integral part of the hospitals' strategic plan.

The Community Benefit Report and Plan is reviewed by the CEO and the entire Executive team, the Community Benefit/Relations Committee of the Community Board, and the Community Board.

Dignity Health's Commitment in Ventura:

In addition to supporting the ministry of the St. John's hospitals Dignity Health's commitment to the area is evidenced by the Dignity Health Community Investment Program loan for community redevelopment in Ventura County. Dignity Health from a corporate level has provided funding or loans for several low income housing projects in Ventura County. Most recent is Valle Naranjal in Piru. This multi-million dollar project by Cabrillo Economic Development Corp. (a not for profit developer) will provide 66 farm worker families with affordable housing using "Green" building on the site of a former bracero farm labor camp. Residents there give thanks for the opportunities for themselves and their children—this investment program gives hope where hope is needed and improves lives now for a better future.

Non-quantifiable Benefits

St. John's Hospitals work collaboratively with community partners in local capacity building and in community-wide activities. Some of St. John's involvement includes:

- Board Member, Hospital Association of Southern California
- Board Member, Gold Coast Health Plan
- Board member, Economic Development Corporation of Oxnard
- Board Member, Boys and Girls Club of Oxnard/Port Hueneme
- Board Member, Economic Development Collaborative Ventura County
- Board Member, Livingston Memorial Visiting Nurse Association & Hospice Foundation
- Oxnard Chamber of Commerce
- Oxnard Ministerial Association
- Oxnard Rotary
- Brain Injury Center of Ventura County

Among the community building activities is the Health Ministry Department monthly "County Networking Meeting." This voluntary meeting provides a forum for Human Services organizations

and government agencies to dialogue, exchange information, discover new resources and make connections for their day to day work that benefits the broader community of Ventura County.

The efforts of the St. John's Ecology Committee (a group of volunteer leaders) demonstrate our commitment to the environment of our communities by reducing our ecological. A measure of success for this group is that SJRMC is the only hospital in Ventura County to receive the 2012 Partner for Change with Distinction award from Practice Greenhealth.

St. John's hospitals have also partnered with local colleges and universities to serve as training sites for students training to become nurses. Our partners in building healthcare capacity are:

California State University, Channel Islands—RN Program (BSN)
Ventura College—RN Program
Oxnard College—LVN Program

St. John's hospitals are the largest healthcare employer in Ventura County. SJRMC employs 1339 people (full and part time); whose average salary is \$40 per hour. The annualized economic benefit across 10 incorporated cities in Ventura County (where most of our employees live) for the combined employees of St. John's hospitals is approximately \$148 million dollars.

COMMUNITY

Definition of Community

Community is defined as the resident population within the hospitals' service areas. While SJPVH in Camarillo and SJRMC in Oxnard serve all of Ventura County, the primary service areas (PSA) and associated zip codes are as follows: Camarillo 93010 & 93012, Oxnard 93030, 93033 & 93035, Port Hueneme 93041

Under the guidance of the Community Relations and Benefits Committee of the Community Board, St. John's has shifted from concentrating solely on the needs of its PSA to a balance that takes into account the needs throughout the region of Ventura County, with particular attention to the disproportionate unmet healthcare needs of vulnerable populations. Data cited in the Description of the Community section below is drawn from our 2009 Community Needs Assessment, which is available on the St. John's webpage at

http://www.stjohnshealth.org/stellent/groups/public/@xinternet_con_sjo/documents/webcontent/sjcommunityneedsassessment.pdf.

Community Needs Index (CNI)

The Community Needs Index (CNI) is a tool developed by Dignity Health that accurately pinpoints communities in St. John's service areas with the greatest barriers to healthcare access. This tool uses socioeconomic data to provide an "at a glance" view of disproportionate unmet healthcare needs in a geographic area, and correlates that need with hospitalization for preventable health conditions. Within St. John's PSA the zip code with the greatest need as identified by the CNI is 93030. This validates the findings and needs identified in the 2009 Community Health Needs Assessment (refer to service area CNI attached as Appendix C).

Description of the Community

St. John's hospitals, like other Dignity Health facilities, define the community as the geographic area served by the hospital, considered the primary service area. The most recent Thomson Reuters data is used for this report and for strategy and planning to address community needs. The CHNA also provides data for strategy and planning.

- Population – the population total for the St. John's Regional Medical Center Primary Service Areas is 236,827.
- Race/Ethnic Diversity –72.8% of the population is Latino Caucasian, 16.1% is Non-Latino Caucasian, 6.9% is Asian, 2.3% African American and 1.9% "other."
- Adult Education – 34.5% of the adults in the service area have less than a high school education.
- Unemployment – among the cities in the service area, the unemployment rate is 6.2%.
- Income - the average household income for the area is \$70,214.
- Home Ownership/renters - renters comprise 41.1% of the population.
- Insurance – 16.96% of the population are on Medicaid while 12.86% are uninsured.
- The CNI score is for the PSA is 4.1 (on the high end of the "Second Highest" range).
- The service area is also served by Community Memorial Hospital and the Ventura County Medical Center, both located in Ventura, Ojai Valley Community Hospital (part of Community Memorial system) in Ojai, Santa Paula Hospital (county owned/operated) in Santa Paula, St. John's Pleasant Valley Hospital (Dignity Health), Los Robles Regional Medical Center in Thousand Oaks and Simi Valley Adventist Hospital in Simi Valley.
- The areas served are federally designated as a Medically Underserved Area (MUA).

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment

California State Senate Bill (SB) 697, the Community Benefit Legislation, passed in 1994. This legislation encouraged not-for-profit hospitals to consult with community groups and local government officials to identify and prioritize the needs of their communities. Additionally, it paralleled St. John's commitment to assess the health status of its community. In keeping with SB 697, and our own desire to serve our community, St. John's conducts a Community Health Needs Assessment (CHNA) of the community every three years to determine the greatest unmet healthcare needs, in our service area, with the most recent assessment completed during 2009.

As part of the community health needs assessment process, St. John's Hospitals collaborated with other healthcare organizations in Ventura County to form the Community Health Needs Assessment Collaborative Group (CNACG). The main purpose of CNACG was to assess the healthcare needs of Ventura County residents by identifying the existing community needs. The CNACG provided the mechanism to bring representatives from local hospitals and healthcare agencies together to review and discuss the needs in the county. The CNACG members jointly developed survey questions, selected the methodology, and shared the cost of the survey administration and survey analysis. The Innovative Research Group in Thousand Oaks was contracted to provide project oversight, help update the survey tool, conduct the survey, and analyze the data.

The result of the 2009 CHNA survey presented a comprehensive picture of the healthcare issues facing Ventura County. Healthcare topics such as access to different resources, availability of services, and concerns about costs of services were some of the issues examined to determine the healthcare needs and preferences of Ventura County residents. The CHNA identified the following top five unmet needs:

- **AVAILABILITY, ACCESS AND COST** of healthcare services, with growing community concern for the numbers of uninsured and underinsured in Ventura County
- **CHRONIC DISEASE MANAGEMENT, PREVENTION, AND EDUCATION** with emphasis on obesity, diabetes, HIV/AIDS, heart disease, and cancer (including breast, cervical and prostate cancer)
- **WOMEN'S HEALTH SERVICES** including perinatal access and education for low-income women (particularly women of Latino/Hispanic ethnicity), mammography, and Pap smears
- **ADULT AND CHILD IMMUNIZATIONS** (ages 0 – 2; Hepatitis A and B; flu and pneumonia shots)
- **CHILDREN AND YOUTH HEALTH AND WELLNESS**, with concern for obesity, smoking, dental health, alcohol use, teen pregnancy, asthma, environmental and safety issues.

Un- and Under Insured

The recession of 2009 and following world-wide financial crises have taken their toll at the local level extending the conclusions of the CHNA that between 2000 and 2009 insurance problems showed an increase of 18.3%. The CHNA also indicated that the cost of services increased 16.7%. The CHNA notes that the percentage of children who are covered by any type of health insurance dropped by 15.3%, which is affirmed by the Ventura County Health Status 2011 report that 7.2% of all children under 18 years of age are not covered by any insurance. Both the short- and the long-run trend indicate that there was a significant decline in the percentage of children who are covered by any type of health insurance. Similarly, in the long-run period of 2000 – 2009, there was a significant decrease (24.7%) in the percentage of residents who stated that they were covered by private insurance. At the same time, there was a significant increase in the percentage of the residents who stated that they were covered either by Medi-Cal (9.8%) or Medicare (5.1%), yet the percentage of residents who stated that they were covered by Healthy Families decreased by 7.7%. Most significant is the fact that one quarter (24.6%) of respondents indicated that they do not have any type of health insurance coverage for the adult members of their household. Both the short- and the long-run trend indicate that there has been a significant decline in the percentage of Ventura County residents covered by any type of health insurance. From 2006 – 2009, there was a 9.1% decline in the percentage of Ventura County residents covered by any type of health insurance. This index showed a 16.0% decline for the long run from 2000 – 2009. This gap in insurance coverage, both for children and adults, is one of the top healthcare concerns in Ventura County. The 2009 CHNA survey also indicates that the top three healthcare services with the highest accessibility ratings were hospital care (92.7%), followed by basic primary care (91.3%), and dental healthcare (90.4%). Community Benefit planning has thus been focused on meeting the needs of those who are un/under insured outside the hospital setting. For 2012, the focus will take a new turn to Community Wellness and Prevention.

Compared with other ethnicities, the number of Latinos with diagnosed diabetes mellitus is much higher in the 18 – 44 age group. Rates are also high among African-Americans in the county. The study indicates that early detection and education for developing healthy living habits at young

ages are the most important steps to consider in preventing and aiding with management of diabetes. Nationwide, the problem of obesity and the rise of diabetes, not only among adults but also in children, has been a highly publicized public health concern.

Preventive Medicine

Among female respondents, while about one out of twelve (8.3%) indicated that they are not aware of cancer screening procedures such as breast exam or mammogram, about nine out of ten (89.5%) said that they are aware of such procedures. Compared to the 2000 survey, there is a significant decline (5.0%) in the percentage of women who said that they or a member of their household had received a clinical breast exam or mammogram. Compared to the 2006 survey, there is a significant increase (7.8%) in the percentage of women who said that they or a member of their household had received a pap smear. However, a reverse pattern is observed for the long-run period of 2000 to 2009. During this time period, there is a significant decrease (11.0%) in the percentage of women who said that they or a member of their household had received a pap smear. The California Cancer Registry indicates that Ventura County ranks seventh in the state for invasive breast cancer.⁶

From 2000 to 2009, there was a significant increase in the percentage of residents who had been diagnosed with cervical/uterine cancer (8.0%) and skin cancer (5.3%). On the other hand, the percentages of respondents diagnosed with prostate cancer and colon cancer decreased by 8.8% and 7.0%, respectively. The lack of preventive services has a disproportionate impact on those who earn less, with the \$15,000 to \$25,000 and \$25,000 to \$50,000 earners, the working poor, being the most impacted by lack of access to preventive services.

Respondents were almost equally split in regard to the flu vaccination. While 48.0% of respondents indicated that they had a flu shot, almost the same percentage (49.8%) stated that they did not have a flu shot in the past twelve months. Both the short- and the long-run trend indicate that there was a significant increase in the percentage of Ventura County residents who had flu shots during the last twelve months. From 2000 to 2009, there was a 5.8% increase in the percentage of Ventura County residents who had flu shots.

Perinatal Needs

The birth rate in recent years (2000 to 2007) has been at a stable rate of 14 to 15 per thousand people in the county. In 2007, there were 1,150 mothers who fell in the category of teen mothers, 19 years of age or younger. The total number below 18 years of age (17 or younger) is about 415. Out of 1,150 total teen births, 920 identified themselves as Latino. Also, 351 out of the total number of 415 representing total teen births for girls age 17 or younger are Latino. These numbers reflect a significant social and economic impact on the well-being of these mothers and their children, at present as well as for a long time to come.

Ventura County shows a lower rate of low birth weight (LBW) than the state in all the mentioned years (2001 to 2007) except 2004. LBW is associated with a number of health issues in children, which can continue throughout their lives. Latinos and African-Americans have the lowest rate of prenatal care among all the ethnicities in the county. A number of cities in the western part of the county show a lower first trimester prenatal care amount relative to the eastern part of the county. Furthermore, teen mothers have the greatest problem in taking good care of themselves and their

⁶ California Cancer Registry, see <http://www.cancer-rates.info/ca/index.php>

children in regard to starting their prenatal care in a timely manner. Teen counseling that provides education and finds creative ways of helping these young mothers is of great importance.

Obesity

Obesity among low income Ventura County youth continues to grow; particularly in children between the ages of 5 and 19, exceeding both national and California percentages, i.e., 22.7% of low income Ventura County children ages 5 – 19 are overweight. The study also indicates that the trend of the last decade shows a big gap between the goal rate of obesity set for 2010 and current rates. It also shows that in the case of children of lower income, the trend worsened during recent years. This is confirmed by recent studies that indicate that Port Hueneme and Oxnard rank among the top 20 communities in California for adolescent obesity. Further study is needed to identify possible underlying causes, but developing healthy habits, including sound nutrition, refraining from smoking, and physical activity or children are key issues.

ASSETS ASSESSMENT & COMMUNITY BENEFIT PLANNING PROCESS

The needs identified in the Community Health Needs Assessment, St. John's strategic plan, and Dignity Health's Horizon 2020 strategic plan yielded this Community Benefit Plan, and guide St. John's hospitals in our ministry of healing to the community. In fiscal year 2012, Community Education Physician Consultant John Ford MD, St. John's Mission Integration Team, St. John's Community Health Education Department and Health Ministries staff members again reviewed the data from the CHNA to determine top needs on which to focus our resources and energy. These same teams then reviewed community assets as outlined in the Ventura County Health Status 2011 report (see: http://www.vchca.org/docs/publichealth/ventura_county_health_status_2011.pdf?sfvrsn=0), and then analyzed staff competencies as an asset and other resources (budget, FTEs, physical space, mobile unit, etc) to address these identified needs. Based on these findings, measurable objectives were defined, and where appropriate, additional partners in the community were identified with whom St. John's could seek to collaborate.

Timeline

Date collection of June 2012

August – September 2012 Mission leadership, Community Education staff, and medical staff reviewed fiscal year 2012 outcomes and plans for service area, formulated objectives, and implemented Community Benefit Plan update.

August – October 2012 Top healthcare priorities reviewed by Mission Leadership, medical and other staff, community healthcare workers and the Community Board's Committee of Community Relations/Benefits members.

November 2012 Community Benefit Plan completed and approved by St. John's Executive Leadership and Community Board.

November 2012 Community Benefit Plan forwarded to Dignity Health corporate office and Office of Statewide Health Planning and Development.

December 2012 the Community Benefit Report & Plan posted on the St John's website including a request for input from the community

Participants

Input on specific issues—needs currently being met, types of community members served, and special needs groups—was sought from representatives from the following areas:

- Hospital Executive Leadership
- St. John's Sister of Mercy Sponsors
- St. John's Community Board
- Community Health Education Department members
- Financial Operations
- St. John's Healthcare Foundation
- St. John's Medical Staff representative(s)
- Strategic Planning/Business Development staff
- Health Ministry Program staff
- Healthy Beginnings Program staff
- Faith Community Nurse network

St. John's leadership has determined our primary foci are growth, quality, and physician integration as the areas that are critical to the organization's success in accomplishing its mission, including (1) working with community leadership to develop programs that address disproportionate unmet health needs, (2) addressing unmet health needs by developing new ways to effectively break down barriers to care in our communities, and (3) extending our advocacy role to improve everyone's access to healthcare.

St. John's 2012 – 2013 strategy, as it relates to the community, calls for St. John's to continue to enhance and expand access and services to persons with disproportionate unmet healthcare needs through programs such as our obesity prevention and diabetes mellitus initiatives. It also calls for continuing our team approach as we collaborate to develop, implement, and evaluate our community benefit efforts through a team that includes members from St. John's hospital leadership, physicians, and nurses; allied healthcare providers; and community agencies and community members.

Developing St. John's Community Benefit Implementation Plan

St. John's Community Benefit Programs are continually reviewed throughout the year using the strategic objectives established by St. John's Executive Leadership; Dignity Health, recent community needs assessment data, and perceived needs of the community as identified by St. John's Community Relations/Benefits Committee. Additionally, the Advancing the State of the Art in Community Benefit (ASACB) principles are reference tools used to develop and maintain standardized reporting and review templates as reflected in the Program Digests on pages 20-27. These standards establish criteria for charitable behavior that facilitate institutional engagement, demonstrate alignment with charitable mission, strategic planning and increase accountability for performance in the community benefit.

How Will the Community Benefit Report/Plan be shared?

The St. John's Community Benefit Report is made available to the community, and disseminated at presentations, meetings, community events, via newsletter mailings and online at our website, www.stjohnshealth.org. It will also be posted on the St. John's website and the by Dignity Health on the corporate website.

Core Principles

Five Core Principles provide the framework to guide the selection and prioritization of community benefit activities and provide for a comprehensive review of community benefit programs. The Core Principles will provide the framework for Tier I – III program digests. The core principles include:

1. Emphasis on Disproportionate Unmet Health-Related Needs (DUHN) – Seek to respond to those communities/neighborhoods with disproportionate unmet health-related needs. The program must include outreach mechanisms and program design elements that ensure access to residents within DUHN communities.
2. Emphasis on Primary Prevention – Address the underlying causes of persistent health problems through health promotion, disease prevention and health protection.
3. Build a Seamless Continuum of Care – Emphasize development of evidence-based links between clinical services and community-based services/activities.
4. Build Community Capacity – Target resources to mobilize and build the capacity of existing community assets.
5. Emphasis on Collaborative Governance – Engage diverse community stakeholders in the selection, design, implementation and evaluation of program activities.
6. As programs are planned consideration is given to other assets and organizations in the community with whom St. John's could leverage or collaborate.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives

This overview summarizes the concepts and processes used to review St. John's community benefit programs, the findings from the review, and the factors that will help focus our community benefit strategy to make efficient and appropriate use of our limited charitable resources.

As a result of a comprehensive community benefit program review, St. John's Hospitals have established baseline activities and identified proposed program enhancements. These programs have been further prioritized by placing them in a tier classification. These tiers indicate a level of needed attention and resources. Tier I programs will focus additional hospital and community resources in order to effectively address community need. Tier II programs can successfully meet goals and core principle enhancements with limited resources and few new resources. Tier III programs can maintain activities "as is" as they are satisfactorily addressing their intended purposes. Tier IV represents a program(s) whose life span may be coming to an end, either from lowered community needs or fewer clients because another organization(s) is offering a similar program.

Tier I

- Diabetes Programs (including case management)
- Hospital Admission Readmission Reduction Programs
- Chronic Disease Self Management
- CHF Self Management
- Youth Obesity Prevention Programs
- Health Ministries Basic Needs

Tier II

- Heart Services
- St. John's Cancer Center of Ventura County

Tier III

- Faith Community Nurse Ministries
- Community Grants
- Immunization Programs
- Outreach Programs
- Mobile Health Clinic Outreach
- Senior Health Connection

Tier IV

- Healthy Beginnings

By further segmenting our community benefit programs by tiers, we have established priorities for the use of our charitable resources. Most of our programs effectively address their identified purposes and goals and are able to continue their activities with few needed enhancements. Tier II and, most importantly, Tier I programs will require increased resources. Consistent with the CHNA and other national data, diabetes and youth obesity present significant, immediate, and long-term health risks for the residents of Ventura County, especially for those in the disproportionate unmet health needs (DUHN) populations. Establishing the programs that address these risks and community needs as high priorities gives us a clear strategy for action as we move forward and emphasize community health improvement and help reduce the demand for high cost medical care.

Reducing Health Disparities

Consistent with the Affordable Care act, Dignity Health's Horizon 2020 strategic plan calls our hospitals to decrease inpatient readmissions for ambulatory care sensitive conditions upon completion of a Chronic Disease Self Management Program (CDSMP) for a period of at least six months. Baseline data will follow establishment of this chronic disease self management workshop series. Hospital Admission Readmission Reduction Program (HARR): Strategic goals and objectives by Dignity Health align with those in the most recent community needs assessment, and were the basis for the recommended goal to reduce hospital utilization by program participants in a selected cohort through active participation in a preventive health intervention. St. John's has identified diabetes and obesity (as a precursor to diabetes as well as other chronic diseases), as the high priority health issues in our communities on which we will focus our greatest efforts. As such, St. John's has maintained a steadfast community focused campaign to decrease uncontrolled diabetes admission rates of identified participants in specified preventive health interventions by five percent.

Specifically, the goals for the youth obesity and diabetes programs are:

- Reduce obesity among youth (through Dignity Health Community Grants)
- Decrease disease complications associated with obesity.
- Identify individuals in the community with diabetes and intervene to prevent further diabetes related complications.
- Provide people with diabetes the support, knowledge and resources to manage their diabetes and to delay the development of the disease.

- Decrease ED and/or hospital utilization as a result of preventive health interventions for diabetes.

Specific enhancements for each program have been identified that will support achievement of these program goals. Notably, the programs have engaged additional community partners to increase community capacity for diabetes and youth obesity interventions, initiated a community based case management program for our diabetes patients, and established appropriate measurement strategies to meet our system-wide goal to decrease hospital utilization of program participants with diabetes mellitus.

Congestive Heart Failure (CHF) has also been identified as an Admission/Readmission priority. The evidence based proven CHAMP® program, from the Mercy Heart and Vascular Institute, will be utilized to assist CHF patients & community members to avoid admissions/reduce readmissions and thus improve the quality of life for those who suffer from CHF by empowering them to gain knowledge and better control of their chronic disease. This is achieved through: education about the disease processes, symptoms, nutrition, medications and activity. During FY 2013 we will:

- Educate physicians about the value of the program and engage physician buy-in through evidenced outcomes.
- Identify those patients and community members most likely to benefit, especially those who are un/under insured not residing in a facility.
- Create a process for referral and enrollment that is comprehensive, including physician orders to enroll at discharge.

What is not being addressed and why

The health needs of the community are extensive and St. John's assets are limited. As a result, certain identified needs are not being addressed or are being addressed indirectly or programmatic activity is being curtailed as other county assets address the identified needs. Most notable among these are youth obesity and perinatal care.

- Youth Obesity—recent reports indicate that Oxnard & Port Hueneme are among the highest rated school districts in California for youth obesity (<http://articles.latimes.com/2011/nov/10/local/la-me-childhood-obesity-20111110>). St. John's currently does not possess the community education assets to directly address this significant health issue. Instead, we have collaborated (through our Dignity health Community Grants Program) with our local Boys & Girls Club, supporting their Triple Play Program.
- Community Ecological issues are not being addressed due to lack of resources to meaningfully influence the community at large; however St. John's is taking a leadership position in local healthcare ecology (as described herein) focusing on its own ecological footprint.
- Perinatal Care—our CPSP Healthy Beginnings Program has been successfully addressing the needs of un/underinsured pregnant women for many years. A health organization in Ventura County (Clinicas) started their own CPSP program and has slowly been attracting our former client base for Health Beginnings. Given the decreased enrollment in the program we will phase out Healthy Beginnings during 2013, referring this group to Clinicas for perinatal care, and refocusing staff to our Basic Needs Program.

Planning for the Uninsured/Underinsured Patient Population

Using the ASACB program review guidelines, every St. John's program offering was assessed with respect to its effectiveness in reaching populations with disproportionate unmet health-related needs (DUHN). The Program Updates and Report found in the next section of this report demonstrate St. John's focus on providing for the uninsured and underinsured patient populations in our service areas.

Additionally, St. John's has a Financial Counseling and Assistance Policy (ARI-01 which may be viewed at http://stjohnsmore.chw.edu/images/d/db/ARI-01_Financial_Counseling_8-08.pdf) and in accordance with that policy financial assistance information is given to all patients. Financial Counseling is available which informs and assists patients with seeking government or third party payment, and/or a discount. A Payment Assistance Policy (ARI-03) also provides relief for those seeking to pay over time (see http://stjohnsmore.chw.edu/images/5/58/ARI-03_Payment_Assistance%2C_Uninsured_Patient_Billing_and_Collections_Guidelines_3-10.pdf) consistent with the Dignity Health Patient Payment Assistance Policy (Appendix D).

Information about the patient financial assistance policy is presented to all patients upon admission, during free screening clinics, and made available at support groups in which DUHN community members participate. It is also reinforced at management council meetings and related St. John's staff functions.

DESCRIPTION OF KEY PROGRAMS AND INITIATIVES

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Relations/Benefit Committee, Executive Leadership, the Community Board and Dignity Health receive quarterly updates on program performance and news.

The following pages include Program Digests for a few key programs that address one or more of the Initiatives identified above.

A. DIABETES HOSPITAL ADMISSION READMISSION REDUCTION PROGRAM											
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Availability, access, and cost of healthcare services ✗ Chronic disease management, prevention and education ✗ Women's health services <input type="checkbox"/> Adult and children's immunizations <input type="checkbox"/> Children and Youth Health and Wellness 										
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity <input type="checkbox"/> Collaborative Governance 										
Link to Community Needs Assessment	St John's 2009 Community Needs Assessment and corresponding Community Needs Index (CNI) Support the Diabetes Horizon Program in the area of addressing the DUHN of the High risk for undiagnosed and/or under-treated type 2 diabetes among the Latino Hispanic population of Oxnard, California, in the key zip codes of 93030, 93033, 93035, 93036, and 93041, and Camarillo in the zip code of 93010, and 93012.										
Program Description	<p>SJRMC & SJPVH are committed to reducing the complications, and associated hospital readmissions of type 2 diabetic community members, by identifying and recruiting a combined cohort from both hospitals of 50-75 community members diagnosed with diabetes interested in preventing further hospitalization due to complications that may arise from unmanaged, or uncontrolled diabetes. In addition to preventing hospital admission, the following related secondary outcomes measures will also benefit program participants:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">SHORT TERM</th> <th style="text-align: left;">LONG TERM</th> </tr> </thead> <tbody> <tr> <td>Glycemic Control</td> <td>Morbidity</td> </tr> <tr> <td>Blood Pressure</td> <td>Mortality</td> </tr> <tr> <td>Lipid/Cholesterol levels</td> <td>Quality of Life</td> </tr> <tr> <td>Body Mass index</td> <td>Economic factors (assoc w/ cost of Treatment)</td> </tr> </tbody> </table>	SHORT TERM	LONG TERM	Glycemic Control	Morbidity	Blood Pressure	Mortality	Lipid/Cholesterol levels	Quality of Life	Body Mass index	Economic factors (assoc w/ cost of Treatment)
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Glycemic Control	Morbidity										
Blood Pressure	Mortality										
Lipid/Cholesterol levels	Quality of Life										
Body Mass index	Economic factors (assoc w/ cost of Treatment)										
FY 2012											
Goal FY 2012	<p>Primary Goal:</p> <ul style="list-style-type: none"> • Participants in the Diabetes Horizon 2013 program will avoid re-admissions to the hospital or the ER due to preventable diabetes complications for 6 a month's period following program intervention. <p>Secondary Goal:</p> <ul style="list-style-type: none"> • Reduction of HbA1C levels, with goal of reaching normal ranges (under 7.0%). • Reduction in Blood Pressure, with goal of reaching normal ranges (< 130/80). • Self-identified % increase in overall general health and well being. 										
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 50% of the participants in hospital intervention program will not be admitted to the hospital/ER within six month of the intervention due to preventable diabetes complications and uncontrolled diabetes. 										

	<ul style="list-style-type: none"> • 5% reduction HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). • 5% reduction in Blood Pressure values for program participants with values outside normal ranges ($\geq 130/80$). • 5% increase in participant physical activity. (As self reported).
Baseline	<ul style="list-style-type: none"> • 100% of the participants in the cohort reported a hospital admission at the beginning of the program. • HbA1C and blood pressure baseline values of the participants are determined during the first assessment of the fiscal year. • Baseline physical activity level of the cohort is determined by the initial diabetes behavioral assessment results as self reported. <p>Baseline data includes results from FY11:</p> <ul style="list-style-type: none"> • 94% reduction of hospital admissions due to preventable diabetes complications and uncontrolled diabetes for program participants. • 8% reduction of HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). • 9% reduction in systolic blood pressure for the program participants with systolic blood pressure values outside the normal ranges and 13% reduction in diastolic blood pressure for the participants with diastolic blood pressure values outside normal ranges ($\geq 130/80$). • 21% increase in participant physical activity. (As self reported).
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Identify and recruit program participants. • Provide diabetes education and screening programs. • Refer participants to the Chronic Disease Self Management Program.
Results FY 2012	<ul style="list-style-type: none"> • 99.24% of the participants in hospital intervention program were not admitted to the hospital/ER within six month of the intervention due to preventable diabetes complications and uncontrolled diabetes. (1% of the previously hospitalized cohort and 100% of the preventive cohort program were not admitted to the hospital/ER within six month of the intervention due to preventable diabetes complications and uncontrolled diabetes.) • 10% reduction of HbA1C levels for program participants with baseline levels outside normal ranges ($\geq 7.0\%$). • 5% reduction in systolic and diastolic blood pressure values for program participants with values outside normal ranges. • 25% increase in participant physical activity. (As self reported). <p>Additionally the following results are reported:</p> <ul style="list-style-type: none"> • 1971 screenings and services were provided to the program participants. • 208 HBA1c screenings • 156 Lipid panels • 158 Blood Glucose screenings • 216 BMI measurements • 216 Blood Pressure screenings • 1017 Individual and group encounters • 80 Eye and foot screenings • 538 contacts in Chronic Disease Self-Management Workshops (English and Spanish).
Hospital's Contribution / Program Expense	Support for the Diabetes Hospital Admission Readmission Reduction Program was included in St. John's Operational Budget in the amount of \$134,973.
FY 2013	

Goal FY 2013	<p>Primary Goal:</p> <ul style="list-style-type: none"> Participants in the Diabetes Horizon program will avoid re-admissions to the hospital or the ER due to preventable diabetes complications for 6 a month period following program intervention. <p>Secondary Goal:</p> <ul style="list-style-type: none"> Reduction HbA1C levels, with goal of reaching normal ranges (under 7.0%). Reduction in Blood Pressure, with goal of reaching normal ranges (< 130/80). Self-identified % increase in overall general health and well being.
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> 60% of the participants in hospital intervention program will not be admitted to the hospital/ER within six months of enrolling in the program. 5% reduction HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). 5% reduction in Blood Pressure values for program participants with values outside normal ranges ($\geq 130/80$). 5% increase in participant physical activity. (As self reported). Enroll 20 Diabetes Horizon participants in Chronic Disease Self-Management Workshops.
Baseline	<ul style="list-style-type: none"> Participant's hospitalizations rate will be determined based on the patient's status at the beginning (for old patients) program and when new patients are enrolled to the program. HbA1C and blood pressure baseline values of the participants are determined during the first assessment of the fiscal year. Baseline physical activity level of the cohort is determined by the initial diabetes behavioral assessment results as self reported. <p>Baseline data includes results from FY12:</p> <ul style="list-style-type: none"> 99.24% of the participants in hospital intervention program were not admitted to the hospital/ER within six month of the intervention due to preventable diabetes complications and uncontrolled diabetes. 10% reduction of HbA1C levels for program participants with baseline levels outside normal ranges ($\geq 7.0\%$). 5% reduction in systolic and diastolic blood pressure values for program participants with values outside normal ranges. 25% increase in participant physical activity. (As self reported).
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Identify and recruit program participants. Provide diabetes education and screening programs. Refer participants to the Chronic Disease Self Management Program.
Community Benefit Categories	Community Health Improvement

B. CONGESTIVE HEART FAILURE (CHF) PROGRAM

Hospital CB Priority Areas	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Availability, access, and cost of healthcare services <input checked="" type="checkbox"/> Chronic disease management, prevention and education <input type="checkbox"/> Women's health services <input type="checkbox"/> Adult and children's immunizations <input type="checkbox"/> Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs	This program is open to all community members with congestive heart failure at no cost,

Assessment	including the poor and underserved.
Program Description	SJRMC & SJPVH are committed to reducing hospital re-admissions of Congestive Heart Failure (CHF) community members by identifying and recruiting candidates for the Congestive Heart Failure Program. The Congestive Heart Failure Program provides education to patients diagnosed with CHF during the hospital stay in addition to providing discharge instructions. This program provides education, risk assessment and referrals to CHF patients. The CHF Program is a multipronged approach 1) Home health follow-up, 2) Cardiac Rehab and 3) CHAMP®. Nurses evaluate CHF patients and recommend they participate in one or more of the program's levels based on appropriateness. Patients enrolled in CHAMP® are provided consistent telephone follow-up and education, thereby decreasing the number of readmissions to the hospital. In addition, the CHF program participants are referred to the Chronic Disease Self-Management Program.
FY 2012	
Goal FY 2012	<p>Primary Goal:</p> <ul style="list-style-type: none"> Participants in the Congestive Heart Failure Program will avoid re-admissions to the hospital within 30 days. <p>Secondary Goal:</p> <ul style="list-style-type: none"> The hospital will increase the number of patients enrolled in the CHAMP® program.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> 40% of the participants enrolled in CHAMP® will not be re-admitted to the hospital within 30 days. Enroll 100 participants in CHAMP®. Refer to CHAMP® all appropriate patients.
Baseline	<p>FY 2011:</p> <ul style="list-style-type: none"> 67% of the CHF appropriate patients were not re-admitted to the hospital within 30 days. 64 participants were enrolled in CHAMP®.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Provide on-going education for staff and healthcare providers about the value of the CHF Program. Work with the Mercy Health & Vascular Institute to provide consistent telephone follow-up and education to patients enrolled in CHAMP®. CHF team will conduct regular meetings to identify strategies to increase program enrollment. Identify CHF program candidates and refer to the appropriate program level. Provide discharge planning, CHF symptom management education, home health service evaluation and referral to the appropriate resources. Provide follow-up visits, assessments and education to CHF participants. Refer and enroll patients to Living Well: Chronic Disease Self-Management Program and conduct program.
Result FY 2012	<ul style="list-style-type: none"> 100% of the participants enrolled in CHAMP® were not re-admitted to the hospital within 30 days. 177 participants were enrolled in CHAMP®. All the appropriate patients were referred to CHAMP®.
Hospital's Contribution / Program Expense	Support for this program was included in St. John's Operational Budget in the amount of \$16,356. The CHAMP Program is offered in collaboration with Mercy Health & Vascular Institute.
FY 2013	
Goal FY 2013	<p>Primary Goal:</p> <ul style="list-style-type: none"> Participants in the Congestive Heart Failure Program will not be readmitted to the hospital/ER within 30 days. <p>Secondary Goal:</p> <ul style="list-style-type: none"> The hospital will increase the number of patients enrolled in the CHAMP®

	program.
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> 80% of the participants enrolled in CHAMP® will not be re-admitted to the hospital within 30 days. Enroll 100 participants in CHAMP®. Refer to CHAMP® all appropriate patients.
Baseline	FY 2012: <ul style="list-style-type: none"> 100% of the participants enrolled in CHAMP® were not re-admitted to the hospital within 30 days. 177 participants were enrolled in CHAMP®. All the appropriate patients were referred to CHAMP®.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Provide on-going education for staff and healthcare providers about the value of the CHF Program. Work with the Mercy Health & Vascular Institute to provide consistent telephone follow-up and education to patients enrolled in CHAMP®. CHF team will conduct regular meetings to identify strategies to increase program enrollment. Identify CHF program candidates and refer to the appropriate program level. Provide discharge planning, CHF symptom management education, home health service evaluation and referral to the appropriate resources. Provide follow-up visits, assessments and education to CHF participants. Refer and enroll patients to Living Well: Chronic Disease Self-Management Program and conduct program.
Community Benefit Categories	Community Health Improvement Services

C. SENIOR WELLNESS PROGRAM

Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Availability, access, and cost of healthcare services ✗ Chronic disease management, prevention and education ☐ Women's health services ✗ Adult and children's immunizations ☐ Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity ✗ Collaborative Governance
Link to Community Needs Assessment	Senior citizens make up 12% of the population, with the number of seniors predicted to increase over the next ten years.
Program Description	The Senior Wellness Program has been an integral part of St. John's Community Health Education Department for 26 years. The Senior Wellness Program consists of programs that aim to provide seniors with tools to improve their health and wellness. Seniors can participate in the following programs: Energizer's Walking Program, English and Spanish support groups; Spanish-language exercise classes, Chronic Disease Management classes and other health education classes, health screenings, bone builders classes, flu and pneumonia clinics, Health Insurance Counseling and Advocacy Program, wellness lectures, and wellness clinics offered at three senior centers. Blood pressure and blood glucose screenings are offered during the wellness clinics and the Energizer's Walking Program. In addition, HbA1C screenings are offered to all participants who have diabetes.
FY 2012	
Goal 2012	<ul style="list-style-type: none"> Monitor and manage hypertension and diabetes among seniors. Prevent a medical crisis and hospitalization through early referral. Improve health and wellness of seniors.

2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 90% of program clients will NOT have a critical value on blood pressure level. • 90% of program clients will NOT have a critical value on blood sugar levels. • Senior Wellness Program participants will display a 5 % increase in knowledge of health and disease management as demonstrated in pre-and post-tests. • 75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the fiscal year.
Baseline	FY 2011: <ul style="list-style-type: none"> • 2 (.058%) out of 3,427 blood pressure screenings of program clients had a blood pressure critical value (above 180/110). • 5 (.26%) out of 1,920 blood sugar screenings of program clients with diabetes had a blood glucose critical value (above 300 mg/dl). • 10% increase in knowledge in health and disease management classes measured by pre and post test. • 75% of Walking Program participants with diabetes maintained throughout the year an HbA1C level below 7.0%.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Utilize 2009 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of interventions. • Enroll participants in program, provide interventions and monitor their blood pressure and blood sugar. • Refer participants to the Chronic Disease Self Management Program.
Result FY 2012	FY 2012: <ol style="list-style-type: none"> 1. 100% of program clients did NOT have a critical value on blood pressure level (above 180/110). 2. 97% of program clients did NOT have a critical value on blood sugar levels. (above 300 mg/dl). 3. Senior Wellness Program participants displayed a 12 % increase in knowledge of health and disease management as demonstrated in pre-and post-tests. 4. 85% of Walking Program participants with diabetes achieved an HbA1C of 7% or less by the end of the fiscal year. <p>Additionally, the Senior Wellness Program provided the following free services:</p> <ul style="list-style-type: none"> • 4,667 contacts in walking program • 297 contacts in English Diabetes Education and Support group meetings • 103 contacts in Spanish Diabetes Education and Support Group meetings • 587 received flu and/or pneumonia immunizations • 10 received shingles shot • 2,826 blood pressure screenings • 1,665 blood glucose screenings • 41 cholesterol/glucose screenings • 238 contacts in group health education • 152 contacts in Prevention and Management of Diabetes classes • 1,119 contacts in exercise classes • 276 contacts at health fairs (includes 77 Bone Density Screenings and 65 Blood Sugar Screenings) • 449 contacts in English and Spanish Chronic Disease Self-Management Workshops
Hospital's Contribution / Program Expense	<p>Support for this program was included in St. John's Operating Budget. St. John's offers conference rooms to Bone Builders Classes, Health Insurance Counseling and Advocacy Programs. St. John's Auxiliaries and Golden Classics collaborated with the community health education staff to offer free health screenings, health information, and assistance with walking program and flu and pneumonia shots. Total expenditure was \$53,513.</p>

FY 2013	
Goal 2013	<ul style="list-style-type: none"> • Monitor and manage hypertension and diabetes among seniors. • Prevent a medical crisis and hospitalization through early referral. • Improve health and wellness of seniors.
2013 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 90% of program clients will NOT have a critical value on blood pressure level. • 90% of program clients will NOT have a critical value on blood sugar levels. • Participants will display a 5 % increase in knowledge at health and disease management classes as demonstrated in pre-and post-tests. • 75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the fiscal year.
Baseline	FY 2012: <ul style="list-style-type: none"> • 100% of program clients did NOT have a critical value on blood pressure level (above 180/110). • 97% of program clients did NOT have a critical value on blood sugar levels. (above 300 mg/dl). • Senior Wellness Program participants displayed a 12 % increase in knowledge of health and disease management as demonstrated in pre-and post-tests. • 85% of Walking Program participants with diabetes achieved an HbA1C of 7% or less by the end of the fiscal year
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Utilize 2009 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of interventions. • Enroll participants in program, provide interventions and monitor their blood pressure and blood sugar. • Refer participants to the Chronic Disease Self Management Program.
Community Benefit Categories	A1-a Community Health Education – Lectures/Workshops A1-c Community Health Education – Individual Health Education A1-d Community Health Education – Support Groups A1-e Community Health Education - Self-help A2-d Community Based Clinical Services – Immunizations/Screenings

D. Faith Community Nurse (FCN) Network	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Availability, access, and cost of healthcare services ✗ Chronic disease management, prevention and education ☐ Women's health services ☐ Adult and children's immunizations ☐ Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity ✗ Collaborative Governance
Link to Community Needs Assessment	<p>The Faith Community Nurse (FCN) Network aims to educate and support Faith Community Nurses (FCNs) in identifying, addressing and eliminating health disparities in their place of worship. FCNs will be trained on identifying areas of need pertaining to health education and disease/injury prevention, early intervention, and increased awareness of and access to resources in order to improve the health status of their respective communities. Developing a healing model focusing on the whole person, emphasizing wellbeing, disease prevention and health promotion integrated with the faith values of respective denominations will assist the Health System and the partnering faith communities in delivering health information and other preventive and health screening services to the community.</p>

<p>Program Description</p>	<p>Faith community nursing is a pivotal ministry of congregational life affecting the health of the individual members and influencing the wholeness and well being of the broader community. It is an opportunity for the Health system to move towards a more intentional dialogue with the faith community through Faith Community Nurses (FCNs) and congregational members, so that both institutions may claim their collaborative role as healing centers within the community. Within this Partnership, FCNs are prepared (through an accredited curriculum) to work with congregational leadership and members of their parish to redefine integrative concepts of health, healing and wholeness. The model will help define the improved health status of the community and potential savings of health care dollars through improved transitions in care by involvement of FCNs in the discharge process and beyond. Additionally individualized education by a trusted member of the congregation (FCN) may also improve individuals' self management skills to more effectively manage their chronic medical conditions at home thereby reducing unnecessary/preventable hospital admissions.</p>
<p>FY 2013</p>	
<p>Goal FY 2013</p>	<ul style="list-style-type: none"> • Promote awareness of the benefits of faith community nursing and health ministry. • Promote the education of Faith Community Nurses (FCNs). • Build collaboration among FCNs in our service area. • Develop Faith Health Partnerships with faith communities that focus on the whole person emphasizing wellbeing, disease/injury prevention and health promotion integrated with the faith values of their respective denominations. • To lift the bar on the practice and ministry of Faith Community Nursing and impacting the recognition of this specialty practice within Dignity Health. • Promote health and wellness at the community level.
<p>2013 Objective Measure/indicator of success</p>	<ul style="list-style-type: none"> • FCN Network Supervisor complete FCN preparation course through Azusa Pacific University (APU). • Identify 5-8 RNs to take FCN Preparation Course through APU during the Fall of 2012 (course ends 12/12/12). • Conduct 1-day training for Lay Health Leaders who are instrumental in the development and sustainment of the Faith Health Ministries being established. • Hold monthly Faith Community Nurse Network (FCNN) Meetings for FCNs and Lay Health Leaders providing ongoing education opportunities, networking and support. Meetings to cover: Spiritual Care Education, Advanced Care Planning, and presentations by community resource organizations. This monthly gathering also provides for supportive networking, problem-solving and teambuilding for participants. • Develop at least 4 Faith Health Partnerships – as evidenced by signed Covenants/agreements. Through the process of developing these partnerships we will help faith communities establish Faith Health Ministries to address their identified health needs. • Plan and implement 2 Church Health Fairs conducted by volunteer RNs/FCNs. • Hold 2 Continuing Education (CEU) opportunities for nurses and other health professionals on topics related to Faith Community Nursing. • Mass mailing to 150-200 local places of worship in our service area to inform and educate them on Faith Community Nursing and recruit them to participate in the monthly FCNN meetings. • Have in-person meetings with at least 8 different church leaders to discuss development of a Faith Health Ministry and recruitment of potential FCNs from their faith community. • Recruit and enroll 2 RNs/FCNs to the CDSMP facilitators training and have them facilitate at least 1 six-week CDSMP workshop series. • Collaborate with other Dignity Health Faith Community Nurse program

	<p>Coordinators/ Supervisors by hosting bi-monthly conference calls to learn from each other's programs and interventions and by participating in at least 1 in-person meeting or conference.</p>
<p>Baseline</p>	<p>Through the community needs assessment process it is clear that this program is needed to provide leadership and support to Faith Communities, Faith Community Nurses and Lay Health Leaders working to integrate faith values and health care response. The need for Health Care Reform during this time of economic upheaval is responded to through this practice/ministry as the congregation becomes more of a health resource to many "new" disenfranchised. This model of a health system working with the Faith Community is unique in this service area. Anchoring trained FCNs within a Health/Medical system increases potential for health promotion, more appropriate accessing of health care resources and more appropriate use of health care dollars. Dignity Health is undertaking this initiative in order to strengthen the work of faith based nurses in the Ventura County Service Area through fellowship, education, support and ongoing identification of participants. The program seeks to collect and identify actual data clarifying the advantage of partnering a Medical System with Faith Communities extending the service area across a broader spectrum.</p>
<p>Intervention Strategy for Achieving Goal</p>	<ul style="list-style-type: none"> • Collaborate with Livingston Memorial VNA & Hospice on promoting Faith Community Nursing and establishing the Faith Community Nurse Network. • Create a various print media on the new FCNN and secure a table at the annual Nursing Skills Fair at SJRMC & SJPVH to encourage nurses to sign up for FCNN mailing list. • Meet with church leaders from various congregations to promote Faith Community Nursing. • Create yearly flyer for FCN Network Monthly Meetings. • Secure presenters (from community organizations that provide various resources to at-risk/DUHN populations) for monthly meetings in order inform and educate members as well as to create networking opportunities. • Mail informational FCNN letter and brochure to local Faith Communities. • Article published (Saturday, June 9, 2012) in local newspaper (The Ventura County Star) regarding Faith Community Nursing and the FCN Network. • Promote FCNN internally to staff via articles in employee newsletter--Checkpoint. • Collaborative work with Dignity Health's 3 other Faith Community Nurse Program Coordinators. Initiate monthly conference calls with the other sites. • Work with Nursing Education to ensure requirements are met for providing CEUs. • Work with FCNs to identify individuals, from their faith community, with chronic disease diagnosis and empower them to effectively self-manage their condition and appropriately access resources already offered in the community. • Provide training sessions for lay health leaders. • Provide scholarships or tuition reimbursement for RNs to prepare as FCNs through Azusa Pacific University (APU). • Develop evaluative system to track integrative data for St. John's and Faith Communities. FCNs will use this system to document and report aggregate data to FCN Network Supervisor. • Recruiting congregational members to start participating in the health education & wellness events within the Faith Community. • Develop a consistent methodology to evaluate educational events held within the Faith Community.

These implementation strategies specify community health needs that St. John's Hospitals has determined it is best suited to meet in whole or in part and that are consistent with our mission and available resources. St. John's reserves the right to amend this implementation strategy as

circumstance warrant. For example, some needs may become more pronounced and require enhancement to strategic initiatives. During the three year period ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that St. John's Hospitals then should refocus our limited resources to best serve the community.

Community Benefit and Economic Value

Summary of Benefit Expense

St. John's Pleasant Valley Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2011 through 6/30/2012

	Persons Served	Expense	Revenue	Benefit	%Expenses	%Revenues
Benefits for Living in Poverty						
Traditional Charity Care	202	\$469,148	\$0	\$469,148	0.6	0.5
Unpaid Cost of Medicaid	2,549	\$13,642,070	\$6,991,121	\$6,650,949	8.0	7.4
Community Services						
Community Benefit Operations	0	\$39,812	\$0	\$39,812	0.0	0.0
Community Building Activities	0	\$280	\$0	\$280	0.0	0.0
Community Health Improvement Services	1,705	\$44,449	\$0	\$44,449	0.1	0.0
Financial and In-Kind Contributions	0	\$33,283	\$0	\$33,283	0.0	0.0
Totals for Community Services	1,705	\$117,824	\$0	\$117,824	0.1	0.1
Totals for Living in Poverty	4,456	\$14,229,042	\$6,991,121	\$7,237,921	8.7	8.1
Benefits for Broader Community						
Community Services						
Community Building Activities	807	\$3,212	\$0	\$3,212	0.0	0.0
Community Health Improvement Services	1,516	\$11,142	\$0	\$11,142	0.0	0.0
Totals for Community Services	2,323	\$14,354	\$0	\$14,354	0.0	0.0
Totals for Broader Community	2,323	\$14,354	\$0	\$14,354	0.0	0.0
Totals - Community Benefit	6,779	\$14,243,396	\$6,991,121	\$7,252,275	8.7	8.1
Unpaid Cost of Medicare	14,019	\$42,434,005	\$30,411,263	\$12,022,742	14.4	13.5
Totals including Medicare	20,798	\$56,677,401	\$37,402,384	\$19,275,017	23.1	21.6

St. John's Regional Medical Center - Oxnard
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2011 through 6/30/2012

	Persons Served	Expense	Revenue	Benefit	Expenses	Revenues
Benefits for Living in Poverty						
Traditional Charity Care	1,858	\$3,163,788	\$0	\$3,163,788	1.3	1.2
Unpaid Cost of Medicaid	21,979	\$66,829,171	\$43,771,108	\$23,058,063	9.5	9.1
Community Services						
Community Benefit Operations	0	\$150,814	\$0	\$150,814	0.1	0.1
Community Building Activities	0	\$169	\$0	\$169	0.0	0.0
Community Health Improvement Services	26,778	\$454,603	\$1,130	\$453,473	0.2	0.2
Financial and In-Kind Contributions	45,167	\$490,674	\$4,322	\$486,352	0.2	0.2
Health Professions Education	44	\$2,339	\$0	\$2,339	0.0	0.0
Totals for Community Services	71,989	\$1,098,599	\$5,452	\$1,093,147	0.4	0.4
Totals for Living in Poverty	95,826	\$71,091,558	\$43,776,560	\$27,314,998	11.2	10.8
Benefits for Broader Community						
Community Services						
Community Building Activities	1,106	\$7,348	\$0	\$7,348	0	0
Community Health Improvement Services	16,925	\$212,768	\$440	\$212,328	0.1	0.1
Financial and In-Kind Contributions	273	\$7,274	\$0	\$7,274	0	0
Totals for Community Services	18,304	\$227,390	\$440	\$226,950	0.1	0.1
Totals for Broader Community	18,304	\$227,390	\$440	\$226,950	0.1	0.1
Totals - Community Benefit	114,130	\$71,318,948	\$43,777,000	\$27,541,948	11.3	10.9
Unpaid Cost of Medicare	14,640	\$93,517,674	\$75,924,105	\$17,593,569	7.2	6.9
Totals including Medicare	128,770	\$164,836,622	\$119,701,105	\$45,135,517	18.5	17.8

Telling Our Story

St. John's Hospitals are committed to soliciting feedback and meaningful information from the communities we serve to assist in developing goals for our Community Benefit plan. To that end, St. John's collaborates with organizations in Ventura County to identify those areas of greatest need and opportunity for involvement. The Community Benefit Plan itself is shared and/or publicized:

- With our Community and Foundation Boards
- At presentations and meetings (such as our monthly Networking meeting described above)
- Online in the St. John's website (at www.stjohnshealth.org) and on our 'physicians only' web page
- At community events (health fairs, etc.)
- Through our Newsletter which is mailed to residents in the area
- With every Dignity Health Community Grants information request.
- To local care health professional organizations (e.g. physician and nursing organizations)
- In an e-mail to all hospital staff and to our Auxiliaries
- Copies will be available at each hospital through the Administration and Community Education offices.
- On the St. John's Website
- On the Dignity Health corporate website

Through this dissemination we hope reach a broad spectrum of both the consumer population, especially those in need or who are underserved, and potential future partners to create dialogue that will lead to program expansion and improvement in the healthcare of the communities we serve.

Appendix A

Executive Leadership & List of Community Board Members FY2013:

Executive Leaders:

+Laurie Eberst (Pres. & Chief Executive Officer)
Kimberly Wilson (VP & Chief Operating Officer)
Eugene Fussell MD (VP & Chief Medical Officer)
Raye Burkhardt RN (VP & Chief Nurse Officer—SJPVH)
Cathy Frontczak RN (Interim VP & Chief Nurse Officer—SJRMC)
Robert Wardwell (VP & Chief Financial Officer)
Chris Champlin (VP & Chief Strategy Officer)
Ed Gonzales (VP Human Resources)
Aaron Peace (VP Development)
+George West (VP Mission Integration)

Community Board Members

Suzanne Chadwick (VP Banking)
Margaret Cortese (Clinical Psychologist)
David Edsall Esq. (Attorney & Foundation Chair)
Mary Fish (Retired Dir. of a Residential Care Facility)
Thomas Holden O.D. (Mayor of Oxnard)
+Lynn Jeffers MD (Medical Staff)
Ann Kelley MD (Medical Staff)
+Michael Lavenant Esq. (Attorney)
Christopher Loh MD (Medical Staff)
Laura McAvoy Esq. (Attorney)
Sandy Nirenberg (Dir. Camarillo Hospice)
Sr. Joan Marie O'Donnell RSM (Sister of Mercy sponsor)
Jack Rotenberg MD (Medical Staff)
+Sylvia Munoz Schnopp (City Council, Port Hueneme)
+Martin Shum (Community Board Chair & Business Owner)
Donald Skinner (Retired Pres. of a Technology Corp.)
Steven Soule MD (Chief of Medical Staff)
Carl Wesley (Pres. General Contracting firm)
Lee Wan MD (Medical Staff)
+Jeri Williams (Chief of Oxnard Police Dept.)
+Celina Zacarias (Director, Cal-State Univ. Channel Islands)

(+ indicates member of the Community Relation/Community Benefits Committee)

Appendix B

Community Relations/Community Benefits Committee Organization Plan Fiscal Year 2013

Members

- **From Community Board:** Lynn Jeffers, Michael Lavenant, Sylvia Schnopp, Jeri Williams, Celina Zacarias (committee chair)
- **From Administration:** VP Mission Integration (George West), Director of Marketing (Frank Austin), CEO (Laurie Eberst)

Vision and Mission

The Community Relations/Benefit ("CR/B") Committee shall be responsible for ensuring a positive and consistent image and reputation for the hospitals and an image rooted in St. John's mission committed to furthering the healing ministry of Jesus and dedicating resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for the sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community

Foundational expectations include:

- Establish St. John's Regional Medical Center and St. John's Pleasant Valley Hospital as the hospitals of choice for Ventura County residents, from all perspectives, including patient, employee, physician and the community; and
- Outreach to our community consistent with our vision and mission, including the provision of community benefits.
- Advocacy as needed on behalf of the hospitals and their communities.

Committee Responsibilities

The Community Relations Committee shall:

1. Monitor compliance with Ethical and Religious Directives for Catholic Health Services and Dignity Health Mission
2. Consider, and where necessary make recommendations on, matters presented to it by the Mission Integration Office
3. Assist in the design of public outreach strategies and strategic marketing programs
4. Review community, press and governmental body relations
5. Advocate

Operations Procedure

On the third Thursday of each month, the CR/B Committee shall meet from 8:00-9:00 a.m. in the Executive Board Room. The core meeting agenda shall include the following:

- Reports by Senior Management and discussion concerning

- Compliance and mission integration during the last reporting period
- Status of current community outreach programs
- Status of current press relations
- Status of current government/regulator relations
- Current marketing and future planned marketing
- Advocacy

Roles and Responsibilities

The CR/B Committee shall elect two officers: a Chairman and a Secretary.

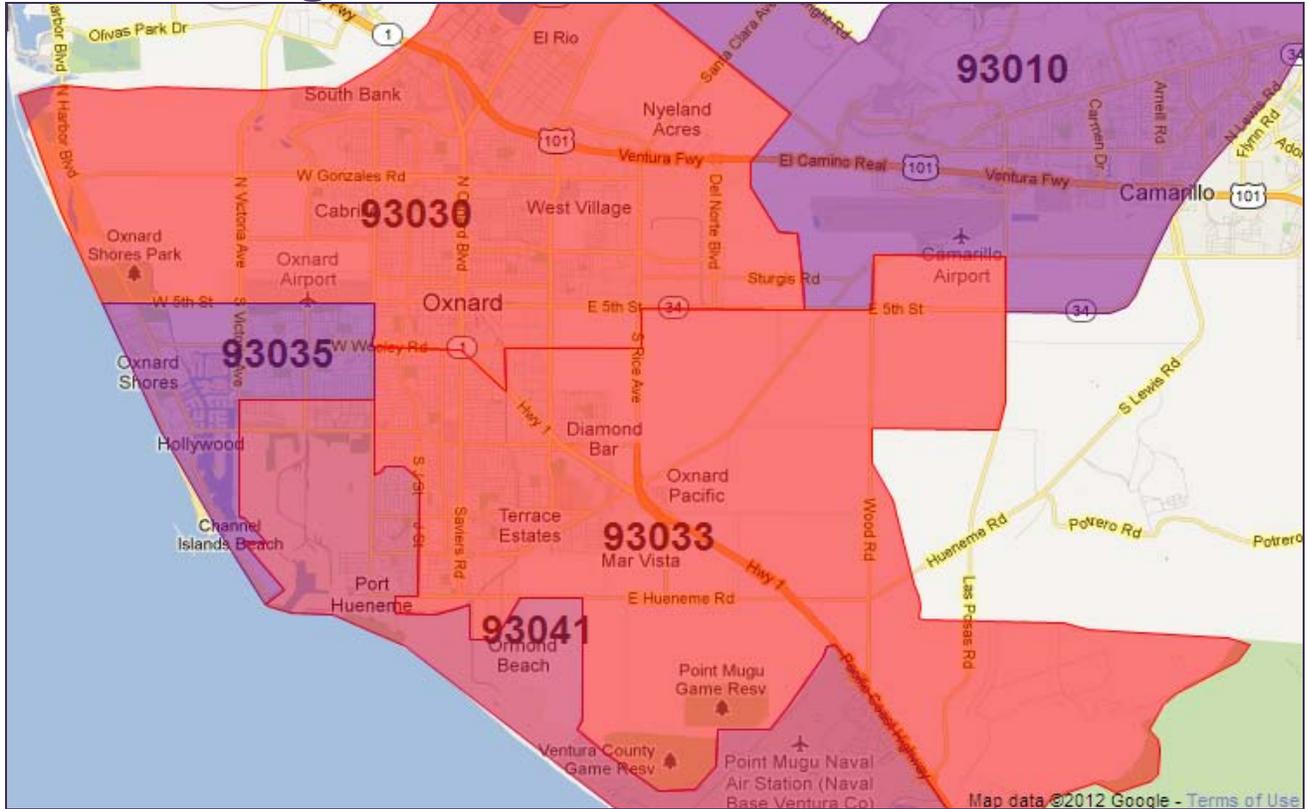
Policy and Resource Guidance:

- Dignity Health Community Board Resource Guide
- Dignity Health Governance Policies
- Dignity Health Community Grants Process materials
- Ethical and Religious Directives for Catholic Health Care Services

Appendix C

Dignity Health Community Needs Index for

St. John's Regional Medical Center



Lowest Need

1 - 1.7 Lowest

1.8 - 2.5 2nd Lowest

2.6 - 3.3 Mid

3.4 - 4.1 2nd Highest

Highest Need

4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County	State
93010	2.8	43795	Camarillo	Ventura	California
93030	4.4	62143	Oxnard	Ventura	California
93033	4.2	79797	Ventura County	Ventura	California
93035	3	26567	Oxnard	Ventura	California
93041	4	21591	Port Hueneme	Ventura	California

CNI Score Median: 4

Note—Though Zip code 93036 does not show separately on the above map the CNI provides evaluation of the geographic area.

Appendix D

Dignity Health Patient Payment Assistance Policy

DIGNITY HEALTH
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY
(June 2012)

Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be

processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

IN IMPLEMENTING THIS POLICY, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.