



St. John's Regional Medical Center
Community Benefit Report FY 2014
Community Benefit Implementation Plan FY2015



Dignity Health.
St. John's Hospitals

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A message from Chuck Cova, Dignity Health Senior Vice President Operations, Central Coast Service Area and Ann Kelley, MD, Chair of the Dignity Health St. John's Hospitals Community Board.

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At Dignity Health St. John's Regional Medical Center we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 103 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and required by its governing body, Dignity Health complies with mandates at each of its facilities, including those in Nevada and Arizona; and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

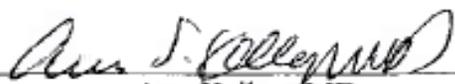
In fiscal year 2014, St. John's Regional Medical Center provided \$33,315,639 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$56,059,200.

Dignity Health's St. John's Hospitals Community Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 30, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 805-988-2701.



Charles J. Cova
SVP Operations, Central Coast



Ann Kelley, MD
Chairperson, Board of Directors

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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, a not-for-profit corporation. Together, St. John's Hospitals represent the largest acute care health organization in Ventura County. With over 1,785 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, with community leaders' support, established St. John's Hospital near the coastal plain of Oxnard in 1912 as a six-room wooden structure. It grew to be St. John's Regional Medical Center (SJRMC) a 265-bed facility on a 48-acre campus in northeast Oxnard, a community that has a land use mix of residential, agricultural and industrial, including a large Navy base and a vacation harbor area. SJRMC 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), and neurology. Accredited by The Joint Commission with certification as a Chest Pain Center, it is also serves as home to St. John's Cancer Center of Ventura County, St. John's Regional Spine Center, and St. John's Center Surgical Weight Loss Center. St. John's Hospitals have the only 24/7 Critical Care Intensivist Physician program in Ventura County.

St. John's continues the legacy of healing and community service in the Catholic social tradition. In response to those issues identified in our 2013 Community Health Needs Assessment and 2014 Latino Community Health Needs Assessment © (which are posted on the St. John's and Dignity Health web pages), St. John's continues its commitment to meet the health care needs of those who are un/under insured, seeking to address not only ill-health but the underlying socioeconomic conditions that exacerbate healthcare disparities through multiple programs and by collaborating with other community organizations

Chronic Disease Self Management Program (CDSMP) seeks to empower those who suffer from chronic diseases and their families by use of the Stanford model of evidenced based education and support. Facilitated by Stanford model trained/certified educators, classes are highly participative; build the participants' confidence in their ability to manage their health and fulfilling lives while reducing the healthcare resource utilization.

Diabetes Hospital Admission/Readmission Reduction (HARR) program aims at reducing the complications and associated hospital readmissions of community members with type 2-diabetes. Educators provide enhanced diabetes-related preventative and screening services to a cohort of 50-75 participants. The program seeks to reduce the long term burden on government arising from this 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, with information, education, treatment, and self-management tools to manage their diabetes. This program acts as an additional "safety net" in providing a variety of free services and connects those in need with community health resources.

Community Immunizations 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 preventable communicable diseases in the County. Lessening the burden on Emergency and other healthcare services and improving school attendance.

Senior Health/Wellness Programs consist 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, Health Insurance Counseling, wellness classes and screening clinics offered at three county senior centers in Oxnard.

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 program designed to assist those who have Heart Failure and their families manage the disease in order to improve their quality of life, increase interactions with their physician and avoid unnecessary utilization of healthcare resources in the county.

Health Ministry programs address the socioeconomic causes of healthcare disparity by meeting basic needs of families and individuals, especially the poor. This is accomplished through a food bank and durable goods center 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. In addressing basic needs economically disadvantaged or marginalized individuals/families are then able to free-up financial resources for healthcare needs. Meeting those needs empowers the needy/marginalized healthcare consumer to pursue better care.

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 un/underinsured individuals thus possibly averting a health crisis for the individual and a drain on health care resources.

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 create a grass roots, volunteer public health nursing network on a localized faith community basis which adds community health resources.

In summary, during FY2014, the value of SJRMC unsponsored net community benefit expense totaled \$33,315,639. This figure excludes the unpaid cost of Medicare which was \$22,743,561.

MISSION STATEMENT

Dignity Health St. John's Hospitals' Mission

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

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.

Our Brand

Hello humankindness® is the daily expression of our mission and values through word and deed, acknowledging that medicine has the ability to cure and humanity has the power to heal.

ORGANIZATIONAL COMMITMENT

Background— 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 102 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.¹ Because Medicare and Medicaid increased reimbursement coverage, hospitals began caring for fewer uninsured individuals therefore resulting in less uncompensated care (i.e. charity care). This IRS Ruling 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 Service Areas, through our 2013 Community Health Needs Assessment and 2014 Latino Community Health Needs Assessment, then evaluating the available resources of the hospital, focusing those resources available where there is the greatest need. Combining this legal setting with the Dignity Health Statement of Common Values,² the Ethical Directives for Catholic Health Care Services,³ our Catholic heritage and an outcomes targeted approach based on identified needs, our programs focus on 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.”⁴

SJRMC has held to community service as a guiding principle in our ministry of healing. Community wellness with justice and care for all has been at the forefront of strategic planning and Community Board oversight (Leadership and Community Board rosters are found in Appendix A). 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, SJRMC’s commitment to providing benefit to the community can be found throughout the organization. The Vice President of Mission Integration is charged with management of these programs as an active member of the Leadership Team and the liaison to the Community

¹The Hilltop Institute, “Hospital Community Benefits after the ACA: The Emerging Federal Framework,” January 2011 Issue Brief.

² See:

http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/stgss047977.pdf

³ 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>

⁴ 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>

and Foundation Boards for community benefits. Community benefit/outreach activities are also an integral part of the hospitals' strategic plan. This Community Benefit Report and Plan is reviewed by the CEO and the Senior Leadership team, the Community Benefit/Relations Committee of the Community Board, and finally reviewed and approved by the St. John's Hospitals Community Board.

Dignity Health's Commitment in Ventura:

In addition to supporting the ministry of the SJRMC, Dignity Health's commitment to the area is evidenced by the Dignity Health Community Investment Program for community redevelopment in Ventura County. Dignity Health has provided funding or loans for several low income housing projects in Ventura County to Cabrillo Economic Development Corp., a not for profit developer of high quality affordable housing. Through these grants and loans Dignity Health has helped provide more than 200 families high quality affordable housing in Ventura County.

Non-Quantifiable Benefits

SJRMC works collaboratively with community partners in local capacity building and in community-wide activities. Some of SJRMC's involvement includes: 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, and the Oxnard Ministerial Association.

Among the community building activities is the Health Ministry Department monthly "County Networking Meeting" which provides a forum for individuals from government, private and not-for-profit human services and health care organizations from all over Ventura County to dialogue, learn about programs and opportunities for their clients, exchange information, explore potential new resources and make connections for their daily 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 Hospitals Ecology Committee demonstrate SJRMC's commitment to the environment of our communities by reducing the hospital's ecological impact. St. John's Hospitals are the leading ecologically conscious healthcare facilities in Ventura County with the most notable measure of our success being that both SJRMC and SJPVH are the only healthcare facilities in Ventura County to have received National Awards in 2014 from Practice Greenhealth®.

SJRMC also partners with colleges and universities to provide clinical training for their nursing programs and other programs as an internship site for those seeking careers in health care. The following institutions have had students or interns at SJRMC during FY 2014:

- California State University, Channel Islands—RN Program (BSN and MSN)
- Ventura College—RN Program (AA)
- Oxnard College—LVN Program (AA)
- East Stroudsburg University of Pennsylvania—MPH program
- California State University, Northridge—MPH program

St. John's hospitals are the largest healthcare employer in Ventura County. SJRMC employs 1,298 people whose average salary is \$40 per hour. These employees provide an estimated economic benefit across 10 incorporated cities in Ventura County (where most of our employees live) of more than \$80,000,000.

COMMUNITY

Definition of Community

Community is defined as the people residing within the hospital's service area. While SJRMC serves all of Ventura County, the Primary Service Area (PSA) of SJRMC is defined as the population residing in the following zip codes: Oxnard 93030, 93033 and 93035, Port Hueneme 93041 and Camarillo 93010.

SJRMC not only focuses on the needs of its PSA but also takes into account the needs throughout Ventura County. Data cited in the Description of the Community section below is 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 (note: some data below has been updated from the time of the 2013 CHNA).

Description of the Community

The 2013 CHNA and the most recent Community Needs Index (see Appendix C) is used for this report and for strategy planning. Of particular note is the following:

Community Demographics

- Population – the population for Ventura County is 835,981, with 242,518 in the PSA.
- Age Groups – 30.9% of the population is under age 18 with seniors comprising 13.1%.
- Gender Diversity – 50.4% of the population is female, 49.6% male.
- Race/Ethnic Diversity – 74.9% of the population is Latino, 13.8% is Non-Latino Caucasian, and 7.4% is Asian, 2.2% African American and 1.7% “other.”
- Adult Education – 34.5% of the adults in the area have less than a high school education.
- Poverty Status – the poverty rate for the service area is 14.6%; the poverty rate increases to up to 18% in certain areas of Oxnard.
- Unemployment and Income – among the cities in the service area, the unemployment rate is 6.9%. The estimated per capita income for the PSA in 2012 was \$19,229, with renters as 44.2% of the population.
- Primary Language and Linguistic Isolation – English and Spanish are the primary languages spoken households within the PSA. 33.0% of the County population report speaking a language other than English at home, compared to 44.5% in the PSA and 67.4% in Oxnard who report a language other than English used at home.
- 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.
- SJRMC serves 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 to identify areas with the greatest needs on a scale of 1 to 5. This tool uses socioeconomic data to provide an “at a glance” view of disproportionate unmet needs in a geographic area. Within SJRMC's PSA the zip code with the greatest need as identified by the CNI is 93033. This validates the findings and needs identified in the 2013 Community Health Needs Assessment and 2014 Latino CHNA (refer to CNI attached as Appendix C). The CNI median score for the PSA is 4.2, in the “Highest” range.

Hospitals Serving Ventura County include Community Memorial Hospital (CMH) and the Ventura County Medical Center, both located in Ventura, Ojai Valley Community Hospital in Ojai (part of CMH system), Santa Paula Hospital in Santa Paula (county system), 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, passed in 1994, required not-for-profit hospitals to consult with community groups and local government officials to identify and prioritize the needs of their communities. Section 501(r) of the Federal Patient Protection and Affordable Care Act also requires 501c (3) hospitals to triennially complete a Community Health Needs Assessment (CHNA) and annual implementation plans. St. John's most recent CHNA was completed in 2013 with a focused Latino Community Needs Assessment follow-up in 2014.

The process for the 2013 CHNA for the SJRMC 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. Invitations were sent to organizations that specialized in providing “human services” to the broad population of ethnically diverse populations and potential patient/healthcare consumers for a hearing that was held on May 1, 2012 at SJRMC. The hearing was chaired by the Vice President of Mission Integration and facilitated/documentated by Hospital Community Benefit Staff. Health care consumers were interviewed randomly as they participated in activities related to maintaining/improving their 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). New data sources were identified and utilized, including the 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 the State of California and Healthy People 2020.

Health 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 2020 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.

Community Wellness Integration Leaders (CWIL), a group of leaders from SJRMC, 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.

Although the analysis of the 2009 data integrated with the new 2013 and 2014 data tended to highlight trends and comparisons within Ventura County and the hospital specific PSA communities served, there was a serious focus on the state of our PSA communities now, and how best we can serve immediate needs in addition to potential future needs of our communities in light of a changing healthcare environment under the Affordable Care Act.

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. The disparities in socio-economic status presents the challenge that no single program, or “cookie-cutter”/one program “fits-all” approach can meet the health needs of the populations that we serve. Programs must be tailored to specific demographic groups. This 2013 CHNA conclusion was recently affirmed by the Ventura County Health Care Agency.⁵
2. Lack of Financial Resources (especially Poverty) as it affects access to Health care, especially among the marginalized, uninsured and under-insured and those considered as living in poverty that are impacted the worse. The effect was that financial resources or financial insecurity plays a larger role than ever before for individuals/families in priority setting for their healthcare needs.⁶
3. Chronic Diseases, including: diabetes, heart failure and other heart diseases, respiratory diseases and cancer, because these diseases present a burden of recurring resource intensive impact on the utilization of limited healthcare resources.
4. Obesity Rates, particularly among adolescents, in terms of both current and future impact to health of the community, especially in terms of how obesity leads to other medical conditions such as diabetes and heart disease.
5. Mental Health Services in terms of resources and access for the poor.
6. Environmental issues as they may impact health as a contributing factor in exacerbating medical conditions or, through long term exposure, create a medical condition requiring treatment

⁵ Transforming Ventura County Communities, http://www.vchca.org/docs/public-health/transforming-vc_report_final.pdf?sfvrsn=0

⁶ *Ibid*, p.1

Un- and Under Insured

The 2013 CHNA indicated that the cost of healthcare services increased 16.7% from 2009. The 2013 CHNA also 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-term trends 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 trends 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. The impact of Affordable Care Act is yet to be determined locally, mainly due to a significant segment of the population that cannot qualify for coverage under the ACA.

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 Non-Latino Caucasians.

Compared with other ethnic groups 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. Data 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.⁷

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-term trends indicate that there was a significant increase in the percentage of Ventura County residents who had flu shots during the last twelve months.

⁷ California Cancer Registry, see <http://www.cancer-rates.info/ca/index.php>

Obesity

With some national estimates that all of America will be overweight or obese by the year 2048,⁸ at a local level obesity among 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. Data also indicates that the trend of the last decade shows a big gap between the goal rate of obesity set for 2020 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 (52.6%) and Oxnard (47.9%) rank 2nd and 21st respectively among the communities in California for adolescent obesity.⁹ Further study is needed to identify possible underlying causes, but developing healthy habits, including sound nutrition, refraining from smoking, and regular physical activity for 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 2013 CHNA 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 2014 to minimize their environmental footprint through a comprehensive environmental plan. SJRMC received the Partner for Change with Distinction award from Practice Greenhealth.

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. SJRMC maintains a program to address this but it cannot be included in Community Benefit reporting due to statute limitations.

ASSETS ASSESSMENT & COMMUNITY BENEFIT PLANNING PROCESS

The needs identified in the 2013 CHNA, St. John's Hospitals strategic plan, and Dignity Health's Horizon 2020 strategic plan all provided input to this Community Benefit Plan, and guide St. John's hospitals in our ministry of healing to the community. In fiscal year 2014, Community Education Medical Director 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 2013

⁸ See http://www.nature.com/aj/formerly_published.html

⁹ See: http://www.publichealthadvocacy.org/research/overweightdocs2012/Overweight-2010_CCPHA%20Study_FINAL.PDF

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 report¹⁰ 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 SJRMC could seek to collaborate.

Timeline

August – October 2014 Mission leadership, Community Education staff, Health Ministry staff and the community health medical director reviewed fiscal year 2014 outcomes and 2015 plans for the service area, formulated objectives, and implemented this Community Benefit Plan.

August – October 2014 Top healthcare priorities reviewed by Mission Leadership, medical director and other staff, community healthcare workers and the Community Board's Committee for Community Relations/Benefits.

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

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

January 2015 the Community Benefit Report & Plan will be 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 Leadership
- St. John's Sister of Mercy Sponsors
- St. John's Community Board
- Community Health Education Department members
- Financial Operations Staff
- St. John's Healthcare Foundation
- St. John's Community Health Medical Director (medical staff member)
- Strategic Planning/Business Development staff
- Health Ministry Program staff
- Healthy Beginnings Program staff
- Faith Community Nurse network staff

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 Hospitals' 2014 – 2015 strategy, as it relates to the community, calls for SJRMC to continue to enhance and expand access and services to persons with disproportionate unmet healthcare needs through programs such as our heart failure 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

¹⁰see: http://www.vchca.org/docs/publichealth/ventura_county_health_status_2011.pdf?sfvrsn=0

that includes members from St. John's hospital leadership, physicians, and nurses; allied healthcare providers; and community agencies and community members.

St. John's Hospitals Community Board reviews, approves, and offers broad based support for the community health activities of SJRMC. The board, representing a cross-section of the community, has members from a wide spectrum of businesses and community based organizations in the hospital's PSA and an understanding of the top five healthcare needs that emerged from the 2013 CHNA. 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: design/focus, and quality.

Developing St. John's Community Benefit Report and Plan

SJRMC Community Benefit Programs are continually reviewed throughout the year using the strategic objectives established by hospital Senior Leadership; Dignity Health, 2013 CHNA and 2014 LCHNA data, and perceived needs of the community as identified by St. John's Community Relations/Benefits Committee and the Community Board. 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 SJRMC 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 by Dignity Health 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 Focus I – III program digests. The core principles include:

1. Emphasis on Disproportionate Unmet Health-Related Needs (DUHN) —Responding 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. Mobilizing other Resources--As programs are planned consideration is given to other assets and organizations in the community which St. John's could leverage.

Summary of Key Programs and Initiatives

This overview summarizes the processes used to review SJRMC 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 resources. The Community Wellness Integration Leaders team used a "values based discernment process" (as described in the Dignity Health Statement of Common Values) and a comprehensive community benefits programs review. That

process resulted in establishing three-pronged approach to meeting the needs of the communities we serve as identified in our 2013 CHNA (and subsequent 2014 LCHNA). Programs have been categorized in accordance within the three areas of focus and also linked to the Dignity Health Mission Standards.¹¹ Each focus is intended to reduce the burden on government through better stewardship of available healthcare resources.

Focus I, Addressing Disparities that Impact Healthcare:

- Health Ministries' Basic Needs Programs
 1. Food Pantry & Durable Goods Closet
 2. Community Loans for medications, rent, utilities (Foundation funded)

Focus II, Healthcare Consumer Empowerment through Education

- Hospital Admission/Readmission Reduction (HARR) Programs
 1. Diabetes Programs (including case management)
 2. Chronic Disease Self Management (CDSM)
 3. Heart Failure Self Management (CHAMP®)
- St. John's Cancer Center of Ventura County
 1. Nurse Navigator Program (grant funded)

Focus III, Addressing Prevention

- Immunization Programs
- Health Fairs
 1. Mobile Health Outreach
- Senior Health Connection
 1. Walking Program (Grant Funded)
 2. PACE (Arthritis Society)
 3. Cancer & Osteoporosis screenings
- Community Grants
 1. Youth Obesity Prevention
- Faith Community Nurse Program (in Collaboration with Livingston Visiting Nurse Foundation)

This focused approach improves prioritization and identified need linkage while offering a framework for further innovation in meeting community needs.

Reducing Health Disparities

Consistent with the Affordable Care Act's moving toward population health management, Dignity Health's Horizon 2020 strategic plan calls our hospitals to decrease inpatient readmissions (and over utilization of emergency resources) for ambulatory care sensitive conditions through Hospital Admission Readmission Reduction (HARR) programs. Strategic goals and objectives by Dignity Health align with those in the 2013 CHNA, 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. SJRMC has identified diabetes, as the high priority health issue in our communities on which we will focus our greatest efforts. As such, SJRMC 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 diabetes and obesity programs are:

- Identify individuals in the community with diabetes and intervene to prevent further diabetes related complications.

¹¹http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/stgss044503.pdf

- 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.
- Decrease disease complications associated with obesity
- Reduce obesity among youth (through Dignity Health Community Grants)

Other chronic diseases are also identified to inclusion in HARR. Upon completion of a Chronic Disease Self Management Program (CDSMP) participants will not require emergent care or hospitalization for a period of at least six months. Baseline data will follow establishment of this chronic disease self management workshop series.

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 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.

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 empower and improve the quality of life for those who suffer from CHF. This is achieved through: education about disease processes, symptoms, nutrition, medications and activity. During FY 2015 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 in the electronic medical record.

What is not being addressed and why:

The health needs of the community are extensive and SJRMC assets are limited. As a result, certain identified needs are not being addressed or are being addressed indirectly or programmatic activity is being reduced as other county assets address the identified needs. Most notable among these is direct youth obesity intervention.

- 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.
- Mental Health Needs of the Poor—at present SJRMC lacks sufficient resources to address this need. Nevertheless, through collaboration free mental healthcare will be provided at our largest health fair during FY2015, and we also maintain an on-call contract with a bilingual Licensed Marriage Family Therapist to provide counseling that may exceed current staff capabilities.
- Environmental Issues Impacting Health—SJRMC lacks the resources to address these issues in the community. However, SJRMC is committed to reducing our own environmental impact in the community.

Planning for the Uninsured/Underinsured Patient Population

Using the guidelines described above, every SJRMC 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 SJRMC's focus on providing for the uninsured and underinsured patient populations in our service area.

Additionally, SJRMC 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 also provides relief for those seeking to pay over time by installment (see Appendix D)

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

PROGRAM DIGESTS

Chronic Disease Management especially Heart Failure (HF) Program	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Addressing Disparities that Impact Healthcare ✗ Healthcare Consumer Empowerment through Education ✗ Addressing Prevention
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>According to the 2013 CHNA and the 2014 LCHNA, chronic disease is prevalent among the primary needs in our service area. Heart Failure (HF) is one of the chronic diseases identified as the most common reason for hospitalization among the elderly, accounting for one-fifth of all admissions.¹ Consequently, Medicare beneficiaries with HF are among the most costly to Medicare; they represent 14% of the population, but account for 43% of Medicare Part A and B spending.² This Chronic Disease Management Program is open to all community members with heart failure including the poor and underserved at no cost to all participants.</p>
Program Description	<p>St. John's Regional Medical Center & St. John's Pleasant Valley Hospital are committed to give all persons with heart failure and their family members within our community the knowledge and support necessary to help them maintain the highest quality of life and reducing their risk of being readmitted to any hospital or emergency department. St John's Hospitals will identify and recruit candidates for the Heart Failure (HF) Program from the community and within our hospitals. The Heart Failure Program provides education for a wide variety of patient needs to all patients diagnosed with HF. This education is in addition to discharge instructions provided to those admitted in hospital settings. This program provides education, risk assessment and referrals to HF patients. The comprehensive HF Program is a multipronged approach :1) Home health follow-up (when applicable), 2) Cardiac Rehab and 3) Congestive Heart Action Management Program ® (CHAMP®) Nurses evaluate HF 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 all hospitals. In addition, the HF program participants are referred to the following free services and open to the public: Chronic Disease Self-Management Program classes (Stanford Model), Cholesterol, Diabetes and Healthy Heart educational classes and other programs available based on their needs.</p>
FY 2014	
Goals FY 2014	<ul style="list-style-type: none"> • Participants in the Heart Failure Program will not be readmitted to any hospital/Emergency Department within 30 days of enrollment. • The hospital will increase the number of patients enrolled in the CHAMP® program.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 80% of the participants enrolled in CHAMP® will not be re-admitted to any hospital within 30 days. • Engage local physicians to increase patient participants in CHAMP®. • Refer to CHAMP® all appropriate patients with referrals.
Baseline	<p>FY 2013:</p> <ul style="list-style-type: none"> • 67% of the HF appropriate patients were not re-admitted to any hospital within 30 days. • 98 participants were enrolled in CHAMP®.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Provide on-going education for staff and healthcare providers about the value of the HF Program. • Work with the Mercy Health & Vascular Institute to provided consistent telephone follow-up and education to all patients enrolled in CHAMP®. • Cardiovascular team will conduct regular meetings to identify strategies to increase program enrollment. • Identify HF program candidates and refer to the appropriate program level. • Provide discharge planning, HF symptom management education, home health service evaluation and referral to the appropriate resources. • Provide follow-up visits, assessments and education to HF participants. • Refer and enroll patients to Stanford Model outcomes based "Living Well: Chronic Disease Self-Management Program." • Refer and enroll patients with co-morbidities as appropriate to diabetes self management program. • Refer and enroll patients with co-morbidities as appropriate to cholesterol classes. • Refer and enroll patients to Healthy Heart (Heart Failure) management classes.
Result FY 2014	<ul style="list-style-type: none"> • 89.77% of the participants enrolled in CHAMP® were not re-admitted to any hospital or emergency department within 30 days. • 335 community participants were enrolled in CHAMP®. • All the appropriate patients were referred to CHAMP®.

	<ul style="list-style-type: none"> St. John's Case Managers provided initial evaluation, and referral to local county medical facilities (including clinics) when indicated for those recruited within St John's Hospitals.
Hospital's Contribution / Program Expense	Support for this program was included in St John's Hospitals Operational Budget. The CHAMP® program is offered in collaboration with Mercy Health & Vascular Institute. Total spent on CHAMP® program during FY2014 was \$40,590.
FY 2015	
Goal 2015	<ul style="list-style-type: none"> Improve the health and quality of life of those that suffer from heart failure, enabling them to better manage their disease and reducing their need to be admitted or readmitted to any hospital or emergency department. Increase the number of patients enrolled in the CHAMP® program. Increase enrollment of underserved through outreach; collaborate with community; continue to maintain reduction in number of hospitals admissions and readmissions for enrolled participants.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> 90% of the participants enrolled in Heart Failure Program /CHAMP® will not be re-admitted to the hospital/ED within 30 days. 85% of CHAMP® patients will be on ACEI or ARB medication after enrollment in the program. 85% of CHAMP® patients will be on Beta Blocker medication after enrollment in the program.
Baseline	FY 2014: <ul style="list-style-type: none"> 89.77% of the participants enrolled in CHAMP® were not re-admitted to the hospital within 30 days. 335 participants were enrolled in CHAMP®. All the appropriate patients were referred to CHAMP®. St. John's Case Managers provided initial evaluation, and referral to local county medical facilities (including clinics) when indicated for those participants recruited within St John's Hospitals. This Chronic Disease Management Program remained open to all community members with heart failure including the poor and underserved at no cost to all participants.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> Engage physicians to increase patient participants in CHAMP®. Refer to CHAMP® all appropriate patients. Enhance the telephone based monitoring program by offering Tele-Health electronic monitoring services to prevent hospital readmissions within 6 months of enrolling in the CHAMP® Program Provide on-going education for staff and healthcare providers about the value of the HF Program. Work with the Mercy Health & Vascular Institute to provided consistent telephone follow-up and education to all patients enrolled in CHAMP®. Cardiovascular team will conduct regular meetings to identify strategies to increase program enrollment. Identify HF program candidates and refer to the appropriate program level. Provide discharge planning, HF symptom management education, home health service evaluation and referral to the appropriate resources. Provide follow-up visits, assessments and education to HF participants. Refer and enroll patients to Living Well: Chronic Disease Self-Management Program and conduct program. Refer and enroll patients to Healthy Heart educational classes. Refer patients to Cholesterol and Diabetes educational classes as appropriate.
Community Benefit Category	A1-a Community Health Education – Group Health Education and Individual Health Education A1-d Community Health Education – Support Group

Senior Wellness Program	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Addressing Disparities that Impact Healthcare ✗ Healthcare Consumer Empowerment through Education ✗ Addressing Prevention
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 13.1% of the population with the number of seniors predicted to increase over the next ten years.

Program Description	<p>The Senior Wellness Program has been an integral part of St. John's Community Health Education Department for 27 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; health related English and Spanish education and support groups; exercise classes; Chronic Disease Self-Management Workshops, six month Living With Diabetes Program; other health education classes; health screenings; Senior Wellness Programs at local senior centers; adult immunization and flu shot clinics. HbA1C screenings are offered to all participants who have diabetes. All of these services are bilingual and free to the community. The following collaborate with St. John's and use St. John's facilities for these programs which benefit seniors:</p> <p>Ventura County Area Agency on Aging: Health Insurance Counseling and Advocacy Program RSVP Organization: Bone Builders Class Alzheimer's Organization: Classes and Support Groups Brain Injury Center: Brain Injury Support Group</p>
FY 2014	
Goal FY 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 knowledge and behaviors among seniors. • Provide free health screenings for uninsured and/or low-income 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 screening. • 90% of program clients will NOT have a critical value on blood sugar screening. • 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 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 screening <ul style="list-style-type: none"> ◦ (above 180/110) during the year. • 97% of program clients did NOT have a critical value on blood sugar screening <ul style="list-style-type: none"> ◦ (above 300 mg/dl) during the year. • 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 year.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Utilize 2013 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of implementations. • Enroll participants in programs, provide interventions and monitor their blood pressure and blood sugar. • Refer participants to the Chronic Disease Self Management Program
Result FY 2014	<ul style="list-style-type: none"> • 100% of program clients did NOT have a critical value on blood pressure level (above 180/110). • 99% of program clients did NOT have a critical value on blood sugar levels. (above 300 mg/dl). • Senior Wellness Program participants displayed a 16% increase in knowledge of health and disease management as demonstrated in pre-and post-tests. • 100% of Walking Program participants with diabetes achieved an HbA1C of 7% or less by the end of the year. <p>Additionally, the Senior Wellness Program provided the following free services:</p> <ul style="list-style-type: none"> • 4,924 contacts in Walking Program • 170 contacts in English Diabetes Education and Support group meetings • 16 contacts in Spanish Diabetes Education and Support Group meetings • 854 flu shots • 2,994 blood pressure screenings • 1,905 blood glucose screening • 50 contacts in group health education • 944 contacts in Spanish exercise classes • 45 participants completed the six-month Diabetes Horizon Program • 54 completed 6 week Chronic Disease Self-Management Class • 41 Cholesterol Class
Hospital's Contribution / Program Expense	<p>Support for this program was included in St. John's Operational Budget. St. John's offers hospital conference rooms to Bone Builders Class, Health Insurance Counseling and Advocacy Program and other health organizations and applies the cost to community benefit. St. John's Volunteers 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 shots.</p>

FY 2015	
Goal 2015	<ul style="list-style-type: none"> • Monitor and manage hypertension and diabetes among seniors in the programs. • Prevent a medical crisis and hospitalization through early referral for those in the programs. • Improve health and wellness knowledge and behaviors among seniors. • Provide free health screenings for uninsured and/or low-income seniors. • Increase chronic disease self-management skills of participants.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 90% of program clients will NOT have a critical value on blood pressure screening. • 90% of program clients will NOT have a critical value on blood sugar screening. • 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 year. • Offer two Chronic Disease Self-Management Workshops in English and two in Spanish.
Baseline	FY 2014: <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
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Utilize 2013 CHNA to organize and coordinate increased outreach to DUHN communities and measure effectiveness of implementations. • 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 Category	A1-a Community Health Education – Group Health Education and Individual Health Education A1-d Community Health Education – Support Group A2-d Community Based Clinical Services – Immunizations/Screenings E3 In-kind Donations: Free Use of Facilities for Classes and Support Groups

Mobile Health Screenings Health Program (NEW)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Addressing Disparities that Impact healthcare ✗ Healthcare Consumer Empowerment through Education ✗ Addressing Prevention
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>According to the 2013 Community Health Needs Assessment and the 2014 Latino Community Health Needs Assessment, chronic disease is so prevalent that is a primary health need in our service area. Diabetes type II is at high risk for under diagnosed and/or under treated among the Latino Hispanic population of our community. This program is targeted primarily to the poor and underserved. It reaches the working poor with no insurance and the Latino population by providing access to free or very low cost healthcare services for low income underinsured children and adults, and offer preventative health education to the community.</p>

FY 2014—new program see baseline below	
FY 2015	
Goal 2015	<ul style="list-style-type: none"> • Improve immunization rates for children and adults within our community. • Improve school readiness for children through prevention, vaccinations, and early interventions. • Improve early recognition and awareness of chronic disease risks among the adult population served with prevention, early detection, early interventions and increased immunization rates. • Seek grant funding for continuation and growth of Shots for Kids and Adults and St John's Mobile health Screenings services including increased staff and clinic operational needs. • Increase partnerships for provision of mobile health screenings and education for community partners, school districts, migrant programs, family resource centers, local parishes, immunization clinics and for the newborn population • Increase education and awareness on the importance of health screenings and immunizations to all populations served
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Increased number of children and adults receiving health screenings. • Increased number of children and adults receiving immunizations. • Increased number of community events. • Increased grant dollars secured for Mobile Health Screenings unit and Shots for Kids and Adults program. • Increased number of persons getting health education.
Baseline	<p>The 2013 CHNA notes that St John's Service area continues to have high rates of poverty with limited access to healthcare. The current economic situation is impacting many insured, which are now under or uninsured, creating the need for more community based, affordable healthcare services. Families need assistance with building children's readiness for school and providing basic health screenings, immunizations, health education and referrals for follow-up care helps with this need. In addition, many pediatricians are beginning to send their newborn patients to the Shots for Kids and Adults clinics for immunizations as many families cannot afford the cost of this service or copayments. Providing Health screenings and immunizations for children and adults provides convenience for families that have limited transportation.</p> <p>During FY2014:</p> <ul style="list-style-type: none"> • Provided 1049 immunizations on adults (854 flu vaccines) • Provided 311 immunizations on children (189 flu vaccines) • Provided 109 TB (PPD) tests. • Provided 1350 Body Mass Index screenings • Provided 1457 Blood Pressure Screenings • Provided 1360 Blood Glucose screenings • Provided 991 Blood hemoglobin (anemia) screenings • Provided 367 Cholesterol screenings
Implementation Strategy for Achieving Goal	<p>Implementation strategies are:</p> <ul style="list-style-type: none"> • Increase participation at our regularly scheduled Community Health Fairs and Shots for Kids and Adults Clinics in order to provide more residents with access to a model continuum of care demonstrated by an 5% increased in Immunizations given to children and adults over previous year and 5% increase in total number of Health Screenings over previous year. • Enhance our work with other health care entities to implement a model continuum of care. • Increase utilization of our wellness programs to create improved mechanisms that will enhance follow-up, and retention of participants. • Continue to provide health related services, education for diabetes and other chronic conditions, health screening testing to uninsured/underinsured populations at no cost to the patient in the health fairs and mobile screenings unit or in the hospital, and free or low cost immunizations to children and adults.
Community Benefit Category	<p>A1-a Community Health Education – Group Health Education and Individual Health Education A2-d Community Based Clinical Services – Immunizations/Screenings</p>

Diabetes Self-Management Programs (Redesigned)

Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Addressing Disparities that Impact healthcare ✗ Healthcare Consumer Empowerment through Education ✗ Addressing Prevention
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	According to the 2013 CHNA 73.5% of the population in Oxnard identified themselves as Hispanic/Latino. According to the American Diabetes Association Hispanics are 1.7 times more likely to be diagnosed with diabetes than whites. In addition, 67% of the population in Oxnard reported they do not speak English at home. The 2014 Latino CHNA identified that 40% of the participants surveyed reported not having health insurance.
Program Description	The Hello! Living Well with Diabetes and ¡Hola! Vivir Bien con Diabetes self-management program provides free health screenings, including lab work (HbA1C, lipid panel), height/weight, and blood pressure readings, health education, 1:1 counseling, and diabetes supplies (if needed).
FY 2014	
Goal FY 2014	<p>Primary Goal:</p> <ul style="list-style-type: none"> • Participants in the Diabetes Horizon program (old program name) 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 Goals:</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 Measure/Indicator of Success	<ul style="list-style-type: none"> • 60% of the participants in hospital intervention program will not be admitted to the hospital or have an ER visit to treat their diabetes within six months of enrolling in the program. • 5% reduction HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). • 5% reduction in Blood Pressure values for program participants with values outside normal ranges ($\geq 130/80$). • 5% increase in participant physical activity. (As self reported). • Enroll 20 Diabetes Horizon participants in Chronic Disease Self-Management Workshops.
Baseline	<p>FY 2013:</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. • 28% increase in participant physical activity. (As self reported).
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Bilingual health education and laboratory screening events were held 8/3/2013, 9/14/2013, 11/2/2013, 1/11/2014, 4/12/2014 and 6/28/2014. • Subsequent five-hour bilingual health education programs were provided as follow-up educational sessions or stand alone events on 8/17/2013, 9/28/2013, 11/16/2013, 11/23/2013, 1/25/2014, 3/15/2014, 4/26/2014, and 4/30/2014. • Diabetes foot screening events were held on 8/21/2013. • Diabetes classes were held at three community locations in Spanish.
Result FY 2014	<ul style="list-style-type: none"> • 45 participants (or 100%) were not admitted to a hospital or ER for diabetes during their 6 months of enrolling in the program. • 26 of 39 participants (or 67%) reduced their HbA1C levels by 5% or more upon completion of the program. 13 of 39 (33%) did not reduce their HbA1C by 5%. [6 participants' HbA1C was at or below target throughout the program and were excluded from this evaluation.] • 32 participants had a blood pressure exceeding normal range when they entered the program. 12 of the 32 participants (or 38%) reduced their blood pressure by 5%. [13 participants' blood pressures were within normal range and were excluded from this evaluation.] • 25 of 45 participants (or 56%) increased their physical activity 5% per week as self-reported and 22 participants (or 49%) achieved 150 minutes or more of physical activity per week by the end of the program. • 16 participants (or 36%) attended the Chronic Disease Self-Management Workshop.
Hospital's Contribution / Program Expense	Support for the bilingual Diabetes Self-Management Program was included in St. John's Hospitals Operational Budget.

FY 2015	
Goal 2015	The redesigned program will increase individuals' health literacy and self-efficacy as related to diabetes for the population residing within St. John's primary service through a six-month evidenced-based health promotion/education program, Hello! Living Well with Diabetes or Self Management Program (HLWD).
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • By the third quarter of FY'15, the need for a Hello! Living Well with Diabetes Self Management Program in Camarillo at SJPVH will be determined. The program would be facilitated through collaboration and peer educators. • Through an HbA1C lab test, 70% of individuals' in the HLWD program with an HbA1C $\geq 7.5\%$ will decrease their HbA1C level by 5.0% after six-months. • 70% of the participants will show an increase of 10 points between their pre- and post- test knowledge test scores. • 50% of the participants will report an increase of 10% in their reported minutes per week of exercise by the conclusion of the six-month program. • Three diabetes health education outreach sessions will be held in Spanish in FY'15.
Baseline	Based upon FY2014 results and supported through both the 2013 CHNA and the 2014 Latino CHNA chronic disease awareness, health insurance status, and the prevalence of diabetes substantiates continuance of a bilingual Hello! Living Well with Diabetes or ¡Hola! Vivir Bien con Diabetes Self-Management Program in St. John's primary service area.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Plan and conduct four bilingual health education and laboratory screening events as identified in department protocols and program guidelines. • Evaluate the effective of a six-week pilot program with more frequent meetings through pre and post test results (health screening and pre- and post-test). • Expand participant recruitment to include physician referrals, community referrals and hospital referrals. • Collaborate with heart failure coordinator to develop a system to identify heart failure patients with diabetes and refer them to the diabetes education programs. • At the conclusion of the Hello! Living Well with Diabetes or ¡Hola! Vivir Bien con Diabetes Self-Management Program participants will be encouraged to regularly attend the monthly diabetes support group meetings.
Community Benefit Category	Community Health Improvement A1. Community Health Education A2. Community-Based Clinical Services/Health Screenings.

Health Ministry—Basic Needs Program	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Addressing Disparities that Impact healthcare <input type="checkbox"/> Healthcare Consumer Empowerment through Education <input checked="" type="checkbox"/> Addressing Disparities that Impact healthcare
Program Emphasis	<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 checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	The health issues being seen in our community are closely related to the financial disparity the clients are facing. Our Food Pantry has become a source of supplemental food rather than emergency food distribution. Families are counting on items distributed to stay healthy and well fed.
Program Description	St. John's Health Ministry Basic Needs Program promotes social justice in the community at large by helping the underserved and vulnerable in a compassionate way. The resources are dedicated to help people meet their basic needs and improve quality of life. Services include – distribution of food bags, hot meals and clothing; rent, utilities, lodging and prescription assistance; bus passes, community referrals and holiday programs (Adopt a Family, Thanksgiving and Christmas Food Baskets).
FY 2014	
Goal FY 2014	<ul style="list-style-type: none"> • Strengthen collaboration with Our Lady of Guadalupe Catholic Parish, Food Share and Whole Foods Market in order to continue current distribution in La Colonia neighborhood and increase food access of healthy food. • Increase fundraising efforts through St. John's Foundation with the intention of being able to loan/grant funds 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.
2014 Objective Measure/indicator of success	<ul style="list-style-type: none"> • Increase distribution of protein items and fresh fruits and vegetables. • Provide clean new/good condition clothing to needy families through the Adopt a Family Program and weekly distributions.

	<ul style="list-style-type: none"> Assist individuals/families that are having financial difficulties due to health issues or reduction in work hours.
Baseline	<ul style="list-style-type: none"> Supplemental food was distributed at the Pantry, serving 1,750 families several times a year (which resulted in providing food for 24,598 people when we count all family members every time they were served). Distributed 116,117 lbs of food from Food Share. 16,875 food bags were distributed at the Food Pantry. 2,109 people received new/good condition clothing during FY 2014. 611 people received bus passes for transportation needs 218 people received emergent rent assistance @ \$13,869 257 people received emergent utilities assistance @ \$9,591 9 people received emergent lodging assistance @ \$960 6 people received emergent prescription assistance @ \$740. 14 people received miscellaneous needs assistance @ \$1,003.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Supply healthy food (weekly) to 150 families and provide ready to eat food (hot meals) for homeless population or families without cooking facilities. Provide emergency financial assistance and basic budgeting counseling to families in need of funds for : <ul style="list-style-type: none"> ➤RENT ➤UTILITIES ➤FOOD ➤MEDICATION PRESCRIPTIONS ➤TRANSPORTATION (ESPECIALLY FOR HEALTH NEEDS)
FY 2015	
Goal 2015	<ul style="list-style-type: none"> Increase protein pounds distributed by 5%. Reduce distribution of low nutrients dense food items by 3%.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> 2,000 extra food bags will be distributed this year at the Pantry. Add one additional shopping day to Food Share and increase food donations pick up at other local businesses, like Lassen's and Panera Bread.

These implementation strategies specify community health needs that SJRMC has determined it is best suited to meet in whole or in part and that are consistent with our mission and available resources. SJRMC 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 or other organizations in the community may decide to address certain needs. In such circumstances SJRMC may then refocus our limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

Summary of Benefit Expense

A clinical cost accounting system was used to calculate the following:

St. John's Regional Medical Center - Oxnard
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2013 through 6/30/2014

	Persons Served	Expense	Revenue	Benefit	Expenses	Revenues
Benefits for Living in Poverty						
Financial Assistance	1,325	\$3,605,577	\$0	\$3,605,577	1.4	1.6
Medicaid	25,708	\$60,777,279	\$32,126,893	\$28,650,386	10.9	12.2
Community Services						
Community Benefit Operations	0	\$139,070	\$0	\$139,070	0.1	0.1
Community Building Activities	29	\$17,712	\$0	\$17,712	0.0	0.0
Community Health Improvement Services	23,675	\$243,841	\$27,254	\$216,587	0.1	0.1
Financial and In-Kind Contributions	44,544	\$333,993	\$33,568	\$300,425	0.1	0.1
Health Professions Education	51	\$2,938	\$0	\$2,938	0.0	0.0
Totals for Community Services	68,299	\$737,554	\$60,822	\$676,732	0.3	0.3
Totals for Living in Poverty	95,332	\$65,120,410	\$32,187,715	\$32,932,695	12.5	14.5
Benefits for Broader Community						
Community Services						
Community Building Activities	283	\$11,361	\$0	\$11,361	0.0	0.0
Community Health Improvement Services	18,257	\$410,048	\$76,564	\$333,484	0.1	0.1
Financial and In-Kind Contributions	266	\$37,059	\$0	\$37,059	0.0	0.0
Totals for Community Services	18,819	\$459,508	\$76,564	\$382,944	0.1	0.2
Totals for Broader Community	18,819	\$459,508	\$76,564	\$382,944	0.1	0.2
<u>Totals - Community Benefit</u>	<u>114,151</u>	<u>\$65,579,918</u>	<u>\$32,264,279</u>	<u>\$33,315,639</u>	<u>12.7</u>	<u>14.7</u>
<u>Unpaid Cost of Medicare</u>	<u>15,827</u>	<u>\$96,768,898</u>	<u>\$74,025,337</u>	<u>\$22,743,561</u>	<u>8.7</u>	<u>10.0</u>
<u>Totals including Medicare</u>	<u>129,978</u>	<u>\$162,348,816</u>	<u>\$106,289,616</u>	<u>\$56,059,200</u>	<u>21.3</u>	<u>24.7</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, forums, community events, etc.)

- 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 Dignity Health system 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

St. John's Leadership & List of Community Board Members FY2014:

Leaders:

Chuck Cova (President & Chief Executive Officer)
Kimburli Wilson (VP & Chief Operating Officer)
Eugene Fussell MD (VP & Chief Medical Executive)
Sahin Yanik MD (VP & Chief Medical Officer)
Cathy Frontczak RN (VP & Chief Nurse Officer)
Robert Wardwell (VP & Chief Financial Officer)
Chris Champlin (VP & Chief Strategy Officer)
Ed Gonzales (VP Human Resources)
Deborah Klein (VP Philanthropy)
+George West (VP Mission Integration)

Community Board Members

Sr. Amy Bayley RSM (Sister of Mercy Sponsor)
Joe Burdullis (retired CEO in the Agriculture industry)
Suzanne Chadwick (SVP Banking)
Mary Fish (Retired Director of Surgery Center)
Joe Hernandez (CEO of JHC Benefits)
+Lynn Jeffers MD (Medical Staff)
+ Ann Kelley MD (Chair & Medical Staff)
Christopher Loh MD (Medical Staff)
Laura McAvoy Esq. (Attorney)
Henry Montes MD (Medical Staff)
Sandy Nirenberg (Executive Director Camarillo Hospice)
Sr. Joan Marie O'Donnell RSM (Sister of Mercy Sponsor)
Michael Powers (Director Ventura County Healthcare Agency)
Jack Rotenberg MD (Medical Staff)
+Sylvia Munoz Schnopp (City Council, Port Hueneme)
Donald Skinner (Retired President of a Technology Corp.)
Steven Soule MD (Chief of Medical Staff)
Carl Wesely (President General Contracting firm)
Lee Wan MD (Medical Staff)
Carl Wesely (CEO of a Construction firm)
+Jeri Williams (Chief of Oxnard Police Dept.)
+Celina Zacarias (Director, Cal-State Univ. Channel Islands)
Jerry Zins, (Chair, St. John's Foundation & CEO of a Wealth Management firm)

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

Appendix B

Community Relations/Community Benefits Committee Organization Plan & Charter Fiscal Year 2014

Members

- **From Community Board:** Celina Zacarias (chair), Jeri Williams, Sylvia Munoz Schnopp, Lynn Jeffers MD, ex officio Dr. Ann Kelley.
- **From Administration:** VP Mission Integration (George West), Sr. Dir. of Marketing (Paul Petite), Physician Market Development (Leonora Darcel)
- **From the Community-at-large (as chosen by the chair and approved by the Board Exec. Comm.):** Andrea Milton, Martin Shum, Nancy Vasquez RN, Capt. Vasquez (liaison role only), Tony Ow, Cynthia Duke, Colleen Nevins RN, Ernie Villegas, Carla Castillo.

Vision and Mission

The Community Relations/Community Benefit Committee shall be responsible for ensuring a positive and consistent image 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 Dignity Health, the St. John's hospitals, their physicians and their communities.

Committee Responsibilities

The Community Relations/Benefits Committee shall:

1. Monitor compliance with the Ethical and Religious Directives for Catholic Health Services, Dignity Health Statement of Common Values and Dignity Health Mission
2. Consider, and where necessary make recommendations on, matters presented by the Mission Integration Office, Marketing Dept., and Physician Relations.
3. Assist in the design of public outreach strategies and strategic marketing programs including physicians.
4. Review community, press and governmental body relations
5. Advocate when needed and identify community advocacy opportunities.
6. Provide an avenue for input from non-board community members-at-large.

Operations Procedure

Meet each month at a time and place that is convenient to members. The core meeting agenda shall include the following:

- Reports by Administration and discussion concerning
 - Plans and programs in compliance with the mission of St. John's and Dignity Health
 - Status of current community outreach programs
 - Status of current press relations
 - Status of current government/regulator relations
 - Current marketing and future planned marketing
 - Advocacy needs identification and plans to address those needs
 - Increase positive responsive relationships with the communities in the market area by incorporating 7-9 non-board community members to serve for one-year terms (renewable), as selected by the Chair of the Committee and approved by the Board Executive Committee.

Roles and Responsibilities

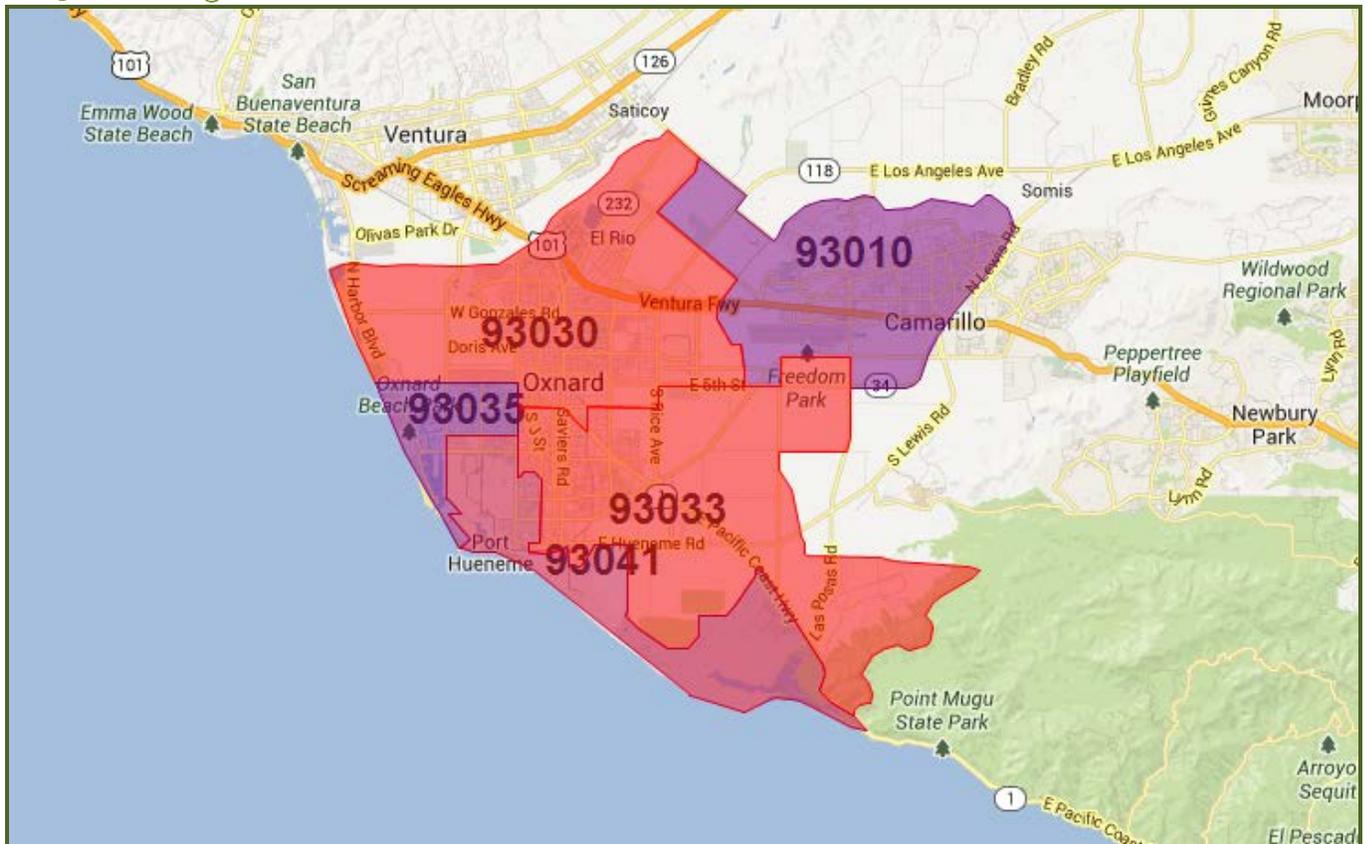
The Committee shall elect two officers: a Chairman and a Secretary.

Policy and Resource Guidance:

- Dignity Health Community Board Resource Guide, chapters on community relations
- Dignity Health Governance Policy: Community Relations
- Ethical and Religious Directives for Catholic Health Care Services
- Dignity Health Statement of Common Values

Appendix C

Dignity Health Community Needs Index for St. John's Regional Medical Center



Lowest Need

→ Highest Need

■ 1 - 1.7 Low
 ■ 1.8 - 2.5 2nd Low
 ■ 2.6 - 3.3 Mid
 ■ 3.4 - 4.1 2nd High
 ■ 4.2 - 5 Highest

	Zip Code	CNI Score	Population	City	County	State
■	93010	3.2	43,729	Camarillo	Ventura	California
■	93030	4.4	62,971	Oxnard	Ventura	California
■	93033	4.6	83,323	Oxnard	Ventura	California
■	93035	3.6	28,409	Oxnard	Ventura	California
■	93041	4.4	24,086	Port Hueneme	Ventura	California

PSA's CNI Mean Score = 4.0 ■ (2nd Highest) & CNI Median Score = 4.2 ■ (Highest)

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

Note—Both the Mean and Median need index increased in 2014 over the CNI scores of 2013.

Appendix D

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.