St. John’s Hospitals’
Community Health Needs Assessment 2013

St. John’s Regional Medical Center | Oxnard, CA
St. John’s Pleasant Valley Hospital | Camarillo, CA
# Table of Contents

I. 2012 St. John’s Hospitals’ Community Health Needs Assessment Summary  
   A. Description of Communities Served  
   B. CHNA Process  
   C. Broad Interests of the Communities Served  
   D. Priorities  
   E. Community Assets Identified  

II. St. John’s Regional Medical Center and St. John’s Pleasant Valley Hospital Implementation Strategy and Community Benefit Plan Summaries  

Attachments

A. St. John’s Regional Medical Center and St. John’s Pleasant Valley Hospital PSA Demographic Data with Maps and Community Needs Index (Reuters), p. 22

B. Planning Participants  

C. Asset Analysis  

D. Health Data  
   • 2009 Community (Health) Needs Assessment  
   • 2011 Ventura County Community Health Need Assessment  
   • National Healthcare Disparities Report 2011  
   • Income, Poverty and Health Insurance Coverage in the United States: 2011  
   • Hispanic Health Needs Assessment  
   • 2012 State of the Region Report  
   • May 1, 2012 Human Services Hearing Presentation  

E. Summary of Community Engagement  

F. Prioritized Health  

G. Implementation Teams and Implementation Plan Summaries  


I. St. John’s Hospitals’ Community Health Needs Assessment Summary

A Community Health Needs Assessment (CHNA) was completed in 2012 by St. John’s Hospitals’, members of Dignity Health. This CHNA was prepared in accordance to IRS Notice 2011-52, which addresses the CHNA requirements, that apply to section 501(c)(3) hospital organizations enacted by the Patient Protection and Affordable Care Act (PPACA), signed into law on March 30, 2010. Furthermore, California State Senate Bill 697 requires California not for profit hospitals to assess community health assets and needs on a triennial basis.

St. John’s Hospitals consists of two separate hospitals, St. John’s Regional Medical Center (SJRMC) and St. John’s Pleasant Valley Hospital (PVH). The CHNA focused on the primary service areas (PSA) and specific communities served by each hospital. A focused and meaningful CHNA has been developed by utilizing hospital resources to identify the current health needs of the PSA. The results of the CHNA can then be integrated into the strategic plan for each hospital.

SJRMC and PVH are located in Ventura County, California. Ventura County is located on the central coast of California, north of Los Angles, and is comprised of following cities: San Buenaventura (a.k.a. Ventura--the county seat), Oxnard, Thousand Oaks and Camarillo, with other smaller towns such as Ojai, Simi Valley, Moorpark, Fillmore and Port Hueneme, plus several other unincorporated areas. Ventura County includes a major commercial port (Port Hueneme), a large military base (Pt. Mugu Naval Air Station and Port Hueneme Seabee Base) and Channel Islands Harbor, a 166 acre pleasure craft/sporting residential/recreation harbor located in Oxnard. Ventura County is ranked as the 12th (of 58) most populous county in California, with a total population of 823,318, of which 40.3% are Hispanic. Ventura County’s population has grown by 70,121 (or by 9.3%) between 2000 and 2010 and is home to an estimated 74,000 unauthorized immigrants. While the current population of Ventura County is predominantly Caucasian/non-Hispanic, studies indicate that the Hispanic population is the fastest growing population in the county and that this segment will likely reach majority status in the very near future.

A. Description of Community Served

The PSA/communities served were identified through a review of patient’s discharged ZIP codes. Upon review, 75% of the patient’s discharged served by St. John’s Hospitals were from the cities of Oxnard, Port Hueneme, and Camarillo, including the unincorporated areas of ‘El

1 The Health Care Education Affordability Reconciliation Act of 2010 (H.R. 4872) (Reconciliation Act) was signed into law on March 30, 2010 (Pub. L. No. 111-152). The Reconciliation Act amended the Patient Protection and Affordable Care Act and related laws. CHNA are required in Section 9007(a) of the Patient Protection and Affordable Care Act.

Rio’ and ‘Channel Islands.’ These areas are located in southwest Ventura County on the Oxnard Plain, which is bordered by the City of Ventura to the northwest, Thousand Oaks to the southeast and the Pacific Ocean to the west. This PSA is ethnically diverse with 60.5% of the population ethnically identifying themselves as Hispanic, along with 27% White (Non-Hispanic) and 7.4% Asian/Pacific Islander (Non-Hispanic). Between 2000 and 2010, the population of Oxnard has increased 16%, from 170,358 to 197,899. A map of the PSA is provided below as Figure 1, and 2010 Census Data are provided in Attachment A.

B. CHNA Process

The CHNA process was initiated by the Vice President of Mission Integration (VPMI) for St. John’s Hospitals’. The broadest participation possible was sought from stakeholders representing various entities within Ventura County Government, the City of Oxnard, the City of Camarillo, and the City of Port Hueneme. The St. John’s Hospitals’ Community Board Committee on Community Relations and Community Benefits also participated in this assessment. Their input to both process and specific health concerns assisted in elucidating specific areas of the assessment. Lastly, hospital staff and healthcare consumers/community members contributed to the development of this CHNA.

Community Wellness Integration Leaders – Nominal Group

A group of leaders from SJRMC, identified as the Community Wellness Integration Leaders (CWIL) were assembled to critically examine available and current health status data and provide analysis and input. Data sources reviewed are listed in Attachment D. The assessment process spanned 12 months, and included various meetings and input from Dignity Health leadership. Attachment B provides a list of CWIL participants involved with this assessment during 2012.

St. John’s leadership adopted a standard set of criteria to use to develop and evaluate the list of health needs identified through the fact finding process. The criteria included:

+ **Breadth** – the number of persons affected,

+ **Impact** – the seriousness of the issue to the individual and society, especially as it related to mortality,

+ **Vulnerability** – whether/how the health need particularly affected persons who are marginalized and/or un/underinsured,

+ **Longevity** – whether the need will have long-term affect on the people involved (i.e. acute/immediate needs will be given less weight over chronic/long-term needs that seem to be resistant to intervention), and,

+ **Resources** – availability of existing community resources to address the identified issue/need.
The CWIL team utilized a nominal group process to identify community health needs. Each CWIL team member identified their top two health concerns in relation to the criteria mentioned above and they were shared with the group for discussion. Team members then had the opportunity to rank their two top choices. Team members were then giving an opportunity to revise their rankings. These results were then collated to produce a composite ranking. Most notably, the CWIL team during the process shifted their views regarding health issues. This change is the result of the Patient Protection and Affordable Care Act (PPACA) and the refocus from “Episodic Health Care” to “Population Health Management.” This CHNA reflects that new view—changing from identifying diseases for treatment to identifying systemic health needs.

Secondary Data Sources

Statutory changes in CHNA guidance recommend the evaluation and presentation of hospital PSA information, rather than county-wide information. Therefore, this 2013 CHNA has been prepared with a focus on the greater community served by the hospital.

This 2013 CHNA began with a review of the 2009 CHNA, which was based primarily on secondary data augmented by a telephonic random survey. It was co-sponsored by two Ventura County hospitals who selected the Innovative Research Group, which was comprised of professors and graduate students from a private university in Ventura County.

New secondary data sources were identified and are provided as part of Attachment D, which includes the recently published Ventura County Health Status Report (2011). Additional data was also collected from both hospitals including discharge information, and interviews with medical, executive, social service and emergency department staff. Recent secondary indicator data for comparisons was also collected from both Healthy People 2020 and the State of California (including disparities, access, educational and community based programs, health communication and health information technology, obesity, and child obesity).

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. Although the analysis of the 2009 data integrated with the new 2012 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 the best methods to serve immediate and future needs of those communities in light of a changing healthcare environment with the implementation of the PPACA.

Data was also compared to Healthy People 2020 health indicators. Healthy People 2020 are national guidelines for health promotion developed by the U.S. Centers for Disease Control (CDC). Healthy People 2020 contains about 1,200 health objectives, covering 42 topics, developed as attainment goals for the population of 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; and,

• Identify critical research, evaluation, and data collection needs.

Through Healthy People 2020, specific data on health disparities among age groups, gender and ethnicity were obtained. Based on this analysis, St. John’s leadership and the Community Health staff developed discussion topics for a variety of community engagements, including: one to one interviews with civic leaders, questions for open meetings with healthcare consumers and hearing topics for Ventura County Health and Human Services organizations leadership. A variety of community settings were selected with a special emphasis on those persons and areas most impacted by health disparities. Information from these engagements was collated and presented to St. John’s Community Health leadership and staff, whereupon a list of four actionable community priorities was developed (see Appendix F).

C. Broad Interests of the Community Served

The CHNA process was initiated by the VPMI for St. John’s Hospitals’. The broadest participation possible was sought from stakeholders representing various entities within Ventura County Government, the City of Oxnard, the City of Camarillo, and the City of Port Hueneme. In addition, hospital staff and healthcare consumers/community members also contributed to the development of this CHNA.

Health and Human Services Leadership Hearing/Focus Group at SJRMC – May 1, 2012

Invitations were sent to public and private organizations specializing in health and human services within Ventura County to participate in a focus group at SJRMC on May 1, 2012. The organizations that attended the meeting all specialized in providing some sort of services to an ethnically diverse or specifically identifiable population. The focus group was chaired by the VPMI and facilitated/documented by a member of SJRMC community benefit organization/CWIL. That group provided input that largely identified financial concerns regarding consumer choices and access for the significantly diverse populations that they served.

Other Community Outreach

Health care consumers were randomly interviewed during their participation in health promotion activities (e.g. walking programs, health education classes, and senior activity classes) sponsored by St. John’s Hospitals. Consumers’ perspectives ranged over various topics, including: inability to pay (even co-pays, prescriptions and healthy food), timeliness of access to
primary care, concrete knowledge regarding prevention (and ease of access to same), “health care crowding,” ethnically based preferences regarding diet and children’s health.

**Governmental Agency Interview**

As mentioned above, an important element in conducting the CHNA was gathering input from the community through civic leaders. Therefore, the VPMI conducted telephonic or face to face interviews with several elected/government officials of Ventura County and the PSA cities. During the interviews with county leadership, they tended to take pride in the abilities of the county health system to meet resident needs, and the overall relative health status of the residents. Conversely, during the VPMI interviews with city civic leaders, they tended to express greater concern for the health and wellness of their communities, and the impact health needs have on city resources/infrastructure.

The first city civic leader interviewed by the VPMI, verbalized concern that the citizens within the community tended to delay seeking healthcare (i.e. for whatever reason, not being proactive) until the need became a crisis, requiring a 9-1-1 response. While calling 9-1-1 maybe the appropriate action, emergency medical service (EMS) responses in Ventura County require the utilization of multiple public service resources. Typically an EMS response consists of multiple vehicles, including a fire truck and ambulance to the scene of the emergency (home). The civic leader noted that this emergency response practice (waiting to address healthcare needs, until the need becomes an emergency) also negatively impacts the receiving hospital emergency department (ED). The receiving hospital ED is impacted because resources are dedicated to an emergency situation potentially pulling staff from various locations and causing departmental delays, for what may have been at one an avoidable ED visit. This cycle is frequently repeated and since it requires the response of a city fire truck, another part of the city is left potentially “uncovered” for an actual fire emergency.

A different civic leader verbalized a clear set of health priorities for their city, the first priority being the homeless in the community—not from the sense of eradicating homelessness (accepting the likelihood that, “we will always have homeless in the community”), but from the sense of providing for their health needs proactively to prevent the likely infrastructure and healthcare resource drain from neglected conditions among those who are homeless.  

**Priorities**

As previously mentioned, the CWIL team undertook a structured approach to review public health data and conduct interviews of city and county residents and public health officials. This assessment resulted in a list of 20 health needs (Attachment F) which were discussed at two informal community “meetings” and a Health and the Human Services Leadership Hearing/Focus Group at SJRMC on May 1, 2012. The CWIL team utilized the previously mentioned criteria to evaluate the list of 20 health needs identified during the assessment process. The criteria previously mentioned include the following:
+ **Breadth** – the number of persons affected,

+ **Impact** – the seriousness of the issue to the individual and society, especially as it related to mortality,

+ **Vulnerability** – whether/how the health need particularly affected persons living in poverty or reflected health disparities for those who are marginalized and/or un/underinsured,

+ **Longevity** – whether the need will have long-term affect on the people involved (i.e. acute/immediate needs will be given less weight over chronic/long-term needs that seem to be resistant to intervention), and,

+ **Resources** – availability of existing community resources to address the identified issue/need.

Attachment F provides the 20 identified needs and describes the nominal group process. The CWIL team committed to focusing on the affirmed priorities and identified systemic health concerns as ‘top priority’ issues for the community (not all of which may be actionable given resource limitations), plus a need requiring further study:

1. **Diversity**. Diverse needs from a diverse population that views and seeks healthcare differently, and holds differing expectations regarding care which impacts access to healthcare and healthcare delivery modalities.

2. **Lack of financial resources (especially poverty) as it affects access to health care**. As most individuals were negatively impacted by the Great Recession of 2009, the marginalized, uninsured and under-insured, and those considered as living in poverty were impacted the worst. As a result, families tend to consider financial resources or financial insecurity before addressing healthcare needs and identifying priority setting. Basic needs become a priority over health needs.

3. **Education and Communication**, especially as it relates to manageable disease (such as chronic diseases, including: diabetes, heart diseases, respiratory diseases and cancer) and disease prevention/good health.

4. **Obesity** rates among adolescents in terms of both current and ominous future impact to the health of the community.

It should be noted that the assessment process identified some gaps in information. For example, there was insufficient data about various environmental issues for the county other than anecdotal or implied conclusions. It was also determined there was a need for more information on some of the key health issues facing health care consumers in order to get a better sense of future needs planning, especially as it relates to the Hispanic/Latino population. CWIL is commissioning a survey of Latino consumers to provide more information so the public can be better served.
Diversity

Study after study indicates that population diversity yields healthcare disparities, and chronic disease rates are even higher among populations at risk of health disparities, such as Blacks, Hispanics, and people of low socioeconomic status. Current PSA communities served by the two hospitals are very different. The strikingly dissimilar characteristics are provided below, along with the justification used to prioritize diversity as a health concern.

Oxnard, the largest of the PSA cities, has an agriculture based economy, the youngest population, the highest growth rate (as compared to other PSA cities), lowest per capita income, and a predominantly Mexican-American population. The Mexican-American population in Oxnard is so significant (73.5%), that it was identified by the U.S. Census Bureau as having 9th highest Hispanic population percentage for all cities in the United States3. The continued growth of the Mexican-American population requires sensitivity for how health needs are discerned, sought, and the perspective/expectations of Hispanic consumers.

Neighboring Oxnard is Port Hueneme, the smallest PSA city, which has a commercial port and military based economy and also a culturally diverse population. The city has a low median age, but has a low growth rate and a comparatively transient population.

Indicative of the ethnic and cultural diversity is the primary language used by the population in the PSA. According to the 2010 U.S. Census, 67.1% of the population in Oxnard and 68.1% of the population in El Rio CDP report a language other than English is spoken at home. Furthermore, in Oxnard a significant percent of the population identify themselves as not speaking English “very well.” This indicates that another language is their language of choice, which is particularly true for SJRMC PSA of Oxnard, El Rio CDP, and Port Hueneme.

Language impacts access to care and services and helps shape a community

In contrast, neighboring Camarillo’s economy is based on high technology, biomedical industries with a large retail sales center and some significant agriculture. Camarillo also is home to a large, permanent retirement community and a California State University, Channel Islands. However, Camarillo’s mean age is the highest (i.e. oldest) as is the per capita income

and education level. Camarillo enjoys a robust consumer economy with annual per capita retail sales of $20,394 as compared to California’s $12,561.  

It was determined that Camarillo has very different issues compared to the other PSA cities. The population of Camarillo is predominantly Caucasian (61.8%) and 17.2% of the population is over 65, as compared to the rest of California (11.4%). This higher senior citizen population tends to have different healthcare needs as compared to other populations of other cities in the county, especially around health issues associated with aging (e.g. geriatrics, rheumatology, chronic diseases, etc.) and tends to seek healthcare in a manner more appropriate to this age group. The average patient age at PVH is 85, confirming the aging population in Camarillo.

As previously mentioned, the Hispanic population accounts for 60.5% of the total PSA population, but this percentage is almost twice California’s Hispanic population of 37.6%. An even more significant contrast is a comparison of the PSA Hispanic population (60.5%) to the 16.3% Hispanic population in the United States. This cultural diversity and an aging population are expected to dramatically impact all aspects of healthcare needs and infrastructure requirements. For current or future healthcare and healthcare delivery, it will be very important to take into account all aspects of the changing dynamic to meet community needs; as a cookie cutter/single approach will not be sufficient.

*Lack of financial resources (especially poverty) as it affects access to health care*

Following the Great Recession of 2009, economic factors were found to play a significantly stronger role in access to care, but from the consumer side. Individuals and families with limited, or significantly low, financial resources must balance basic needs against prevention and seeking timely care. According to the U.S. Census Bureau, in 2010, there were approximately 42,000 households consisting of about 130,000 persons (nearly one of every five residents) in Ventura County, who were members of a household whose annual income was less than $25,000. As a result, lower income families tend not to seek healthcare unless or until it becomes an emergent need. This fact reaches across age and ethnicity, with the recognized impact that, “health issues are more prevalent among those who are poor and vulnerable than in other segments of the population.”

Primary indicators of poverty vulnerability used include the following:

- Rates of homelessness and overcrowding;
- Unemployment; and,
- Lack of insurance.

---

4 United States Census, [http://quickfacts.census.gov/qfd/states/06/0610046.html](http://quickfacts.census.gov/qfd/states/06/0610046.html)
5 Ibid No. 2
Homelessness and overcrowding data (see table below) indicates that Oxnard is second highest in the county for both homelessness and extreme overcrowding. As an indicator of poverty, the most likely result is that poor health goes hand in hand with poor people\(^7\) thus the community health will be negatively impacted in Oxnard, Port Hueneme, and El Rio. In addition, according to the U.S. Census at least 15% of the population in Oxnard and Port Hueneme are living below the federal poverty level. This number balloons to 22.1% for El Rio CDP, as noted in table below.

The significance of unemployment for healthcare is the resulting loss of employer based health insurance. While Camarillo’s unemployment rate is significantly below the county rate of 5%, Oxnard’s was higher, with the entire county suffering an overall rise in unemployment (see the table following), another indicator of the impact of the Great Recession of 2009.

Children’s coverage tends to be parent dependent and the table below indicates significant coverage, however the most disturbing data is that Ventura County has a higher uninsured

\(\text{http://www.unnaturalcauses.org/series_objectives.php}\)

\(\text{http://content.healthaffairs.org/content/12/1/162.abstract}\)

\(^7\)Ibid
child/adolescent population when compared to the rest of California at 7.2%. The concern is that this can easily translate into passive neglect of preventative care, creating access to care gaps for a significant number of children, and in turn placing them among those vulnerable to communicable and other diseases, most especially chronic diseases, thus negatively impacting prevention.

_Nearly 2 million Californians lost Health Insurance during the recession of 2008 and 2009_

**Health Insurance**

As for other age groups, insurance coverage is as follows:

This information, along with other population data confirms access to healthcare concerns are typically economic in Oxnard and Port Hueneme and age related in Camarillo (with underlying financial concerns). Therefore, while Oxnard healthcare consumers may lack the means or may be under/uninsured due to economic factors, more than 17+% of the population in Camarillo...
utilizes Medicare, potentially limiting their access due to physician agreement of acceptance (based on reimbursement).

In summary, this data indicates that nearly 20% of the children in Ventura County are either uninsured or insured through Medi-Cal (Medicaid), while 25% of working adults under 65 are under/uninsured, and those over 65 are more heavily dependent on Medicare.

The significant lack of comprehensive insurance across all age groups is likely to result in heavy dependence of hospital ED care instead of at a primary physician’s office. Both hospitals reported increases in visits to their emergency departments\(^8\) and an increase in preventable hospitalizations. During the past three years, the cost of uncompensated care for uninsured and Medi-Cal (Medicaid) patients increased between 7% and 15%. St. John’s Hospitals’ estimate that between 12 to 17% of ED visits could be avoided if patients had adequate access to care, or if preventable care was provided sooner. To recall, one civic leader voiced specific concerns that EMS and the accompanying City Fire Department truck to these 9-1-1 calls presents a significant risk to the entire city, by leaving parts of the city “uncovered” for EMS and fire fighting services.

Lastly, mention must also be made of access to dental care for the under/uninsured. This concern was raised by the Human Services leaders convened during a public hearing for this needs assessment as a significant health challenge, not well addressed in Ventura County. Access to existing dental care for those without dental insurance is very costly. The Human Services leaders opined that this has broad impact, from uninsured children who are not exercising good prevention to adults who are unemployed seeking work but whose dental condition make them somehow less than desirable due to appearance. The opinion of the group was that this will likely remain a chronic situation for the county, and as such, dental health (which is not readily measured as an isolated subject) will continue to be problematic for the poor, marginalized, and under/uninsured.

**Education and communication, specifically chronic disease and prevention**

Based upon information provided above, including the diverse population, aging population, and the financial constraints facing many, increasing health literacy through education and communication becomes an important concern. If the population does not have a strong empowerment and self-efficacy related to health literacy, managing chronic diseases and appropriate preventative care cannot be achieved. The lack of comprehensive insurance noted above also negatively impacts chronic disease management, a health need separately identified, for the PSA. Furthermore a review of U.S. Census Data identified that within the PSA the high school graduation rate of residents ranges from a low of 46.9% in El Rio CDP to a high of 92% in Camarillo\(^9\).

---

8 SJRMC—From FY 11 to 12 a 3.2% increase and YTD FY 13 over FY 12 of 12.4%, while PVH experiences an 8.7% increase from FY11 to FY12 and a 14.6% increase for FY 13 YTD.

9 Ibid No. 4
Specifically in relationship to chronic diseases, the CDC reports the following:  

- Chronic disease causes contribute to 7 of 10 deaths in America.
- Nearly 1 in 2 adults live with at least 1 chronic disease (133m).
- Nearly 75% of health care costs are due to chronic diseases.
- Nearly ¼ of those living with chronic disease experience limitations in daily activities.
- Sadly, the percent of children with a chronic disease has increased from 1.8% in 1960 to 7% today.

Therefore, chronic diseases tend to drain healthcare resources more than any other single ailment to the extent that under/uninsured treat chronic diseases seem to be reaching almost epidemic proportions. In Ventura County the best indicator is premature death, see the table below.

![Table: Top Causes of Death and Premature Death, Ventura County Residents 2006-2008](http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm)

Coronary artery disease (including CHF), cancers, respiratory ailments (like COPD) and diabetes prominently contribute to causes of premature death in Ventura County. Generally speaking these are chronic diseases that can be managed by the person suffering from the disease (and her/his family) such that the sufferer’s life span can likely be increased and the quality of the life of the sufferer can be significantly improved. The severity of a chronic disease if left untreated tends to increase with age. Consumer education is essential in managing these conditions. Furthermore, prevention education at all ages, would empower consumers to seek better self care and more timely and adequate medical care.

Obesity, especially adolescent

California childhood and adolescent obesity rates are disturbing and the impact on SJRMC PSA is most significant. In particular for Ventura County, the UCLA Center for Health Policy and Research found that that Port Hueneme ranked second highest in the state of California for overweight/obese children at 52.6% and Oxnard ranked in the top 20 at 47.9%. When compared to Health People 2020 baseline data only 16.2% of children 2-19 years old were considered obese. Children in the Oxnard-Port Hueneme PSA are 300% OVER baseline when compared to the rest of the United States.

This current data does not bode well for the future health of the community especially since the trend is that obese children and adolescents often grow up to be obese adults. The health consequences of obesity are significant. Research has shown the risks for the following conditions also increase:

- Coronary heart disease;
- Type 2 diabetes;
- Cancers (endometrial, breast, and colon);
- Hypertension (high blood pressure);
- Dyslipidemia (for example, high total cholesterol or high levels of triglycerides);
- Stroke;
- Liver and gallbladder disease;
- Sleep apnea and respiratory problems;
- Osteoarthritis (a degeneration of cartilage and its underlying bone within a joint); and,
- Gynecological problems (abnormal menses, infertility).

Therefore, at a local level, such significant percentages of obese children and adolescents approaching adulthood are likely to overload the healthcare system and further negatively impact healthcare infrastructure in Ventura County. As the CDC notes, education and prevention are key to managing this issue.

E. Community Assets Identified

12 Healthy People 2020; http://www.healthypeople.gov/2020/LHI/nutrition.aspx?tab=data#NWS_10_4
13 “Overweight and Obesity among Children by California Cities-2010” op.cit.
The assessment identified a number of strong community assets (Attachment C), including the eight hospitals, six of which are either county owned/operated or not-for-profit and thus also have community benefit programs, several community clinics, multiple urgent care centers, an adequate supply of primary care physicians and dentists, multiple public school districts that form a system within the county each with active home and school associations and numerous religious congregations. Assessment data is summarized in Attachment D.

The CWIL team established implementation strategies for each priority (Attachment F); leaders for each of the four teams also committed to continued service on CWIL team. Each leader is responsible for the following:

+ Finding out what other community organizations are doing regarding the priority;
+ Organizing a team, to include both field professionals and representative community members;
+ Guiding the work of the team, including development of a work plan;
+ Establishing metrics including measurable outcomes indicators;
+ Assuring work is coordinated with other CWIL implementation teams; and,
+ Communicating appropriately with the community at large, especially our Community and Foundation Boards.

The CWIL team is involved in commissioning a further study of the health needs affecting the Hispanic community and the potential impact on health care. The CWIL team will then publish those results when the study is complete. The CWIL team is committed to updating this CHNA if breakthrough information deems it appropriate, and conducting another comprehensive needs assessment in three years.

The CWIL team will also be charged with attempting to fill the information gaps and with developing a better understanding of the social determinants of some of the health issues identified in order to better address one of the overarching goals of Healthy People 2020.

This CHNA will be posted on the websites of Dignity Health and St. John’s Hospitals. A copy can also be obtained by contacting the office of the Vice President for Mission Integration at (805) 988-2701.
II. St. John’s Hospitals’ Implementation Strategy and Community Benefit Plan Summary

FY2012 - 2014 Summary

St. John’s Regional Medical Center (SJRMC) in Oxnard has been serving the health needs of Ventura County and specifically the residents of Oxnard, Port Hueneme and Camarillo for over 100 years. Founded by the Sisters of Mercy in 1913 to serve the all the people of the area and particularly the poor and those in need, St. John’s Hospitals’ continues to carry out its mission of “furthering the healing ministry of Jesus” in all that we do, not only for the approximate 187,000 patients we care for every year, but through outreach we touch thousands more, to improve the health of our communities.

SJRMC is a licensed 265 bed hospital, accredited by the Joint Commission, occupying a 48-acre campus on a single block on the northeast side of Oxnard, California, and is a member of the Dignity Health system. About 62% of the patients are residents of Oxnard or Port Hueneme, and another 23.5% are from Camarillo.

St. John’s Pleasant Valley Hospital (PVH) is a licensed 81 bed hospital, with a 90 bed licensed sub-acute facility (one of only two sub-acute facilities in Ventura County), accredited by the Joint Commission, occupying a city block on the west side of Camarillo, California. Approximately 85% of the acute patients are from Camarillo, with the sub-acute patients coming from all over California.

This portion of the report summarizes the plans for SJRMC and PVH to use existing community benefit programs and develop new community benefit programs that:

1. Address prioritized needs from the 2013 Community Health Needs Assessment (CHNA); and
2. Respond to other identified community health needs as they may arise in the future.

A. Implementation Strategy Development

Members of the CWIL team undertook a structured approach to review public health data and conduct interviews of city and county residents and public health officials. This assessment resulted in a list of 20 health needs (Attachment F) which were discussed at two community “meetings” and a Health and Human Services Leadership meeting. The CWIL team agreed upon on a set of criteria that would be used to evaluate the list of 20 health needs identified through the assessment process. The criteria previously mentioned include the following:

+ Breadth – the number of persons affected,
+ Impact – the seriousness of the issue to the individual and society, especially as it related to mortality,

+ Vulnerability – whether/how the health need particularly affected persons living in poverty or reflected health disparities for those who are marginalized and/or un/underinsured,

+ Longevity – whether the need will have long-term affect on the people involved (i.e. acute/immediate needs will be given less weight over chronic/long-term needs that seem to be resistant to intervention), and,

+ Resources – availability of existing community resources to address the identified issue/need.

Each team member used the criteria to rank the health needs. These individual results were then shared with the CWIL team for discussion. Team members were then given an opportunity to revise their rankings and then these individual rankings were summed to produce a composite ranking.

B. Major Needs and Priority Establishment

The prioritization process identified four priority issues for the PSA and the County, including:

1. Diversity. Diverse needs from a diverse population impacting access and delivery modalities;
2. Lack of financial resources and poverty impacting consumer decision making;
3. Education and communication, especially involving chronic disease (including: diabetes, heart disease, respiratory diseases and cancer) and prevention; and,
4. Obesity rates especially among adolescents.

The CWIL team members invited electronic comment to get community input on the prioritized health needs. These forums confirmed the prioritization presented by the CWIL team and identified potential partner organizations with which to collaborate in addressing these need.

C. How St. John’s Hospitals’ Will Address Identified Community Needs

When the CWIL team reviewed the hospitals’ current community benefit programs, they found the hospitals are meeting the existing community needs through the provision of charity care, Medicaid and other services, and un/under insured prenatal assistance education program; community outreach; and education activities. However, based on the results of this CHNA the CWIL team recommends the following actions to address the needs identified during 2012:
1. Diversity

St. John’s Hospitals’ will continue training and educating staff on cultural diversity, especially as it relates to healthcare. Of particular focus will be Hispanic Culture for SJRMC and Care of the Aged for PVH.

Community Benefit programs, both current and future, must take into account this issue in program planning, and specifically delineate how the community benefit program will adapt to diversity in delivery of the program.

Given the likely growth of Hispanic population, CWIL has also commissioned a follow-on study to survey Hispanic perception of healthcare and specific needs. This study will be completed in 2013.

2. Lack of financial resources (especially poverty) as it affects access to health care

St. John’s Hospitals’ Healthy Ministry Programs will focus on this need by continuing to provide assistance for basic needs such as rent, utilities, etc. and will continue weekly operation of its food pantry in the “Colonia” section of Oxnard. In 2013-14 expansion to the Camarillo area will be considered seeking the assistance of a collaborating site in the City of Camarillo and our community collaborating food supplier, Food Share.

The Shots for Kids and Adults Program will continue to provide immunizations at no or low cost to members of the community. The new Mobile “Wellness Vehicle” will make outreach in the community more a reality. During the next two years we will search for a partner to help St. John’s Hospitals’ take this program to the field workers.

The Faith Community Nurse (FCN) Network and other no/low cost Health Screening programs (such as the collaborative health fair with Sai Baba at Our Lady of Guadalupe Church) will expand as the FCN Network expands.

The SJRMC campus will also look to expand its Emergency Department in the next three years with an estimated cost of $5 Million.

St. John’s Hospitals’ will expand care to the community by opening one urgent care center in Camarillo during 2013. A second urgent care center is planned for the Port Hueneme/Oxnard area by 2015, in collaboration with the Dignity Health Medical Foundation physicians.

St. John’s through its Dignity Health Community Grants program will commit a significant portion of the total $150,000 in grants to increasing access opportunities to those who lack financial means, especially the poor.
3. **Education, especially around chronic disease and prevention (including diabetes, heart disease, respiratory diseases and cancers)**

The individuals’ self-efficacy of health literacy can be increased through educational programs within the community. Therefore, St. John’s Hospitals will expand its offerings of free education classes to the community on Chronic Disease Self Management (CDSM), in English and Spanish. Additionally, Diabetes Self Management and Support Groups will expand.

Training of more educators is an identified priority—especially peer volunteers. We will seek those volunteers from among the FCN Network, the senior citizen community of Leisure Village located in Camarillo, and Spanish speaking Promotoras from the Oxnard community.

We will also seek collaboration with local college’s and university’s nursing programs, beginning with California State University, Chanel Islands in Camarillo to seek volunteers from those entering the medical profession to become trained, free of charge, as educators in the Stanford Model of Chronic Disease Self Management. These new professional volunteers will hopefully offer CDSM classes through their institutions or elsewhere in the county.

The existing “Know Your Numbers” diabetes program currently offered in Oxnard will also be expanded to Camarillo.

4. **Obesity, especially among adolescent**

St. John’s Hospitals lack sufficient resources to address this need directly in the community. However, St, John’s Hospitals through its Dignity Health Community Grants Program will dedicate a significant amount of the total $150,000 in grants to collaborating organizations who are addressing this problem with programs that demonstrate measurable outcomes for success in changing life style to reduce obesity. St. John’s Hospitals’ will also involve its professional Registered Dietician staff in planning and selecting viable programs.

For each of the priority areas listed above, St. John’s Hospitals’ will work via the CWIL team and collaborating community partners with the assistance of Dignity Health leadership to:

- Identify any related activities being conducted by others in the community that could be built upon or incorporated to address the identified health needs;

- Develop measurable goals and objectives so that the effectiveness of programs and other efforts can be measured;

- Build support for the initiatives within the communities served and among other health care providers to address these identified issues;

- Develop detailed action plans for each of the identified health needs; and,

- Further study certain aspects of the identified needs and incorporate those findings into future plans.
Annually at their October meeting, the St. Agnes Community Board, which includes representatives from Oxnard, Port Hueneme, Camarillo and the surrounding community, reviews the prior fiscal year’s Community Benefit Report and approves the Community Benefit Implementation Strategy for addressing priorities identified in the most recent Community Assessment and other plans for community benefit. This report was prepared for the April 25, 2013 meeting of the Community Board.
Attachment A: Dignity Health Community Needs Index

St. John’s Regional Medical Center

CNI Score Median: 4

Note: Though ZIP code 93036 does not show separately on the above map the CNI provides evaluation of the geographic area.
### Attachment A (cont.): Dignity Health Community Needs Index

**St. John’s Pleasant Valley Hospital**

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>CNI Score</th>
<th>Population</th>
<th>City</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>93010</td>
<td>2.8</td>
<td>43795</td>
<td>Camarillo</td>
<td>Ventura</td>
<td>California</td>
</tr>
<tr>
<td>93012</td>
<td>2.0</td>
<td>31085</td>
<td>Camarillo</td>
<td>Ventura</td>
<td>California</td>
</tr>
<tr>
<td>93066</td>
<td>3.4</td>
<td>2739</td>
<td>Ventura County</td>
<td>Ventura</td>
<td>California</td>
</tr>
</tbody>
</table>

**Median CNI Score: 3.4**
Attachment B: Planning Participants (CWIL Team)

Wendy Amaro RN, FCN, BSN, MPH, Faith Community Nurse Supervisor, Diabetes Nurse Educator—responsible for participating in and helping to create a network of nurses in Ventura County that are based in various faith organizations located within the county. For planning purposes, Wendy collected input from several of those organizations and assisted the Health and Human Service Leaders hearing of May 1, 2012 by recording the responses of the group.

Gabriel Guillen RN, BSN, Faith Community Nurse Supervisor, Clinical Nurse II—taking over responsibilities previously held by Wendy, Gabriel brings a distinctive clinical influence especially in the areas of care for chronic disease. Gabriel is continuing the work of network building to improve care beyond the walls of the hospitals.

Lydia Kreil, BA, Supervisor, Health Ministries—responsible for organizing the May 1, 2012 hearing and continuing to network with that group creating a monthly informative meeting and networking opportunity for participants. Lydia also supervises various outreach activities to the community of Oxnard and Ventura County as a whole, listening to the concerns of healthcare consumers, especially those who are poor and marginalized.

Sr. Suzanne Soppe RSM, BA, MPH, Lead Educator, Community Education—Sr. Suzanne is responsible for monitoring Chronic Disease education needs, including Diabetes, Cholesterol and Senior Citizen healthcare consumer concerns. As sister sponsor of St. John’s, Sr. Suzanne also maintains strong ties to various organizations and individuals in the community. Her unique role as a religious places her in the position of both confidant and respected leader in healthcare.

George West, BCCC, BA, BTS, MA, JD, Vice President of Mission Integration—George is responsible for coordinating the planning and execution of the assessment, including making contact with various civic leaders and community members for input. George will also be accountable for execution of the Implementation Plans described in this CHNA.

Ofelia Godinez, Administrative Assistant—provides administrative support for all aspects of the CHNA and serves as the coordinating link for all of the participants.

Providing Oversight Through Our Communities

The following individuals provided oversight of the CHNA through their role as Community Board members for St. John’s Hospitals during 2012 and 2013:

Celina Zacarias, Community Board Member, Director of Community and Government Relations, California State University, Channel Islands, Camarillo, CA

Jeri Williams, Community Board Member, Police Chief for the City of Oxnard, CA

Sylvia Schnopp, Community Board Member, Councilwoman in Port Hueneme, CA
Anthony Trembley Esq., Community Board Member, Attorney in Westlake, CA

Sandy Nirenberg, Executive Director of Camarillo Hospice, Camarillo, CA

Colleen House, Retired Director of the Ventura County Area Agency on Aging

Michael Lavenant Esq. (1970-2012), Attorney, Camarillo, CA (R.I.P)

**Health and Human Services Agencies May 1, 2012 Hearing--invited and attending (marked by *)**:

Attachment C: Asset Analysis

Hospitals:

- St. John’s Regional Medical Center (not for profit—Dignity Health)*
- St. John’s Pleasant Valley Hospital (not for profit—Dignity Health)*
- Community Memorial Hospital (not for profit—Community Memorial Health System)*
- Ojai Valley Hospital (not for profit (Community Memorial Health System)*
- Los Robles Regional Medical Center*
- Thousand Oaks Surgical Hospital (part of Los Robles RMC)
- Simi Valley Hospital (not for profit—Adventist Health)*
- Santa Paula Hospital (County)*
- Ventura County Medical Center (County)*

> Total hospital beds = 1,594

> 8 operating Emergency Departments (noted by * above)*

> Hospital beds per capita for Ventura County = 1/is 522.

Clinics:

- Clinicas del Camino Real,
  - 11 clinic centers (not for profit)
- CMH Centers for Family Health
  - 11 medical office care centers, 4 of which are urgent care centers (not for profit—Community Memorial Health System)
- Ventura County Health Care Services
  - 13 Urgent care and clinic services (County)
  - Ventura County Health
- 18 other Urgent Care centers throughout the county
- Physicians
  - There are approximately 1,085 practicing physicians in Ventura County.

> In a private proprietary (unpublished) report prepared for St. John’s Hospitals’ by Medical Development Specialist consulting service, they found the bed capacity and physician availability for Ventura County and the hospital PSAs to be adequate. However, the median age of the physicians is 55\(^{16}\) thus retirement may be an option for many in the near future. Succession planning to draw more physicians to replace those who do retire may be an issue in the next three years.

\(^{16}\) Ventura County Medical Association. See also “Half of County’s doctors are near retirement age,” Tom Kiskin, Ventura County Star, July 10, 2010.
Attachment D: Health Data

- In addition to the primary data of from the interviews and hearings, the following is a list of secondary data used in the preparation of this report.
- Profile of Ventura County by Southern California Association of Governments’ 2011, (pages 1-31) which may be found at http://www.scag.ca.gov/resources/pdfs/2011LP/VenturaCounty.pdf
- Hispanic Health Needs Assessment (pages 1-207) may be found at: http://pdf.hispanichealth.org/hhna2001_1.pdf
- The State of the Region Report 2012 (pages 1-104) may be found at: http://www.vccf.org/programs/civicalliance/SotR.shtml
- May 1, 2012 Health and Human Services Leaders Hearing PowerPoint presentation—available on request.
- Physician Needs Assessment 2009 by Medical Development Consulting—proprietary study not for publication/distribution.
Attachment E: Summary of Community Engagement

Community engagement included two informal “town hall—meet and greet” type of events and a formal “hearing” of invited leaders from the Health and Human Services organization in Ventura County.

Informal Town Hall, April 4, 2012: Colonia Walking Program, Oxnard Senior Center, Oxnard, CA

Health and Human Services Leaders’ Hearing/Nominal Group, May 1, 2012: SJRMC, Oxnard, CA

Informal Town Hall, July 21, 2012: Leisure Village Center, Camarillo, CA

Additionally, the mayors and county supervisors who represent St. John’s Hospitals’ PSA were interviewed either in-person or by telephone. Interviews were conducted with the following individuals:

1. Kathy Long, Supervisor 3rd District of Ventura County
2. John C. Zaragoza, Supervisor 5th District of Ventura County
3. Tom Holden, Former Mayor of Oxnard
4. Tim Flynn, Mayor of Oxnard
5. Carmen Ramirez, Mayor Pro Tem of Oxnard
6. Sylvia Schnopp, Former Mayor of Port Hueneme & current City Council member
7. Ellis Green, Mayor of Port Hueneme
8. Charlotte Green, Mayor of Camarillo
9. Donald Waunch, former City Council Member of Camarillo

Key findings:

While County Officials were very positive about the County Health Network, city officials verbalized significant concerns about meeting needs. These concerns included: The need for more health education, expansion of health care coverage in general and how it will be implemented, the need for more child maintenance programs, better healthcare delivery for the homeless, teen pregnancy prevention/education, more localized & smaller clinics for target populations, more free health fairs, possibility of “marrying” healthcare delivery and local schools, obesity, meeting the needs of the Mixteco population, availability of care for senior citizens, transportation to care for those without means, use of infrastructure in meeting health needs, appropriate senior housing, lack of care negatively impacting other city resources such as Fire and EMS services.

These concerns were included in the Hearing with Health and Human Services Leaders and were discussed by CWIL members in developing the final list of prioritized needs.
Attachment F: Prioritized Health Needs

The following were the “raw” UNPRIORITIZED needs considered developed by CWIL and by those attending the May 1, 2012 hearing:

1. Age
2. Ambulance Service/EMS
3. Child Care
4. Chiropractic
5. Dental Care
6. Emergency Room
7. Ethnicity
8. Eye Care/Optometrist
9. Family Finances
10. Family Planning Services
11. Home Health
12. Hospice
   a. Home
   b. Residential
13. Inpatient Services
14. Mental Health Services
15. Nursing Home/SNF
16. Outpatient Services
17. Pharmacy
18. Poverty
19. Primary Care
20. Specialist Physician Care
21. Clinics/Urgent Care
22. Public Health Department
23. School or other Institutional Nurse
24. Cancers
25. Diabetes
26. Drugs/Alcohol use/Abuse
27. Heart Diseases
28. HIV/AIDS
29. Mental Disorders
30. Obesity
31. Pneumonia/Flu
32. Respiratory Disease
33. Sexually Transmitted Diseases
34. Stroke and Other Neurological Ailments
35. Suicide
36. Trauma
37. Other – (Environmental impact was identified)

Members of CWIL came to agreement on a set of criteria that would be used to evaluate the list of 33 health concerns/needs identified through the assessment process. The criteria included:

+ **Breadth** – the number of persons affected,

+ **Impact** – the seriousness of the issue to the individual and society, especially as it related to mortality,

+ **Vulnerability** – whether/how the health need particularly affected persons living in poverty or reflected health disparities for those who are marginalized and/or un/underinsured,

+ **Longevity** – whether the need will have long-term affect on the people involved (i.e. acute/immediate needs will be given less weight over chronic/long-term needs that seem to be resistant to intervention), and,
Each team member used the criteria to rank the health needs. These individual results were then shared with the CWIL for discussion. CWIL members participated in the Community Engagement activities and reported to the team their individual perceptions of community concerns. Team members were then given an opportunity to revise their rankings and then these individual rankings were summed to produce a composite ranking.

The final four actionable identified priorities are as follows:

1. **Diversity.** Diverse needs from a diverse population that views and seeks healthcare differently, and holds differing expectations regarding care which impacts access to healthcare and healthcare delivery modalities.

2. **Lack of financial resources (especially poverty)** as it affects access to health care. As most individuals were negatively impacted by the Great Recession of 2009, the marginalized, uninsured and under-insured, and those considered as living in poverty were impacted the worst. As a result, families tend to consider financial resources or financial insecurity before addressing healthcare needs and identifying priority setting. Basic needs become a priority over health needs.

3. **Education and Communication,** especially as it relates to manageable disease (such as chronic diseases, including: diabetes, heart diseases, respiratory diseases and cancer) and disease prevention/good health.

4. **Obesity** rates among adolescents in terms of both current and ominous future impact to the health of the community.
Attachment G: Implementation Teams & Implementation Plan Summaries

1. Diversity. Diverse needs from a diverse population. This task has been assigned to George West, VP of Mission Integration and Gabriel Guillen RN, Faith Community Nurse Supervisor. Their implementation plan specifically includes:

- St. John’s will continue training and educating staff on cultural diversity, especially as it relates to healthcare. Of particular focus will be Hispanic Culture for St. John’s Oxnard and Care of the Aged for St. John’s Pleasant Valley Hospital.
- Community Benefit programs, both current and future, will take into account this issue in program planning and specifically delineate how the community benefit program will adapt to diversity in delivery of the program.

Given the growing Hispanic/Latino population, the CWIL team will commission a follow-on study to survey Hispanic healthcare perceptions regarding needs and utilization. This study will be completed in 2013. The results of this study will be published and serve as a reference for future planning of community benefit programs.  

2. Lack of financial resources and poverty impacting access to health care. This task has been assigned to Lydia Kreil, Supervisor of Health Ministry Programs, Sr. Suzanne Soppe RSM, Lead Educator, Community Education and Wellness Integration Department, Gabriel Guillen RN, Faith Community Nurse Supervisor, Iluminada Camacho, Spanish Educator, Community Education and Wellness Integration Department, and George West, VP of Mission Integration. Their implementation plan specifically includes the following:

- St. John’s Hospitals’ Healthy Ministry Programs will focus on this need by continuing to provide assistance for basic needs such as rent, utilities, etc. and will continue weekly operation of its food pantry in the “Colonia” section of Oxnard. In 2013 expansion to the Camarillo area will be considered seeking the assistance of a collaborating site in the City of Camarillo and our food supplier—Food Share.
- The Shots for Kids and Adults Program will continue to provide immunizations at no or low cost to members of the community. The new Mobile “Wellness Vehicle” will make outreach in the community more a reality. During the next two years we will search for a partner to help St. John’s Hospitals’ take this program to the field workers.
- The Faith Community Nurse Network and other no/low cost health screening programs (such as the collaborative health fair with Sai Baba at Our Lady of Guadalupe Church) will expand as the FCN network expands.
- The SJRMC campus will also look to expand its Emergency Department in the next three years at an estimated cost of $5 Million.
- St. John’s Hospitals’ will expand care to the community by opening one Urgent Care in Camarillo during 2013, with a second in the Port Hueneme/Oxnard area by 2015 in collaboration with the Dignity Health Medical Foundation physicians.
• St. John’s Hospital’s through its Dignity Health Community Grants program will commit a significant portion of the total $150,000 in grants to increasing access opportunities to those who lack financial means, especially the poor.

3. Education and communication, specifically chronic disease and prevention. This task has been assigned to Sr. Suzanne Soppe RSM, Lead Educator, Community Education and Wellness Integration Department, Gabriel Guillen RN, Faith Community Nurse Supervisor, Iluminada Camacho, Spanish Educator, Community Education and Wellness Integration Department, and George West, VP of Mission Integration. Their implementation plan specifically includes the following:

• St. John’s Hospitals’ will expand its offerings of free education classes to the community on Chronic Disease Self Management, in English and Spanish. Additionally, Diabetes Self Management and Support Groups will expand.

• Training of more educators is an identified priority—especially peer volunteers. We will seek those volunteers from among the Faith Community Nurse Network, the senior citizen community of Leisure Village located in Camarillo, and Spanish speaking Promotoras from the Oxnard community.

• We will also seek collaboration with local college’s and university’s nursing programs, beginning with California State University, Chanel Islands in Camarillo to seek volunteers from those entering the profession to become trained, free of charge, as educators in the Stanford Model of Chronic Disease Self Management (CDSM). These new professional volunteers will hopefully offer CDSM classes through their institutions or elsewhere in the county.

• The existing “Know Your Numbers” Diabetes program currently offered in Oxnard will also be expanded to also offering a program in Camarillo.

4. Obesity rates among adolescents in terms of both current and ominous future impact to the health of the community. This task has been assigned to George West, VP of Mission Integration, Lydia Kreil, Supervisor of Health Ministry Programs, Gabriel Guillen, RN, Faith Community Nurse Supervisor, Heidi Fernandez, Chief Dietician, St. John’s Hospitals’, and Sr. Suzanne Soppe, RSM, Lead Educator, Community Education and Wellness Integration Department. Their implementation plan specifically includes the following:

• St. John’s Hospitals’ lack sufficient resources to address this need directly in the community. However, St. John’s through its Dignity Health Community Grants Program will dedicate a significant amount of the total $150,000 in grants to collaborating organizations who are addressing this problem with programs that demonstrate measurable outcomes for success in changing life style to reduce obesity. St. John’s will also involve its professional Registered Dietician staff in planning and selecting viable programs with whom to partner to address this issue.

• Informational Materials will also be explored for development to distribute at various health fairs and other outreach activities.
- Healthy cooking classes will be explored that will also be culturally sensitive to the audience.