



St. John's Pleasant Valley Hospital
Community Benefit Report FY 2014
Community Benefit Implementation Plan FY 2015

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.

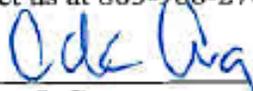
At Dignity Health St. John's Pleasant Valley Hospital we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable 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.

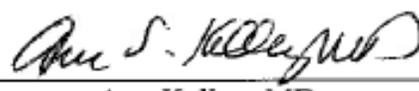
In fiscal year 2014, St. John's Pleasant Valley Hospital provided \$5,133,851 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$19,366,507.

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 1900 employees, and primary service areas of Oxnard, Port Hueneme and Camarillo, St. John's Hospitals also serve all of Ventura County and beyond, including the cities of Ventura, Moorpark, Thousand Oaks and Somis.

Pleasant Valley Hospital was founded in 1974 by a group of Camarillo community leaders and physicians who believed that the young City of Camarillo needed a hospital of its own. In 1993 it merged with St. John's Regional Medical Center in Oxnard, becoming St. John's Pleasant Valley Hospital (SJPVH), one ministry of healing with two hospital campuses, both sponsored by the Sisters of Mercy. SJPVH provides emergent, acute and intensive care, with extensive surgery services, Outpatient Hyperbaric Care and a "five-star" 44 bed Sub-acute facility.

SJPVH continues the Sisters of Mercy heritage of healing and community service in the Catholic social tradition. In response to those issues identified in our 2013 Community Health Needs Assessment (which is posted on the St. John's and Dignity Health web pages), SJPVH continues its commitment to meet the health care needs of the community and 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 collaborations with other community organizations

Congestive Heart Failure Readmission/Reduction (HARR) program utilizing the Congestive Heart Active Management Program (CHAMP®) from Mercy General Hospital's Sacramento Mercy Heart & Valve Institute. This is an evidence based comprehensive program designed to assist those who have Heart Failure and their families to manage their disease in order to improve the quality of their lives, increase interactions with their physician and avoid unnecessary utilization of healthcare resources in the county.

Chronic Disease Self Management Program (CDSMP) seeks to empower those who suffer from chronic diseases and their families by use of an 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.

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 Program consists of several wellness focused activities in collaboration with the Camarillo Healthcare District and Leisure Village Association. These include classes and lectures on topics important to seniors. We also provide free Osteoporosis screenings and skin cancer screenings in collaboration with the Cancer Center of Ventura County, which has a site at SJPVH.

Health Ministry programs address the socioeconomic causes of healthcare disparity by meeting basic needs of families and individuals, especially the poor. Through a financial

assistance program that gives loans and grants to the poor for such basic needs as medications, rent, utilities, transportation and food. Health Ministry also maintains a Food Bank in nearby Oxnard. In addressing basic needs economically disadvantaged or marginalized individuals/families are then able to free-up financial resources for healthcare needs. Meeting those needs can empower 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 the un/underinsured individual 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 SJPVH unsponsored net community benefit expense totaled \$5,133,851. This figure excludes the unpaid cost of Medicare which was \$14,232,656.

MISSION STATEMENT

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 the mission.

Our vision demands that we consistently and effectively live up to both.

Our Mission

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

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

Our Values

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

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

Our Vision

A vibrant, 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 in word and deed, acknowledging that medicine has the ability to cure and humanity has the power to heal.

ORGANIZATIONAL COMMITMENT

Background. Founded as a community hospital in 1974 by civic leaders and physicians, SJPVH has carried out its work of healing for 40 years. In 1993 the leadership of the hospital determined that merger with a larger healthcare facility was in the best interests of the hospital. Those leaders determined that St. John's Regional Medical Center was the best match in terms of values and focus on the community. Pleasant Valley Hospital then became SJPVH, sponsored by The Sisters of Mercy. 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 broader category called 'community benefits' (which includes charity care). This IRS ruling required nonprofit hospitals to provide "community benefits" to retain federal tax-exemption, which broadened the scope beyond charity care to include activities that benefit the community as a whole."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). 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 residents in Ventura County, and particularly in our primary service area through our 2013 Community Health Needs Assessment, evaluating the available resources of the hospital and then focus 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

Despite different beginnings, both St. John's hospitals have held to community service as a guiding principle. Community wellness with justice and care for all has been at the forefront of strategic planning and Community Board oversight (a Senior Leadership staff and Community Board roster is 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, SJPVH's commitment to providing benefit to the community can be found throughout the

¹ The 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>

organization. The Vice President of Mission Integration is charged with management of these programs and is an active member of the Leadership Team and the liaison to the Community 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 entire 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 SJPVH, Dignity Health's commitment to the area is evidenced by the Dignity Health Community Investment Program loans 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. that is a not for profit developer of high quality affordable housing. Through these grants and loans Dignity Health has helped to provide high quality affordable housing to more than 200 families in Ventura County.

Non-Quantifiable Benefits

SJPVH works collaboratively with community partners in local capacity building and in community-wide activities. Some of leadership's involvement includes: Board Member of the Gold Coast Health Plan, Board Member of the Economic Development Collaborative Ventura County and Board member of the Camarillo Hospice.

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 Ecology Committee demonstrate SJPVH'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 hospitals are the only healthcare facilities in Ventura County to have received National Awards in 2014 from Practice Greenhealth®.

SJPVH 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 one or both of the St. John's hospitals 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. SJPVH employs 487 people whose average salary is \$40 per hour. The estimated FY2014 economic benefit across 10 incorporated cities in Ventura County (where most of our employees live) is more than \$30,000,000.

COMMUNITY

Definition of Community

Community is defined as the resident population within the hospital's service area. While SJPVH serves all of Ventura County, the Primary Service Area (PSA) of SJPVH is defined as the people residing in the following zip codes of Camarillo 93010, 93012 and 93066.

SJPVH 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 CHNA).

Description of the Community

The CHNA and the most recent Community Needs Index 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 83,829 in the PSA.
- Age Groups –22.9% of the population is over 60 years old, and 23.2% is under the age of 18.
- Gender Diversity – 51.6% of the population is female, 48.4% male.
- Race/Ethnic Diversity –Non-Latino Caucasian is 64.1%, Latino 22.9%, Asian 10.2%, Black 1.9%., other >1%
- Adult Education – 91.7% have a high school degree, 37.4% have a college education.
- Poverty Status – the poverty rate for the service area is 5.3%.
- Unemployment and Income – among the cities in the service area, the unemployment rate is 6.9%. The estimated per capita income for the area in 2012 was \$37,926, with renters as 29.2% of the population.
- Primary Language and Linguistic Isolation – English is the primary language spoken households within the PSA. 10.4% in the PSA indicate they speak predominantly Spanish compared to 33.0% of the County population that indicate they speak a language other than English at home.
- The hospitals serve an area federally designated as a Medically Underserved Area (MUA).

Community Needs Index (CNI)

The Community Needs Index (CNI) is a tool developed by Dignity Health to identify areas with the greatest needs (CNI attached as Appendix C). This tool uses socioeconomic data to provide an “at a glance” view of disproportionate unmet needs in a geographic area. Within SJPVH's PSA the zip code with the greatest need as identified by the CNI is 93066. This validates the findings and needs identified in the 2013 CHNA. The CNI score for the PSA is 3.0, mid-range.

Hospitals Serving the area 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. SJPVH's most recent CHNA was completed during 2013.

The process for the 2013 CHNA for the SJPVH sought the broadest participation possible from Ventura County, City of Oxnard, City of Camarillo and City of Port Hueneme elected officials, Ventura County Health professionals, the various leaders of Ventura County Human Services organizations—both public and private (who daily serve the needs of the community in various capacities), hospital staff currently involved with community needs and healthcare consumers/community members. Elected/government officials were interviewed in person or by phone. Public and private invitations were sent to organizations that specialized in Human Services to the broad population of both ethnically diverse populations and potential patient/healthcare consumer-type groups for a hearing that was held on May 1, 2012 at St. John's Regional Medical center. The hearing was chaired by the Vice President of Mission Integration and facilitated/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 in collaboration with St. John's Community Benefit staff). 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. Healthy People 2020 is a national program to guide health promotion by the U.S. Center for Disease Control. It contains about 1,200 health objectives covering 42 topics and is designed to be a science based guide for health promotion and disease prevention aimed at improving the health of all people in the United States. Healthy People 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.

A group of leaders from St. John's were assembled to critically examine the data and provide analysis and input, the Community Wellness Integration Leaders (CWIL). 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 2012 and 2013 data tended to highlight trends and comparisons within Ventura County and the hospital specific PSA communities served, there was also a serious focus on the state of our PSA communities now and likely future trends, and how best we can serve immediate and future needs of those communities in light of a changing healthcare environment 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 that have unique needs. This 2013 CHNA conclusion was recently affirmed by the Ventura County Health Care Agency.⁵
2. Lack of Financial Resources (especially fixed income populations in the PSA) 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, as these diseases present a burden of recurring impact on the utilization of limited healthcare resources.
4. Obesity Rates 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/fixed income population.
6. Environmental issues that may impact health as a contributing factor in exacerbating medical conditions or, through long term exposure, create a medical condition requiring treatment.

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-run trend indicate that there was a significant decline in the percentage of children who are covered by any type of health insurance. Similarly, there was a significant decrease (24.7%) in the percentage of residents who stated that they were covered by private insurance. At the same time, there was a significant increase in the percentage of the residents who stated that they were covered either by MediCal (9.8%) or Medicare (5.1%), yet the

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

⁶ *Ibid*, p.1

percentage of residents who stated that they were covered by Healthy Families decreased by 7.7%. Most significant is the fact that 15.6% of the population in Ventura County does not have any type of health insurance coverage for the adult members of their household. Both the short- and the long-run trend indicate that there has been a significant decline in the percentage of Ventura County residents covered by any type of health insurance. This gap in insurance coverage, both for children and adults, is one of the top healthcare concerns in Ventura County. The impact of Affordable Care Act is yet to be determined locally, mainly due to a significant segment of the population in Ventura County that cannot qualify for coverage under the ACA.

Heart disease remains far and away the number one cause of death in Ventura County, followed by motor vehicle trauma, drug overdose, suicide then different forms of cancer. In almost all types of cancers, the rates for Non-Latino Caucasians are higher than the Latino population.

Regarding diabetes, 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.

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

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

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

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

Obesity

Obesity among 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 2010 and current rates. It also shows that in the case of children of lower income, the trend worsened during recent years. 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 a health care facility SJPVH worked diligently during 2014 to minimize its environmental footprint through a comprehensive environmental plan. SJPVH received the Partner for Change with Distinction award from Practice Greenhealth. SJPVH was the first hospital in the United States to receive the DEHP Free Award.

ASSETS ASSESSMENT & COMMUNITY BENEFIT PLANNING PROCESS

The needs identified in the 2013 CHNA, St. John's strategic plan, and Dignity Health's Horizon 2020 strategic plan all provided input to this Community Benefit Plan, and guides SJPVH in its ministry of healing to the community. In fiscal year 2014, Community Education Physician Consultant John Ford MD, St. John's Mission Integration Team, St. John's Community Health Education Department and Health Ministries staff members again reviewed the data from the 2013 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 2011⁸ report 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 SJPVH could seek to collaborate.

⁸see: http://www.vchca.org/docs/publichealth/ventura_county_health_status_2011.pdf?sfvrsn=0

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
- 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

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 St. John's to continue to enhance and expand access and services to persons with disproportionate unmet healthcare needs through programs such as our diabetes mellitus initiatives and create better health care consumers through education and free/low cost health screenings as we move toward population health management. It also calls for continuing our collaborative approach as we develop, implement, and evaluate our community benefit efforts through a team that includes members from St. John's hospital leadership, physicians, and nurses; allied healthcare providers; and community agencies and community members.

St. John's Hospitals Community Board reviews, approves, and offers broad based support for the community health activities of St. John's. The board, representing a cross-section of the community, has members from a wide spectrum of businesses and community based organizations in the hospitals' service area. 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

SJPVH's Community Benefit Programs are continually reviewed throughout the year using the strategic objectives established by St. John's Leadership; Dignity Health, recent community needs assessment data, and perceived needs of the community as identified by Community Benefit Team, St. John's Community Relations/Benefits Committee and the Community Board.

How Will the Community Benefit Report/Plan be shared?

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

Core Principles

Six Core Principles provide the framework to guide the selection and prioritization of community benefit activities and provide for a comprehensive review of community benefit programs. The Core Principles will provide the framework for 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 St. John's community benefit programs, the findings from the review, and the factors that will help focus our community benefit strategy to make efficient and appropriate use of our limited resources. The Community Wellness Integration Leaders team (CWIL as described in our 2013 CHNA) 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 a three-pronged approach to meeting the needs of the communities we serve as identified in our 2013 CHNA. Programs have been categorized in accordance within the three

areas of focus and also linked to the Dignity Health Mission Standards.⁹ Each focus is intended to reduce the burden on government through better stewardship of healthcare resources.

Focus I, Healthcare Consumer Empowerment through Education

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

Focus II, Addressing Prevention

- Immunization Programs
- Health Fairs
 1. Mobile Health Outreach
- Senior Health Connection
 1. Cancer & Osteoporoses screenings
- Community Grants
 1. Youth Obesity Prevention
- Faith Community Nurse Program (a Collaboration with Livingston Visiting Nurse Foundation)
-

Focus III, Addressing Disparities that Impact Healthcare:

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

This focused approach improves prioritization and identifies 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 for ambulatory care sensitive conditions. Hospital Admission Readmission Reduction Programs (HARR): 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. Heart Failure (CHF) has been identified as an Admission/Readmission priority. The evidence based proven CHAMP® program, from the Mercy Heart and Vascular Institute, will be utilized to assist CHF patients & community members to avoid admissions/reduce readmissions and thus improve the quality of life for those who suffer from CHF. 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.

⁹http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/stgss044503.pdf

- Create a process for referral and enrollment that is comprehensive, including physician orders to enroll at discharge in the electronic medical record.

SJPVH has also identified diabetes (and obesity as a precursor to diabetes as well as other chronic diseases), as the high priority health issues in our communities on which we will focus our greatest efforts. As such, SJPVH 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.
- Provide people with diabetes the support, knowledge and resources to manage their diabetes and to delay the development of the disease.
- Decrease hospital utilization (Emergency use and/or inpatient) 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) 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.

What is not being addressed and why:

The health needs of the community are extensive and SJPVH's assets are limited. As a result, certain identified needs are not being addressed or are being addressed indirectly or programmatic activity is being curtailed as other county assets address the identified needs. Most notable among these 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 Hospitals currently do not possess the assets to directly address this significant health issue. Instead, we have collaborated (through our Dignity health Community Grants Program) with our local Boys & Girls Club supporting their Triple Play Program in collaboration with FOODShare Ventura County.
- Mental Health Needs of the Poor—at present SJPVH lacks sufficient resources to address this need. Nevertheless, 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—SJPVH lacks the resources to address these issues in the community. However, both hospitals are committed to reducing their own environmental impact in the community.

Planning for the Uninsured/Underinsured Patient Population

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

Additionally, SJPVH has a Financial Counseling and Assistance Policy (ARI-01 which may be viewed at http://stjohnsmore.chw.edu/images/d/db/ARI-01_Financial_Counseling_8-08.pdf) and in accordance with that policy financial assistance information is given to all patients. Financial Counseling is available which informs and assists patients with seeking government or third party payment, and/or a discount. A Payment Assistance Policy (ARI-03) also provides relief for those seeking to pay over time.

Information about the patient financial assistance policy is presented to all patients upon admission, during free screening clinics, and made available at support groups in which DUHN community members participate. It is also reinforced at management council meetings and related SJPVH 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 ☐ Collaborative Governance
Link to Community Needs Assessment	<p>According to the Community Health Needs Assessment and the Latino Community Health Needs Assessment, 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, Cholesterol, Diabetes and Healthy Heart educational classes and other programs available based on their needs.</p>
FY 2014	
Goal 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 Living Well: Chronic Disease Self-Management Program and conduct program. • Refer and enroll patients as appropriate to diabetes self management program. • Refer and enroll patients 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

	<p>emergency department within 30 days.</p> <ul style="list-style-type: none"> • 335 community 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 recruited within St John's Hospitals. <p>* Number of persons Served reflects only those enrolled in CHF management program. Data reported in the Q3FY14 would be for persons served during the months of October, November, & December,2013</p>
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	<p>FY 2014:</p> <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	Community Health Improvement Services

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 <input type="checkbox"/> Seamless Continuum of Care ✗ Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>According to the Community Health Needs Assessment and the Latino Community Health Needs Assessment, chronic disease is prevalent among the primary needs 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>
Program Description	<p>The St John's Mobile Health Screenings and the Flu Vaccination Clinic is a portable program targeting children and adults in Ventura County targeting primarily the poor and underserved, the working poor with no insurance and the Latino population. The mobile unit targets locations in areas of greatest need as identified in the 2013 <i>Latino Community Health Needs Assessment</i>, are accessible to those least likely to receive health screenings and immunizations from mainstream health care including:</p> <ul style="list-style-type: none"> • Non-English proficient • Migrant/transient • Uninsured/under-insured • Limited transportation • Large families
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 community needs assessment states 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	A1-a Community Health Education – Group Health Education and Individual Health Education A2-d Community Based Clinical Services – Immunizations/Screenings

Senior Wellness-Skin Cancer Screenings	
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	U.S. Census reports that 20% of the population in Camarillo is age 60 or over. The CHNA identified the aging population in Camarillo as a focus area.
Program Description	An initial offering of free skin cancer screenings with health education will be launched in FY'15 at collaborative partner locations in the Camarillo community. According to the CHNA, St. John's was going to focus offerings for the mature Camarillo community.
FY 2014	
Goal FY 2014	The baseline year will be FY 2015.
2014 Objective Measure/Indicator of Success	
Baseline	
Intervention Strategy for Achieving Goal	
Result FY 2014	
Hospital's Contribution / Program Expense	Support for community health education and outreach in Camarillo was included in St. John's Pleasant Valley Hospital's operational budget.
FY 2015	
Goal 2015	Improve individuals' cancer screening opportunities and health literacy in St. John's Pleasant Valley Hospital's primary service area through collaboration with a community partner.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • In FY'15, SJPVH will collaborate with Dignity Health Cancer Center of Ventura County and Camarillo Health Care District to offer six, three hour no cost skin cancer screening events. • <u>Cancer screening education and general health education will be provided to each participant.</u>
Baseline	Based upon the CHNA and other available data, the "baby boomer" and senior community in Camarillo is a growing population. According to the CDC, skin cancer is the most common form of skin cancer in the United States.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Plan and hold six stand-alone skin cancer screening events conducted by an oncology nurse practitioner in the community. • Collaborate with the Dignity Health Cancer Center of Ventura County and Camarillo Health Care District to facilitate the events. • During each event provide 1:1 health education and cancer screening education.
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 Prevention
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. 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 items 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 > TRANSPORTATION
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 Larsen's and Panera Bread.

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

circumstance warrant. For example, some needs may become more pronounced and require enhancement to strategic initiatives or other organizations in the community may decide to address certain needs. In such circumstances SJPVH may then refocus our limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

Summary of Benefit Expense

Through the programs described herein, and other non-programmatic efforts, the total value of community benefit by St. John's Pleasant Valley Hospital for FY2014 was \$5,133,851. This figure excludes the unpaid cost of Medicare which was \$14,232,656. Combined, the unsponsored community benefit SJRMC expenses totaled \$56,0.

Detail for as follows:

St. John's Pleasant Valley Hospital - Camarillo
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	282	\$366,585	\$0	\$366,585	0.4	0.4
Medicaid	3,984	\$12,553,851	\$7,907,250	\$4,646,601	4.9	5.3
Community Services						
Community Benefit Operations	3	\$44,232	\$0	\$44,232	0.0	0.1
Community Building Activities	7	\$263	\$0	\$263	0.0	0.0
Community Health Improvement Services	703	\$20,107	\$0	\$20,107	0.0	0.0
Financial and In-Kind Contributions	4	\$45,543	\$0	\$45,543	0.0	0.1
Totals for Community Services	717	\$110,145	\$0	\$110,145	0.1	0.1
Totals for Living in Poverty	4,963	\$13,030,581	\$7,907,250	\$5,123,331	5.3	5.9
Benefits for Broader Community						
Community Services						
Community Health Improvement Services	1,309	\$8,333	\$0	\$8,333	0.0	0.0
Financial and In-Kind Contributions	20	\$2,187	\$0	\$2,187	0.0	0.0
Totals for Community Services	1,329	\$10,520	\$0	\$10,520	0.0	0.0
Totals for Broader Community	1,329	\$10,520	\$0	\$10,520	0.0	0.0
<u>Totals - Community Benefit</u>	<u>6,292</u>	<u>\$13,041,101</u>	<u>\$7,907,250</u>	<u>\$5,133,851</u>	<u>5.4</u>	<u>5.9</u>
<u>Unpaid Cost of Medicare</u>	<u>15,512</u>	<u>\$47,745,984</u>	<u>\$33,513,328</u>	<u>\$14,232,656</u>	<u>14.9</u>	<u>16.1</u>
<u>Totals including Medicare</u>	<u>21,804</u>	<u>\$60,787,085</u>	<u>\$41,420,578</u>	<u>\$19,366,507</u>	<u>20.2</u>	<u>22.2</u>

Telling Our Story

SJPVH is 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, SJPVH 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, community events, etc.)
- Through our Newsletter which is mailed to residents in the area
- With every Dignity Health Community Grants information request.

- To local care health professional organizations (e.g. physician and nursing organizations)
- In an e-mail to all hospital staff and to our Auxiliaries
- Copies will be available at each hospital through the Administration and Community Education offices.
- On the St. John's Website
- On the Dignity Health 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)
+Sylvia Munoz Schnopp (City Council, Port Hueneme)
Donald Skinner (Retired President of a Technology Corp.)
Steven Soule MD (Chief of Medical Staff)
Carl Wesley (President, General Contracting firm)
Carl Wesley (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 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

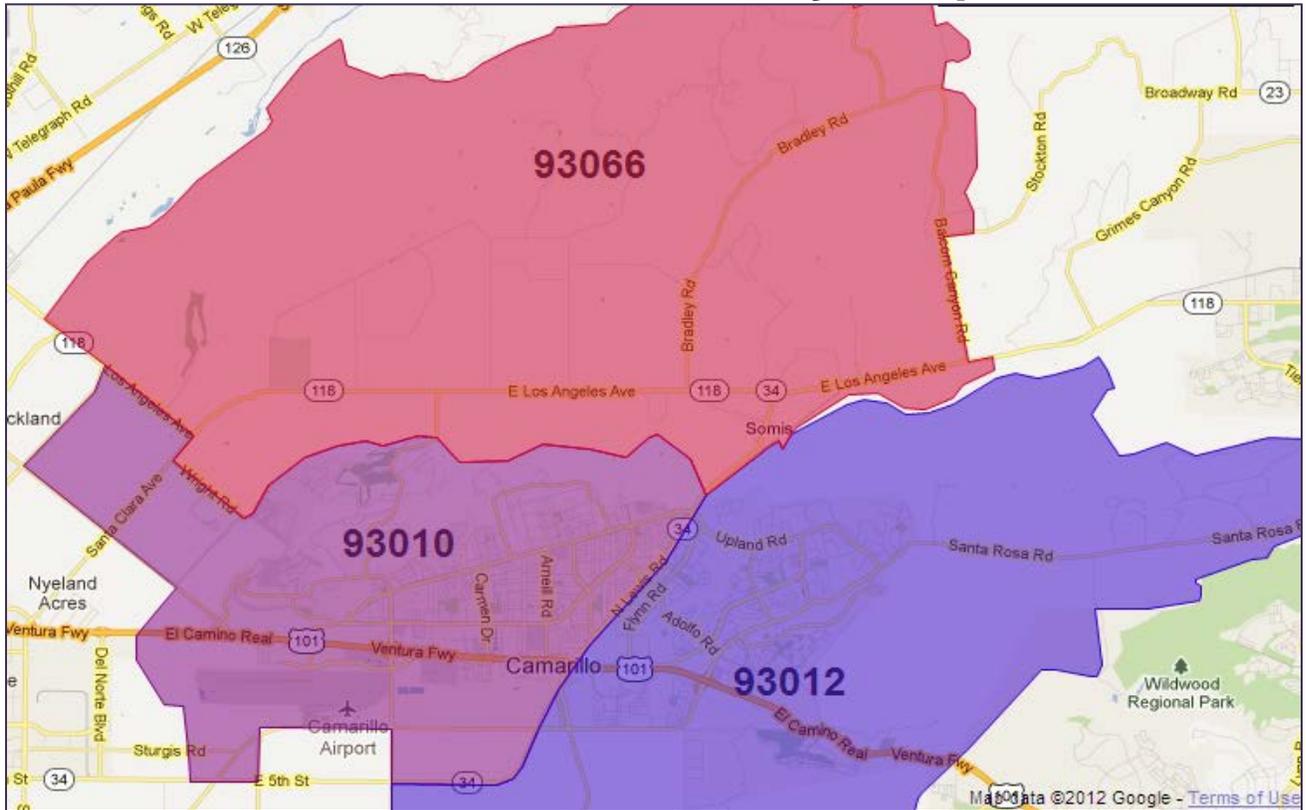
The Committee shall elect two officers: a Chairman and a Secretary.

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 Pleasant Valley Hospital



Lowest Need

1 - 1.7 Lowest

1.8 - 2.5 2nd Lowest

2.6 - 3.3 Mid

3.4 - 4.1 2nd Highest

Highest Need

4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County	State
93010	3.2	43,729	Camarillo	Ventura	California
93012	2.2	36,763	Camarillo	Ventura	California
93066	3.6	3,337	Ventura County	Ventura	California

PSA CNI Mean Score: 2.8 (Mid range) CNI Median Score 3.6 (2nd Highest)

Note—CNI Median increased in 2014 over 2013, with both 93010 and 93066 increasing their need score by 0.2 each.

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.