



Dignity HealthTM

St. John's Hospitals

St. John's Regional Medical Center

Community Benefit Report 2013

Community Benefit Plan 2014

A message from:

Laurie Harting, Dignity Health Sr. Vice President Southern California West Service Area and CEO of St. John's Hospitals, with Dr. Anne Kelley, Chair of the St. John's Community Board.

When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At St. John's Hospitals we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At St. John's Regional Medical Center we share a commitment to optimize the health of our community. In fiscal year 2013 St. John's Regional Medical Center provided \$47, 661,726 in financial assistance, community benefit and unreimbursed patient care, while St. John's Pleasant Valley Hospital provided \$17, 740, 821 in financial assistance, community benefit and unreimbursed patient care. Because we care how we contribute to the quality of life and the environment in our communities, community benefit has always been and will continue to be a key measure of our success.

In accordance with policy, the St. John's Hospitals Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their November 21, 2013 executive meeting.

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Southern California West Service Area,
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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 Hospitals also serve 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 wooden six-bed structure to today's 265-bed facility on a 48-acre campus 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. St. John's Regional Medical Center has the only 24/7 Critical Care Intensivist Physician program in Ventura County.

St. John's hospitals continue the heritage 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 2013 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, seeking to address not only diseases but the underlying socioeconomic conditions that exacerbate healthcare disparities. With foci of Chronic Diseases, especially Chronic Disease Self Management Program (CDSMP), Diabetes Programs, Community Immunizations, Youth Obesity Prevention, Comprehensive Perinatal Services Program (CPSP) called Healthy Beginnings, Congestive Heart Failure (CHF) Readmission Reduction program, a Senior Health/Wellness Program (bilingual), and a multi-faceted approach that addresses basic needs (Health Ministry Program).

Chronic Disease Self Management 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 Stanford model trained/certified facilitators. 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, the members of the cohort are then provided enhanced diabetes-related preventative and screening services; the program seeks to reduce the long term burden on government arising from life limiting disease through education and empowerment.

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.

Perinatal Services program (Under CPSP--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: identifying and referring for treatment of gestational diabetes, avoiding low birth weight , 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 or no 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, thus avoiding increases of preventable communicable diseases in the County and lessening the burden on the use of Emergency and other healthcare services and improving school attendance.

Senior Health/Wellness Program consists of several wellness focused activities through St. John’s Senior Health Connection 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.

Congestive Heart Failure Readmission/Reduction (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 designed to assist those who have CHF to manage their disease and avoid recurring hospitalizations. Through regular phone interaction with a trained health care professional (in Spanish or English) CHAMP® will help recently discharged patients, their family members, and other diagnosed with CHF to 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 utilization of healthcare resources in the county.

Health Ministry programs seek to address the basic needs of families and individuals, especially the poor. This is accomplished through a food bank (The Pantry) and Clothes Closet located in the Colonia district of Oxnard, and through a financial assistance program that gives loans and grants to the poor for such basic needs as medications, rent, utilities, transportation and food. A full description of these programs may be found at http://www.stjohnshealth.org/Medical_Services/community_education. In addressing basic needs economically disadvantaged or marginalized individuals/families are then able free-up financial resources for healthcare needs. In brief it helps in making choices on the assumption that if there is a choice between feeding/housing a person and medications/health needs the basic needs come first. Meeting those needs can empower the needy/marginalized healthcare consumer to pursue better self care.

Faith Community Nursing Network (FCNN) is a group of licensed nurses who have embarked on integrating their professional careers with their spiritual life/faith practice and faith community (i.e. church, temple, synagogue, stake, etc.). Through specialized training in privacy, spirituality, assessing for other than medical needs, a nurse can achieve the added certification of Faith Community Nurse (FCN). These individuals, who embody the Good Samaritan, create a 'grass roots, public health nursing network on a localized faith community base.

Free/Low Cost Health Screenings and Free Health Fairs Program utilizing the Mobil Wellness Vehicle creates health awareness in the community, and provides an opportunity for early detection and referral for care for the un/underinsured individual thus possibly averting a health crisis for the individual and a drain on health care resources. These events teach individuals how to be better health consumers and foster population health management.

To summarize, in FY2013, the value of St. John's unsponsored net community benefit expense totaled \$27,449,157 at St. John's Regional Medical Center. This figure excludes the unpaid costs of Medicare which were \$20,212,569 for SJRMC.

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

Background—historic and statutory. Founded as a ministry by the Sisters of Mercy in 1912 after invitation by the community, St. John’s has carried forth its sacred work of healing for more than 100 years in Ventura County. Providing care to patients as a hospital has always been augmented by the sisters in outreach activities to benefit the community. Statutory requirements have added the need to report this community benefit 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 boarder 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 primary 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 Services,⁴ our Catholic heritage 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 any 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 noting that everyone at St. John’s is engaged in “Sacred Work.” 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). 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

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

³ See

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>

the organization. A particular example of community involvement is the active role the Community Board's 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 as an active member of the Executive Leadership 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 finally approved by 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 to Cabrillo Economic Development Corp. that is a not for profit developer of high quality affordable housing. Through these grants and loans more than 200 families have high quality affordable housing in Ventura County using "Green" building techniques. Residents in all the projects funded give thanks for the opportunities for themselves and their children—this investment program gives hope where hope is needed most 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, Camarillo Chamber of Commerce
- Oxnard Chamber of Commerce
- Oxnard Ministerial Association

Among the community building activities is the Health Ministry Department monthly "County Networking Meeting." This voluntary meeting provides a forum for leaders and individuals from County, private and not-for-profit Human Services organizations and government agencies from all over Ventura County to dialogue, learn about new programs and opportunities for their clients, exchange information, explore potential new resources and make connections for their day to day work that benefits the broader community of Ventura County with a particular focus of those in need and marginalized.

The efforts of the St. John's Ecology Committee (a group of volunteer hospital leaders) demonstrate St. John's commitment to the environment of our communities by reducing the hospital's ecological impact through: education of staff, programs that target resource recycling and new this year food waste composting, St. John's is the leading ecologically conscious

healthcare facility in Ventura County. The most notable measure of our success is that both hospitals have received recognitions from Practice Greenhealth for their efforts in reducing our ecological footprint.

St. John's also partners with our local colleges and universities to provide clinical training for their nursing programs and other universities as an internship site for those seeking careers in health care. The following institutions have had students or interns at St. John's hospitals

- California State University, Channel Islands—RN Program (BSN)
- California State University, Channel Islands—MSN program
- Ventura College—RN Program
- Oxnard College—LVN Program
- East Stroudsburg University of Pennsylvania—MPH program
- Stanford University—summer internship 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. Thus the annualized economic benefit across 10 incorporated cities in Ventura County (where most of our employees live) 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: Oxnard 93030, 93033 & 93035, Port Hueneme 93041, and secondary areas of Camarillo 93010 & 93012,

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 2013 Community Needs Assessment, which is available on the St. John's webpage at http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/235065.pdf

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 Ventura County is 835,981.
- Age Groups – 25% of the area's population is under age 18. Senior citizens make up 12.6% of the population.
- Gender Diversity – 54.3% of the population is female, 45.7% male.
- Race/Ethnic Diversity – 41.2% of the population is Latino, 47.7 % is Non-Latino Caucasian, 7.3% is Asian, 2.2% African American and 1.9% "other."

- Adult Education – 34.5% of the adults in the service area have less than a high school education.
- Poverty Status – the poverty rate for the service area is 14.6%; however, the poverty rate increases to up to 18% in areas of Oxnard.
- Unemployment and Income – among the cities in the service area, the unemployment rate is 6.9%. The average per capita income for the area is \$32,740, with renters making up 44.2% of the population.
- Primary Language and Linguistic Isolation – English and Spanish are the primary languages spoken in most households within the service area. One-third (33.0%) of the county population indicate they speak a language other than English at home, compared to 44.5% in the service area and 67.4% in Oxnard.
- Birth Characteristics – there were 10,656 live births in the service area in 2011. Of those births, an estimated 3.4% did not receive prenatal care until the third trimester or not at all.
- The hospitals serve an area federally designated as a Medically Underserved Area (MUA).

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 and hospital utilization 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 2013 Community Needs Assessment (refer to CNI attached as Appendix D). The CNI score is for the PSA is 4.1, on the high end of the “Second Highest” range.

Hospitals Serving the area include 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, Los Robles Regional Medical Center in Thousand Oaks and Simi Valley Adventist Hospital in Simi Valley.

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment

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 completed during 2009.

The process for this Community Health Needs Assessment was initiated by the Vice President of Mission Integration for the St. John's Hospitals who sought the broadest participation possible from Ventura County, City of Oxnard, City of Camarillo and City of Port Hueneme elected officials, Ventura County Health professionals, the various leaders of Ventura County Human Services organizations—both public and private (who daily serve the needs of the community in various capacities), hospital staff currently involved with community needs and healthcare consumers/community members. Elected/government officials were interviewed in person or by phone. Public and private invitations were sent to organizations that specialized in Human Services to the broad population of both ethnically diverse populations and potential patient/healthcare consumer-type groups for a hearing that was held on May 1, 2012 at St. John's Regional Medical center. The hearing was chaired by the Vice President of Mission Integration and facilitated/documented by Hospital Community Benefit Staff. Health care consumers were interviewed randomly as they participated in activities related to maintaining/improving their health (e.g. walking programs, health education classes, and senior activity classes).

A group of leaders from St. John's were assembled to critically examine the data and provide analysis and input. The assessment took 12 months with various administrative and other meetings and input of leadership from Dignity Health.

Historic data was compared to current data to discern trends, especially in light of the "great Recession" of 2009 and its impact of health and wellness. This 2013 CHNA began with a review of the 2009 CHNA (conducted by Innovative Research Group in collaboration with St. John's Community Benefit staff). New data sources were identified and utilized, including the newly published Ventura County Health Status report of 2011 in the creation of the 2013 CHNA. Additional data from both hospitals (e.g. discharge information and interviews with medical, executive, social service and Emergency Department staff). Recent secondary indicator data for comparisons was also collected from both Healthy People 2020 and the State of California.

Although the analysis of the 2009 data integrated with the new 2012 and 2013 data tended to highlight trends and comparisons within Ventura County and the hospital specific PSA communities served, there was also a serious focus on the state of our PSA communities now and likely future trends, and how best we can serve immediate and future needs of those communities in light of a changing healthcare environment on the verge of implementation of the Affordable Care Act.

Data was also compared with indicators established by Healthy People 2020. Healthy People 2020 is a national program to guide health promotion by the U.S. Center for Disease Control. It contains about 1,200 health objectives covering 42 topics and is designed to be a science based guide for health promotion and disease prevention aimed at improving the health of all people in the United States. Healthy People has established benchmarks and monitored progress over time in order to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

The results of the 2013 CHNA 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 issues impacting healthcare:

1. Diverse needs from a diverse population that views/seeks healthcare differently and holds differing expectations regarding care thus impacting care delivery.
2. Lack of Financial Resources (especially Poverty) as it affects access to Health care, as most socio-economic/age/ethnic strata were negatively impacted by the Great Recession of 2009, with the marginalized, uninsured and under-insured and those considered as living in poverty were impacted the worse. The effect was that financial resources or financial insecurity played a larger role than ever before for individuals/families in priority setting for their healthcare needs.
3. Chronic Disease, including: diabetes, heart diseases, respiratory diseases and cancer.
4. Obesity Rates, particularly among adolescents, in terms of both current and future impact to health of the community.
5. Mental Health Services in terms of resources and access.
6. Environmental issues impacting health.

Un- and Under Insured

The great recession of 2009 and the following world-wide financial crises have taken their toll at the local level extending the conclusions of the CHNA that between 2000 and 2013 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, 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 MediCal (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 15.6% of the population in Ventura County does 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. This gap in insurance coverage, both for children and adults, is one of the top healthcare concerns in Ventura County. With the implementation of the Affordable Care Act healthcare will turn to Population Health Management with our community benefit focus becoming Community Wellness and Prevention.

Heart disease remains far and away the number one cause of death in the county, followed by Motor vehicle trauma, drug overdose, suicide then different forms of cancer. In almost all types of cancers, the rates for Latinos are considerably lower than that for Caucasians (non Latino). The death rate due to breast cancer is comparatively lower in Ventura County than the State of California; likewise there is a decline in rates for colorectal cancer. This is hopeful news as it suggests that better preventive care may be helping to reduce unnecessary death due to cancer.

Compared with other ethnicities, the number of Latinos with diagnosed diabetes mellitus is much higher in the 18 – 44 age groups. 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 females, while about one out of twelve (8.3%) indicate 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. The California Cancer Registry indicates that Ventura County ranks seventh in the state for invasive breast cancer.⁶

There was a significant increase trend 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

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

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 2010) has been at a stable rate of around 15% except for a recent drop in 2010 to 13.5% per thousand people in the county.

Ventura County shows a low birth weight (LBW) rate of 6% with Very Low Birth Weight of 1%. 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 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 (Port Hueneme is number 2 in the state). Further study is needed to identify possible underlying causes, but developing healthy habits, including sound nutrition, refraining from smoking, and regular physical activity or children are key issues identified by the Centers for Disease Control.

Ecological Issues

Air quality depends on a variety of issues which are directly related to our way of life, such as consumption and production (which, for example, may include: various hard and soft goods manufacturing by-products and agricultural products that may use various kinds of chemicals in the production process including pesticides), traffic, population levels, and many other factors, virtually all of which the study indicates have increased over the period studied. The result is that, with the exception of Ojai, the quality of air worsened in Ventura County. The information presented in the Community Health Needs Assessment shows that people with lower income are more likely to be negatively affected by environmental decay. This suggests that ecological/environmental issues need to be monitored in the future to determine the direct impact-on healthcare. As Health Care facilities, St. John's Hospitals worked diligently during 2012 to minimize their environmental footprint through an environmental strategic plan. St. John's Pleasant Valley Hospital was the first hospital in America to be named DEHP free in the United States and SJRMC received the Partner for Change with Distinction award.

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 2013

August – September 2013 Mission leadership, Community Education staff, Health Ministry staff and medical staff reviewed fiscal year 2013 outcomes and plans for service area, formulated objectives, and implemented Community Benefit Plan update.

August – October 2013 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.

January 2014 Community Benefit Plan completed and approved by St. John's Executive Leadership and Community Board.

January 2014 Community Benefit Plan forwarded to Dignity Health corporate office and Office of Statewide Health Planning and Development.

January 2014 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 2013 – 2014 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 and create better health care consumers through education and free/low cost health screenings as we move

toward population health management.. It also calls for continuing our collaborative approach as we 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.

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, program targeting, quality of programs, continuation, termination, monitoring and oversight.

Developing St. John's Community Benefit Report and 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

Six 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.

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
- Immunization Programs
- Outreach Programs

Tier II

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

Tier III

- Faith Community Nurse Ministries
- Community Grants
- 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.
- 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. Adjustments to staff have been made accordingly.

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).

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.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

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 (formerly Catholic Healthcare West) 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 ☐ 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	St John’s 2013 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 2013											
Goal FY 2012	<p>Primary Goal:</p> <ul style="list-style-type: none"> • Participants in the Diabetes Horizon FY 2103 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. 										
2013 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. • 5% reduction HbA1C levels for program participants with levels outside normal 										

	<p>ranges ($\geq 7.0\%$).</p> <ul style="list-style-type: none"> • 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 FY12:</p> <ul style="list-style-type: none"> • 99.24% 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 2013	<ul style="list-style-type: none"> • 99.63% 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. • 28% increase in participant physical activity. (As self reported). <p>Additionally the following results are reported:</p> <ul style="list-style-type: none"> • 2024 screenings and services were provided to the program participants. • 208 HBA1c screenings • 137 Lipid panels • 431 Blood Glucose screenings • 216 BMI measurements • 381 Blood Pressure screenings • 22 Eye and foot screenings • 562 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.
FY 2014	
Goal FY 2014	<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.
2014 Objective	<ul style="list-style-type: none"> • 60% of the participants in hospital intervention program will not be admitted to

Measure/Indicator of Success	<p>the hospital or have an ER visit to treat their diabetes within six months of enrolling in the program.</p> <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). • 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 FY13:</p> <ul style="list-style-type: none"> • 99.63% 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 Assessment	This program is open to all community members with congestive heart failure at no cost, including the poor and underserved.
Program Description	SJPMC & 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 2013	
Goal FY 2013	<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.
2013 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 2013:</p> <ul style="list-style-type: none"> 67% of the CHF appropriate patients were not re-admitted to the hospital within 30 days. 98 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 2013	<ul style="list-style-type: none"> 97.1% of the participants enrolled in CHAMP® were not re-admitted to the hospital within 30 days. 98 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. The CHAMP Program is offered in collaboration with Mercy Health & Vascular Institute.
FY 2014	
Goal FY 2014	<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. Engage physicians to increase patient participants in CHAMP®. Refer to CHAMP® all appropriate patients.
Baseline	<p>FY 2013:</p> <ul style="list-style-type: none"> 98% of the participants enrolled in CHAMP® will not not re-admitted to the hospital within 30 days. 100 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 provided consistent telephone follow-up and education to patients enrolled in CHAMP®. CHF team will conduct regular meetings to identify strategies to increase

	<ul style="list-style-type: none"> 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 20013	
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. 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 (.0006%) out of 3,427 blood pressure screenings of program clients had a blood pressure critical value (above 180/110). 5 (.002%) 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.

	<ul style="list-style-type: none"> 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 2013	<p>FY 2013:</p> <ol 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. <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	Support for this program was included in St. John's Operational Budget. St. John's offers hospital conference rooms to Bone Builders Class and Health Insurance Counseling and Advocacy Program and applied the cost to community benefit. St. John's Auxiliaries and Golden Classics collaborated with the community health education department staff to offer free health screenings, health information, and assistance with walking program and flu and pneumonia shots.
FY 2014	
Goal 2014	<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.
2014 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	<p>FY 2013:</p> <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. Health Ministry—Basic Needs 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	The 2013 Community Health Needs Assessment identified poverty as a significant threat to health in the community in that lack of financial resources limits choices in health care and because basic personal and family needs of food, shelter, transportation often times impacts seeking health care or leading a healthy life style because those basic needs are of greater priority. As a result, regular preventative or even remedial care is not sought.
Program Description	St. John’s Health Ministry Basic Needs Program seeks to provide for those needs of food, shelter and utilities to those whose means/income is limited and whose health us thus at risk for not being able to dedicate resources to their own and their family’s health and wellness.

FY 2013

Goal FY 2013	<ul style="list-style-type: none"> • Provide healthy food by maintaining a Free Food Pantry through a collaborative effort with Our Lady of Guadalupe Catholic Parish who provides the location and FOODSHARE and the US/FDA and other sources for healthy food. • Provide through St. John’s Foundation, a loan/grant program to assist people in need and without means who are at immediate risk of eviction for non-payment, or whose utilities are being turned off, or who cannot afford food or medications, or who are in need of emergent transportation related to healthcare.
2013 Objective Measure/indicator of success	<ul style="list-style-type: none"> • Provide food twice a week to 250 families • Provide clean new/good condition clothing to families in need—especially warm jackets in winter. • Assist 3 individuals at risk per week at least with some sort of financial support for a basic need(s).
Baseline	<ul style="list-style-type: none"> • Groceries were provided to 250 contacts twice a week through the Pantry representing over 5,100 people with 121,802 lbs of healthy food being distributed through the Pantry. • 1,991 people received new/good condition clothing during FY 2013. • 415 people received bus passes for transportation needs • 249 people received emergent rent assistance @ \$13,623 • 293 people received emergent utilities assistance @ \$10,527 • 12 people received emergent lodging assistance @ \$1,466 • 2 people received emergent prescription assistance @ \$83. • 3 people received miscellaneous needs assistance @ \$599.

Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Provide healthy food (including fresh fruits and vegetables) to 250 families twice a week, increasing protein with particular sensitivity to culturally appropriate food for those served. • Provide as needed cash/check assistance and financial case management to those at risk for : <ul style="list-style-type: none"> ➤RENT ➤UTILITIES ➤FOOD ➤MEDICATION ➤TRANSPORTATION
FY 2014	
Goal 2014	<ul style="list-style-type: none"> • Increase people served by 2% distributions at Pantry and Clothes Closet • Increase permanency emergent assistance through counseling re. personal resource management
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Total people served through all contacts (Pantry, Clothes Closet and emergent assistance) will increase by 2% • Recidivism of emergent needs by individuals will decrease by 5% less repeat contacts

E. 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>

Program Description	<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>
FY 2013	
Goal FY 2013	<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.
2013 Objective Measure/indicator of success	<ul style="list-style-type: none"> • FCN Network Supervisor complete FCN preparation course. • Identify 5-8 RNs to take FCN Preparation Course through APU or other institution. • 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 2 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 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.
Baseline	<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</p>

	<p>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>
Intervention Strategy for Achieving Goal	<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 poster on the new FCNN and secure a table at the annual Nursing Skills Fair at SJRMC & SJPVH. Get nurses to sign up for FCNN mailing list. • Meet with church leaders from various congregations to promote Faith Community Nursing in their parish. • 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. • Create Brochure on Faith Community Nurse Network for distribution and promotion of Network. • Mail information letter and brochure to local churches, temples, mosques, synagogues, etc. • Promote FCNN internally to staff via articles in Trendings. • Collaborative work is starting with Dignity Health’s 3 other Faith Community Nurse Program Coordinators. Started having 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.
FY 2014	
Goal 2014	<ul style="list-style-type: none"> • Increase FCN Network membership beyond current level of 24 • Increase church covenants by 2,
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Increase FCNs by 10% (2-3 nurses) • Increase covenants/formal associations with the FCN Network by offering use of the Mobil Wellness Vehicle and Health Fair to those faith communities that formally join the network. • Increase steering committee participation on an interfaith basis through Livingston VNA.

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.

Summary of Benefit Expense

Through these programs, and other non-programmatic efforts, the total value of community benefit by St. John's Regional Medical Center for FY2013 is \$27,449,157 which excludes the unpaid costs of Medicare of \$20,212,569. Combined, the unsponsored community benefit SJRMC expenses totaled \$47,661,726.

Detail for as follows:

**St. John's Regional Medical Center - Oxnard
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2012 through 6/30/2013**

	Persons Served	Expense	Revenue	Benefit	Expenses	Revenues
Benefits for Living in Poverty						
Traditional Charity Care	1,645	\$3,855,782	\$0	\$3,855,782	1.5	1.5
Unpaid Cost of Medicaid	23,819	\$65,537,907	\$40,101,219	\$23,436,688	8.7	9.0
Community Services						
Community Benefit Operations	0	\$126,586	\$0	\$126,586	0.0	0.1
Community Building Activities	144	\$8,585	\$0	\$8,585	0.0	0.0
Community Health Improvement Services	23,523	\$424,245	\$1,665	\$422,580	0.2	0.2
Financial and In-Kind Contributions	44,555	\$298,000	\$2,620	\$295,390	0.1	0.1
Health Professions Education	55	\$2,126	\$0	\$2,126	0.0	0.0
Totals for Community Services	68,277	\$859,542	\$4,275	\$855,267	0.3	0.3
Totals for Living in Poverty	93,741	\$67,253,231	\$40,105,494	\$27,147,737	10.6	10.9
Benefits for Broader Community						
Community Services						
Community Building Activities	762	\$11,205	\$0	\$11,205	0.0	0.0
Community Health Improvement Services	17,579	\$273,848	\$4,350	\$269,498	0.1	0.1
Financial and In-Kind Contributions	296	\$20,717	\$0	\$20,717	0.0	0.0
Totals for Community Services	18,637	\$305,770	\$4,350	\$301,420	0.1	0.1
Totals for Broader Community	18,637	\$305,770	\$4,350	\$301,420	0.1	0.1
<u>Totals - Community Benefit</u>	<u>112,378</u>	<u>\$67,559,001</u>	<u>\$40,109,844</u>	<u>\$27,449,157</u>	<u>10.7</u>	<u>11.0</u>
<u>Unpaid Cost of Medicare</u>	<u>15,294</u>	<u>\$93,500,890</u>	<u>\$73,288,321</u>	<u>\$20,212,569</u>	<u>7.9</u>	<u>8.1</u>
<u>Totals including Medicare</u>	<u>127,672</u>	<u>\$161,059,891</u>	<u>\$113,398,165</u>	<u>\$47,661,726</u>	<u>18.5</u>	<u>19.1</u>

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

Dignity Health Statement of Common Values

STATEMENT OF COMMON VALUES

Our mission is to deliver compassionate, high-quality, affordable health care; serve and advocate for those sisters and brothers who are poor and disenfranchised; and partner with others in the communities we serve to improve the quality of life. In carrying out our healing ministry, we embody the values of dignity, collaboration, justice, stewardship, and excellence.

Dignity

Holding the value of dignity means we show respect for persons, not for anything they do or any rank they hold, but because they reflect the face of God. Because persons are created in communities, respecting dignity also means working toward the common good within the communities we serve. The common good is realized when economic, political and social conditions protect and promote the basic rights of all persons and enable them to reach their common goals. We respect the dignity of all persons without regard to age, gender, sexual orientation, religion, culture, race, ethnicity, gender identity or economic, immigration or employment status. We believe that health care is a social good and a community service and that access to health care is a fundamental right of all persons.

For Dignity Health, respecting the dignity of persons requires reverence at every stage of life's journey from conception to natural death. Therefore, direct abortion is not performed.

Reproductive technologies in which conception occurs outside a woman's body will not be part of Dignity Health's services. This includes in vitro fertilization.

In the context of a mutually respectful and healing relationship with the physician and the clinical team, patients have the right to make medical decisions, including accepting or rejecting treatment, and must give free and informed consent before any intervention. They also have a right to make an advance directive and to name a surrogate decision maker, and they or their surrogates must have access to medical and other information regarding their care. At the same time, patients have a right to privacy--of their persons and of their medical information--and must be able to trust that our record-keeping and information systems are reliable and safe. Patients' families are an integral part of their care, and patient advocates are welcome.

There is no obligation to begin or continue treatment, even life-sustaining treatment, if from the patient's perspective it is an excessive burden or offers no reasonable hope of benefit. Death is a sacred part of life's journey; we will intentionally neither hasten nor delay it. For this reason, physician-assisted suicide is not part of Dignity Health's mission. Although pain management in all its forms is critical in allowing a person to die comfortably and with dignity, palliative care is consistent with all types of treatment and is not limited to those persons who are at the end of life. We attend to all dimensions of the person and consider professional spiritual care essential to our service. Spiritual care encompasses the full range of spiritual services integrated with patient care, including skilled listening presence that assists people of all faiths and those of no faith to tap their own beliefs, values and spiritual practices as they experience illness, trauma, recovery and loss. Consistent with the spiritual foundation of our legacy, we extend this spiritual care to families and coworkers as well as patients.

Collaboration

We understand that the social fabric is woven in partnership with all who are called to serve the community. Our ability to realize our mission depends on our relationships and linkages with others: health care providers, community leaders, physician organizations, government agencies, employers, health plans and individuals. Ours is a community of service and work—we recognize our complex responsibilities as health care providers to patients and their families, as employers, and as corporate citizens. Our commitment to collaboration fosters recognition of richness in diversity of culture and experience. The provision of health care is characterized by necessary hierarchies and by many rules and regulations; however, collaboration marked by trust, transparency and commitment to continuous improvement means that our best work is accomplished by teams of moral equals, with respect for one another's personal and professional gifts. Collaboration among spiritual leaders and communities of faith extends our ability to support the religious preferences and spiritual needs of those we serve. Our commitment to advocate for reasonable and accessible care for all who need it requires us to engage actively in the development of health care networks and avenues that better ensure the health of populations.

Justice

The American ideal of blind justice is balanced at Dignity Health by a biblical sense of justice that is concerned with righting imbalances of power and that expresses a preferential option for the poor. We have a special responsibility for persons who are poor or vulnerable, helping them through direct service and acting as an advocate to change structures oppressive to them. We have a moral responsibility to participate in efforts to reform the national health care system that will result in a more equitable distribution of health care goods and a more rational use of common resources. Dignity Health treats employees—the hands and heart of the ministry-- justly and respectfully, recognizing that a meaningful and humanizing work environment gives people a voice in matters affecting their work; respects and promotes their personal health and professional growth; and provides a just wage. We strive to promote a just culture and workplace relationships that are fair, trusting, and accountable.

Stewardship

Stewardship is the protective care we give our treasures in order to pass them on to the next generation. Our treasures are our human and financial resources, our environment, our heritage, and the trust the public places in us. We guard the safety and integrity of these things carefully. Health care resources belong to the community and as a health care system we are stewards of those resources with the responsibility to use them in a way that advances the health status of the community. In addition, we acknowledge our common duty to be stewards of the earth, and we recognize that we must use the earth's resources in ways that are equitable and ecologically sound. When resources are scarce, we have the responsibility to prioritize their use fairly and publicly.

Excellence

Motivated by compassion and professional integrity, we strive to provide the best care for every patient, at the right time, in the right setting, at an appropriate cost. We recognize that consistency in the way patients with similar conditions are treated is more likely to lead to better outcomes and, with humility and determination, we participate actively in opportunities to improve our service.

We strive to implement evidence-based practices in order to promote safe, high-quality, efficient care that puts patients and their families at the center.

Resolution of Unforeseen Issues

Dignity Health's founders are women religious, for whom contemplation and action are linked in every decision. That tradition has come down to us in the way we go about making important, values-based decisions, specifically in the use of a discernment process that requires significant aspects of the decision be weighed in light of our core values. We try to be sure that stakeholders--people who are affected by the decision--can contribute appropriately to the decision. Options are considered in light of the core values, and after a period of reflection and respectful discussion, a decision is made that balances and honors the relevant values. This process is especially important when decisions are complex, or when the values involved may conflict. When issues that are unanticipated in this document arise between Dignity Health and its partners, we expect all to contribute to a decision that serves the common good. (February 12, 2013)

Appendix B

Executive Leadership & List of Community Board Members FY2014:

Executive Leaders:

+Laurie Eberst (Pres. & Chief Executive Officer, and Sr. VP Operations, Dignity Health, Southern California West Region)
Kimburli Wilson (VP & Chief Operating Officer)
Eugene Fussell MD (VP & Chief Medical Executive, Dignity Health, Southern California West Region)
Cathy Frontczak RN (VP & Chief Nurse Officer)
Robert Wardwell (VP & Chief Financial Officer, and CFO Dignity Health, Southern California West Region)
Chris Champlin (VP & Chief Strategy Officer, and CSO Dignity Health, Southern California West Region)
Ed Gonzales (VP Human Resources, and VP Human Resources Dignity Health, Southern California West Region)
Brian Hammel (VP Development, and VP Development Dignity Health Southern California West Region)
+George West (VP Mission Integration)

Community Board Members

Sr. Amy Bayley RSM (Sister of Mercy sponsor)
Joe Burdulis (Retired CBOE of Agrix)
Suzanne Chadwick (Retired SVP Santa Barbara Bank & Trust)
Mary Fish (Retired Dir. of a Surgery Centers)
Joe Hernandez (Pres. JHC Benefits)
Thomas Holden O.D. (Former Mayor of Oxnard)
+Lynn Jeffers MD (Medical Staff)
+Ann Kelley MD (Medical Staff—Board Chair)
Christopher Loh MD (Medical Staff)
Laura McAvoy Esq. (Attorney)
Henry Montes MD (Medical Staff)
Sandy Nirenberg (Dir. Camarillo Hospice)
Sr. Joan Marie O'Donnell RSM (Sister of Mercy sponsor)
Michael Powers (Dir. Ventura County Health Care Agency)
Jack Rotenberg MD (Medical Staff)
+Sylvia Munoz Schnopp (Marketing/Public Relations Consultant)
+Martin Shum (Retired Business Owner—former chair)
Steven Soule MD (Chief of Medical Staff)
Donald Skinner (Retired Pres. of a Technology Corp.)
Steven Soule MD (Chief of Medical Staff)
Lee Wan MD (Medical Staff)
+Carl Wesley (Pres. General Contracting firm)
+Jeri Williams (Chief of Oxnard Police Dept.)
+Celina Zacarias (Director, Cal-State Univ. Channel Islands)
Jerry Zin Esq. (Attorney & Foundation Chair)

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

Appendix C

Community Relations/Community Benefits Committee Organization Plan Fiscal Year 2014

Members

- **From Community Board:** Lynn Jeffers, Dr. Ann Kelly, Sylvia Schnopp, Martin Shum, Carl Wesley, Jeri Williams, Celina Zacarias (committee chair)
- **From Administration:** Laurie Eberst, George West, and Dir. of Marketing, Dir. Public Relations, and Dir. of Physician Relations

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

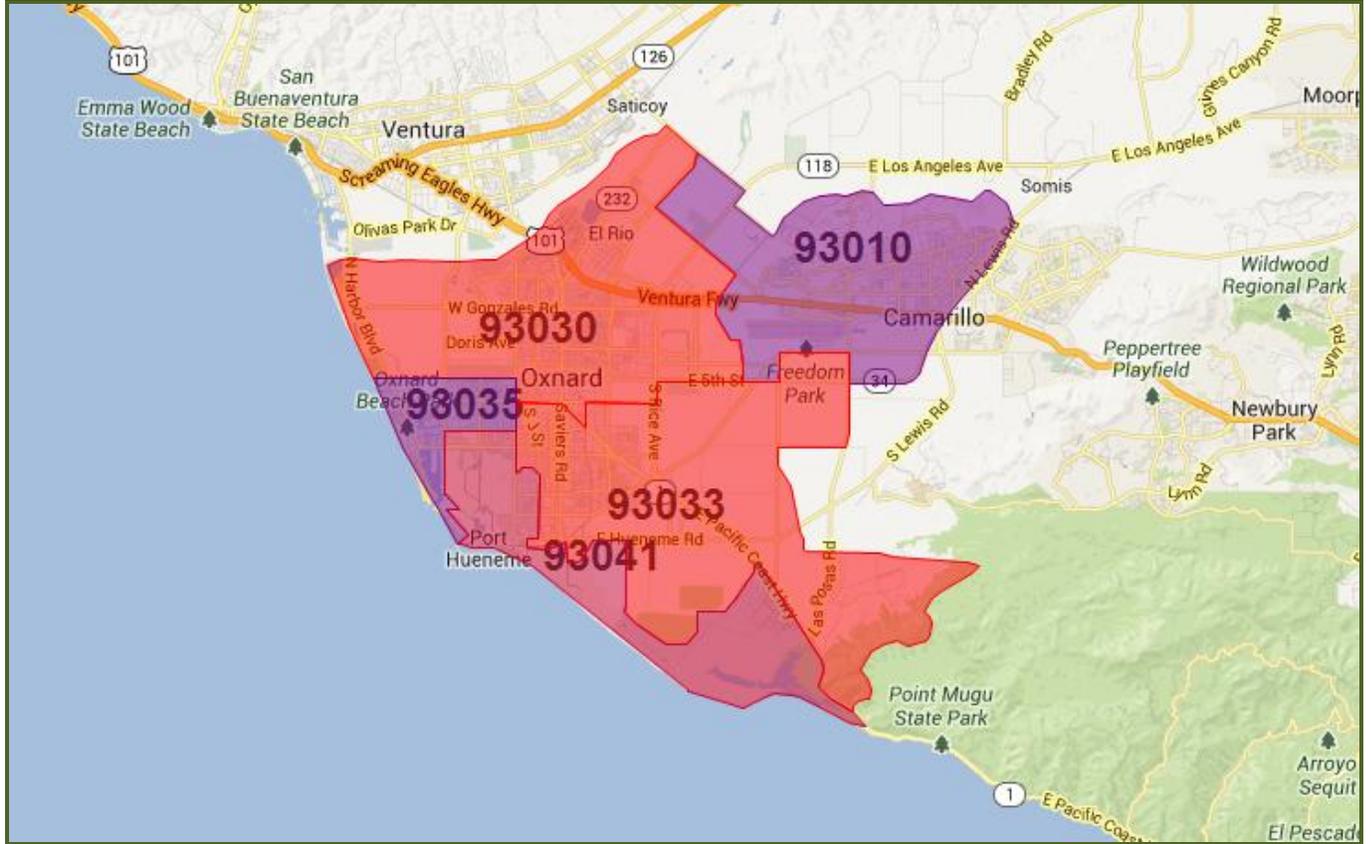
The CR/B Committee shall elect two officers: a Chairman and a Secretary.

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 D

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

4.2 - 5 Highest

Highest Need

	Zip Code	CNI Score	Population	City	County	State
■	93010	2.8	43,795	Camarillo	Ventura	California
■	93030	4.4	62,143	Oxnard	Ventura	California
■	93033	4.2	79,797	Oxnard	Ventura	California
■	93035	3	26,567	Oxnard	Ventura	California
■	93041	4	21,591	Port Hueneme	Ventura	California

CNI Score Median: 4.0 ■ (2nd Highest)

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

Appendix E

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.