



## **Dignity Health St. John's Regional Medical Center**

Community Benefit 2015 Report and 2016 Plan





## A message from

Darren W. Lee, President and CEO of Dignity Health St. John's Hospitals, and Carl Wesley, Chair of the Dignity Health Ventura County Community Board.

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited by and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. Dignity Health's comprehensive approach to community health improvement includes multi-pronged initiatives directed at significant health needs, partnering with others in the community working to improve health, and investing in efforts that address social determinants of health.

Dignity Health St. John's Regional Medical Center shares a commitment to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2015 Report and 2016 Plan describes much of this work. This report meets requirements of not-for-profit hospitals in the Patient Protection and Affordable Care Act to adopt a community health Implementation Strategy at least every three years, and in California state law (Senate Bill 697) to produce an annual community benefit report and plan. Dignity Health complies with both mandates in all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2015 (FY15), Dignity Health St. John's Regional Medical Center provided \$29,164,162 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital's total community benefit expense was \$61,934,028.

Dignity Health Ventura County Board of Directors reviewed, approved and adopted the Community Benefit 2015 Report and 2016 Plan at its October 29, 2015 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 805-988-2688.

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Darren W. Lee  
President/CEO

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Carl Wesley  
Chairperson, Board of Directors

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## EXECUTIVE SUMMARY

The Sisters of Mercy, with community leaders' support, established St. John's Hospital near the coastal plain of Oxnard in 1912 as a six-room wooden structure. In response to community needs it has grown during its century of service to be St. John's Regional Medical Center (SJRMC) a 265-bed facility on a 48-acre campus in northeast Oxnard. Oxnard is a community that has a land use mix of residential, agricultural and industrial, including a large Navy base and a vacation harbor area. SJRMC offers comprehensive medical programs and services, including emergency care, acute physical rehabilitation, cardiac care, cancer care, maternity and childbirth services (including a Neonatal Intensive Care Unit), and neurology. Accredited by The Joint Commission with certification as a Chest Pain Center, it also serves as home to St. John's Cancer Center of Ventura County, St. John's Regional Spine Center, and St. John's Center Surgical Weight Loss Center. St. John's Hospitals have the only 24/7 Critical Care Intensivist Physician program in Ventura County.

St. John's Regional Medical Center in Oxnard and St. John's Pleasant Valley Hospital in Camarillo [note--together referred to as "St. John's Hospitals"] are members of Dignity Health, a not-for-profit corporation. Together, St. John's Hospitals represent the largest acute care health organization in Ventura County. With over 1,785 employees, and primary service areas of Oxnard, Port Hueneme and Camarillo, St. John's Hospitals also serve all of Ventura County and beyond, including the cities of Ventura, Moorpark, Thousand Oaks and Somis.

St. John's 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 (CHNA) and 2014 Latino Community Health Needs Assessment © form the basis of this report and plan. They may be found at <https://www.dignityhealth.org/stjohnsregional/about-us/community-benefit/community-health-needs-assessment>. St. John's continues its commitment to meet the health care needs of those who are un/under insured, seeking to address not only ill-health but the underlying socio-economic conditions that exacerbate healthcare disparities through multiple programs and by collaborating with other community organizations. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the 2013 CHNA report.

The significant community health needs identified are:

1. Diverse needs from a diverse population that views/seeks healthcare differently and holds differing expectations regarding care thus impacting care delivery. \
2. Lack of Financial Resources (especially fixed income populations in the PSA) as it affects access to Health care.
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.

In FY15, Dignity Health SJRMC took numerous actions to help address identified needs. These included: Senior Wellness Program, Heart Failure Program, Mobil Health Screenings and Diabetes Self-Management

- For FY16, the hospital plans to refocus our efforts into three areas Health Care Consumer Literacy, Prevention and meeting Basic Needs where the absence of those needs being met tends to negatively impact healthcare decision making by the healthcare consumer—especially the un and under insured.
- In summary, during FY2015, the value of SJRMC unsponsored net community benefit expense totaled \$29,164,162. This figure excludes the unpaid cost of Medicare which was \$32,769,866.
- This report and plan is publicly available at [www.stjohnshealth.org](http://www.stjohnshealth.org). It shall also be distributed to public officials of Camarillo and Ventura County. Copies will be made available at public events and shall be sent to the Archdiocese of Los Angeles.

# MISSION, VISION AND VALUES

## Our Mission

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

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

## Our Vision

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

## Our Values

Dignity Health is committed to providing high-quality, affordable healthcare 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.

*Stewardship* - Cultivating the resources entrusted to us to promote healing and wholeness.

*Excellence* - Exceeding expectations through teamwork and innovation.

## Hello humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

*Hello humankindness* tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

## OUR HOSPITAL AND OUR COMMITMENT

The Sisters of Mercy, with community leaders' support, established St. John's Hospital near the coastal plain of Oxnard in 1912 as a six-room wooden structure. It grew to be St. John's Regional Medical Center (SJPMC) a 265-bed facility on a 48-acre campus in northeast Oxnard, serving a community that has a land use mix of residential, agricultural and industrial, including a large Navy base and a vacation harbor area. SJPMC offers comprehensive medical programs and services, including emergency care, acute physical rehabilitation, cardiac care, cancer care, maternity and childbirth services (including a Neonatal Intensive Care Unit), and neurology. Accredited by The Joint Commission with certification as a Chest Pain Center and a Stroke Center, it also serves as home to St. John's Cancer Center of Ventura County, St. John's Regional Spine Center, and St. John's Center Surgical Weight Loss Center. St. John's Hospitals have the only 24/7 Critical Care Intensivist Physician program in Ventura County.

SJPMC 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 may be found on the St. John's and Dignity Health web pages), SJPMC continues its commitment to meet the health care needs of the community, 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.

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. Guided by the Dignity Health Statement of Common Values,<sup>1</sup> the Ethical Directives for Catholic Health Care Services,<sup>2</sup> 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."<sup>3</sup>

Rooted in Dignity Health's mission, vision and values, Dignity Health St. John's Regional Medical Center is dedicated to delivering community benefit with the engagement of its management team, Community Board and Healthy Communities Board Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

The Dignity Health Ventura County Community Board ("Community Board"), the governing body for both St. John's hospitals, provides oversight for the community benefit activities in which SJPMC engages. Through monthly meetings of its Healthy Communities Committee individual programs are reported to the Community Board with their input being integrated to improve and guide leaders and programs. The Community Board also provides more up to date information regarding community health needs between the triennial Community Health Needs Assessment. The Community Board through the Healthy Communities

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<sup>1</sup> See

[http://www.dignityhealth.org/stellent/groups/public/@xinternet\\_con\\_sys/documents/webcontent/stgss047977.pdf](http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/stgss047977.pdf)

<sup>2</sup>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>

<sup>3</sup> California Newsreel, Unnatural Causes, 2008. Accessed online August 2012

[http://www.unnaturalcauses.org/series\\_objectives.php](http://www.unnaturalcauses.org/series_objectives.php), <http://content.healthaffairs.org/content/12/1/162.abstract>

Committee plays an active role in taking the data collected during the CHNA process, providing first hand input to establishing health need priorities which then goes into creating an actionable CHNA. The product of these collaborative efforts, our 2013 CHNA and our 2014 Latino CHNA may be found at <https://www.dignityhealth.org/stjohnsregional/about-us/community-benefit/community-health-needs-assessment>, and <https://www.dignityhealth.org/stjohnsregional/about-us/community-benefit/latino-community-health-needs-assessment>, respectively.

While the President/Chief Executive Officer “CEO” includes in his responsibilities Community Benefit programs, operational responsibility is delegated to the Vice President of Mission Integration (VP Mission) who reports to the CEO. The CEO, and the entire executive team, receives regular updates on community benefit programs and their outcomes from the VP Mission. The CEO and executive team on an ongoing basis also provide input to the strategy for meeting identified community health needs.

This strategy is then implemented by a team of community health professionals comprised of the Supervisor of Community Health, Supervisor of Health Ministries and a Sister Sponsor led by the VP Mission. This Community Benefit Leadership Team “CBLT” develops a community benefit plan comprised of programs individually and collaboratively developed by the members of the team. The leaders of this team implement the programs for which they have oversight, report outcomes and challenges to the CBLT and ensure that information is synthesized and reported to the executive team, CEO and Community Board through the Healthy Communities Committee.

Dignity Health St. John’s Regional Medical Center’s community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report.

In addition, Dignity Health is investing in community capacity to improve health. This includes addressing the social determinants of health, through Dignity Health’s Community Investment Program. Dignity Health has provided grant funding or loans for several low income housing projects in Ventura County to Cabrillo Economic Development Corp. a not for profit developer of high quality affordable housing. Through these grants and loans Dignity Health has helped to provide high quality affordable housing to more than 200 families in Ventura County.



## DESCRIPTION OF THE COMMUNITY SERVED

Community is defined as the resident population within the hospital's service area. While Dignity Health St. John's Regional Medical Center serves all of Ventura County, the hospital is located in Oxnard. Oxnard is a suburban community located in the west end of Ventura County. Oxnard had a mixed economy with significant agricultural and industrial elements, a high-tech sector, a commercial harbor, a beach area that attracts vacationers, a large recreational harbor and an active Navy base with an air station. Its Primary Service Area (PSA) was determined by analysis of the highest percent of discharges from the hospital for the year. SJRMC's Community is therefore determined to be the people residing in the zip codes of Oxnard 903030, 93033, 93035, Port Hueneme 93041 and Camarillo 93010. As part of our commitment to mission in raising the common good and improving the quality of life for our communities, SJRMC not only focuses on the needs of its PSA but also takes into account the needs throughout Ventura County. Data cited in this Description of the Community section is from our 2013 Community Needs Health Assessment. The summary description of the community is below, and additional community facts and details can be found in the CHNA report online at [http://www.dignityhealth.org/stellent/groups/public/@xinternet\\_con\\_sys/documents/webcontent/235065.pdf](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).

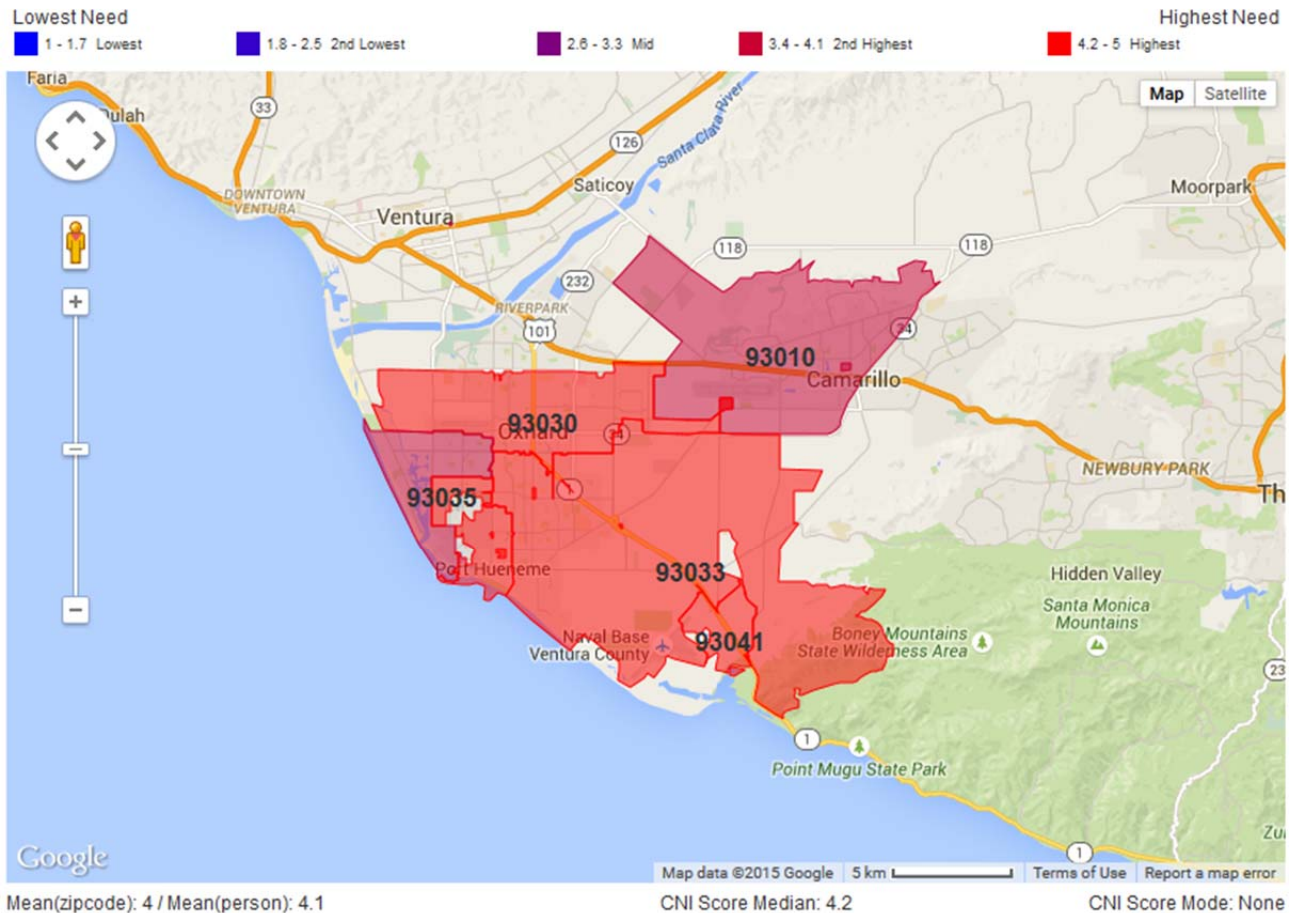
The PSA for SJRMC is unique to Ventura County. Comprising approximately 10% of the population of Ventura County, it is significantly higher in terms of those who are over 60 years of age and more than two-thirds of the population who identify themselves as white non-Latino. The level of education is relatively high with a fairly low unemployment rate (not including the many retirees), with English as the primary language spoken at home.

### Community Demographics

- Population – the population for Ventura County is 835,981, with 243,088 in the PSA.
- Age Groups –30.9% of the population is under the age of 18 with 18.1% over the age of 60.
- Gender Diversity – 50.4% of the population is female, 49.6% male.
- Race/Ethnic Diversity –65.2% of the population is Latino, 23.2\*% Non-Latino Caucasian, 7.1% Asian, 2.3% Black and all others comprise .2%
- Adult Education – 30.6 % do not have a High School Diploma.
- Poverty Status – the poverty rate for the service area is 14.6% with some areas of Oxnard at 18%.
- Unemployment – among the cities in the service area, the unemployment rate is 7.6%.
- Income – Median household income in 2013 was \$63,810.
- Primary Language and Linguistic Isolation – English and Spanish are the primary languages in the PSA with 44.5% in the PSA reporting English is not spoken in the home. In Oxnard that rate jumps to 67.4%.
- Insurance status – 5.8% of the population are uninsured
- The hospital serves an area federally designated as a Medically Unserved Area (MUA). St. John's Regional Medical Center (SJRMC) is in the 93030 zip code of the service area. Ventura County is

also served by: Simi Valley Hospital and Santa Paula Hospital to the north, Los Robles Regional Medical Center and Thousand Oaks Surgery Hospital to the east, and Community Memorial Hospital to the west.

- SJRMC’s PSA Community Needs Index mean score is 4.1 on a 5.0 scale. This represents the second highest category of need on this index of social and economic factors that are correlated with barriers to good health and access to care. See the map below.



Zip Code	CNI Score	Population	City	County	State
93010	3.4	43969	Camarillo	Ventura	California
93030	4.2	63073	Oxnard	Ventura	California
93033	4.4	83515	Oxnard	Ventura	California
93035	3.6	28337	Oxnard	Ventura	California
93041	4.4	24194	Port Hueneme	Ventura	California

# COMMUNITY BENEFIT PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the Healthy Communities Committee and other stakeholders in the development and annual updating of the community benefit plan.

## Community Health Needs Assessment Process

The SJRMC CHNA was adopted in January of 2013. The process for the 2013 CHNA sought the broadest participation possible from Ventura County, City of Camarillo and neighboring communities, 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. In addition health care consumers were selected on a random basis and interviewed as they participated in activities related to maintaining/improving their health.

Historic data was compared to current data to discern trends, with particular concern for the community health impact of the “Great Recession” of 2009. This 2013 CHNA began with a review of the 2009 CHNA. 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). A population specific-Latino Community Health Needs Assessment was undertaken in 2014 and 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.

A group of leaders from St. John’s were assembled to critically examine the data and provide analysis and identify resources available. The assessment took 12 months with various administrative and other meetings and input of leadership from Dignity Health. The SJRMC CHNA may be found at <https://www.dignityhealth.org/stjohnsregional/about-us/community-benefit/community-health-needs-assessment>.

SJRMC 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](http://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.

Through this dissemination we hope reach a broad spectrum of both the consumer population and potential future partners to create dialogue that will lead to program expansion and improvement in the health of the communities we serve.

### **Significant CHNA Health Needs**

The results of the 2013 CHNA presented a comprehensive picture of the issues facing Ventura County and the SJRMC’s PSA in particular. 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.
2. **Lack of Financial Resources (especially fixed income populations in the PSA) as it affects access** to health care, especially among the senior population, marginalized, uninsured and under-insured and those considered as living in poverty that are impacted the most. Lack of financial resources or financial insecurity plays a larger role than ever before for individuals/families in priority setting for their healthcare needs.
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.

The health needs of the community are found to be extensive and SJPVH’s assets are limited. As a result, certain identified needs are not being addressed or are being addressed indirectly such as obesity which is being addressed through a Dignity Health Community Grant. Not being addressed are:

- Mental Health Needs of the Poor—at present SJPVH lacks sufficient resources to address this need.
- Environmental Issues Impacting Health—SJPVH lacks the resources to address these issues in the community. However, the hospital is committed to reducing its own environmental impact in the community, especially in the construction of the new patient wing addition and new chapel.

## Community Benefit Plan Development Process

As a matter of Dignity Health policy, the hospital's community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- **Disproportionate Unmet Health-Related Needs:** Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention:** Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Seamless Continuum of Care:** Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Community Capacity:** Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance:** Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

These five principles were applied to the 2013 CHNA by the Community Health Leadership Team and evaluated in terms of SJRMC resources and the resources of our sister hospital, St. John's Regional Medical Center. The identified needs and five core principles were discussed at an open forum of the monthly Networking Meeting (a county wide gathering of human services agencies), executive leadership and the Healthy Communities Committee of the Community Board. From those discussions an innovative approach was devised to develop programs to address the identified needs in a manner aligned with our strategic plan and consistent with existing resources. The approaches were identified to focus on healthcare literacy, prevention and meeting some of the socioeconomic needs of our communities that often are determinants of health or significantly impact health and wellness family decision making. This is more fully described in the 2015 Report and 2016 Plan section below.

## Planning for the Uninsured/Underinsured Patient Population

SJRMC offers patient financial assistance based on the Dignity Health Financial Assistance Policy, a summary of which is in the Appendix. Financial counseling is available which informs and assists patients with seeking government or third party payment, and/or a discount. A Payment Assistance Policy also provides relief for those seeking to pay over time.

Information about the patient financial assistance policy is presented to all patients upon admission, and is made available to the public at free screening clinics, immunizations, education classes and community health support groups.

# 2015 REPORT AND 2016 PLAN

This section presents programs and initiatives the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It includes both a report on activities for FY15 and planned programs with measurable objectives for FY16.

## SUMMARY

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 needs and program matching 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 re- categorized for 2015-2016 in accordance within the three areas of focus and also linked to the Dignity Health Mission Standards. Each focus is intended to reduce the burden on government through better stewardship of healthcare resources.

### Focus 1, Healthcare Education and Literacy Programs (H.E.L.P.)

- Heart Failure Self-Management (CHAMP®)
- Chronic Disease Self-Management (CDSM)
- Diabetes Self-Management
- Community Health Fairs & Screenings
- Know Your Numbers Program
- St. John's Cancer Center of Ventura County
  - Nurse Navigator Program (grant funded)
  - Oncology Dietician Program (grant funded)

### Focus 2, Addressing Prevention

- Immunization Programs
- Mobile Health Outreach
- Senior Health Connection
- Cancer & Osteoporosis screenings
- Community Grants
  - Obesity Prevention

### Focus 3, People Assistance Through Humankindness (P.A.T.H.)

- Health Ministries' Basic Needs Programs
  - Food Pantry collaboration with the Archdiocese & Our Lady of Guadalupe Parish
  - Community Loans for medications, rent, utilities (Foundation funded)

This focused approach improves prioritization and identifies the 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 create a seamless continuum of care for those we serve in our community. This robust plan will require increased healthcare literacy for the consumer public. After examination of the 2013 CHNA and SJPVH resources the Community Health Leadership Team realigned programs to increase health literacy through a multi-pronged approach. As noted above, Heart Failure (CHF) has been identified as a priority. The evidence based proven CHAMP® program, from the Mercy Heart and Vascular Institute, will continue to 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 evidence based outcomes.
- Identify those patients and community members most likely to benefit, especially those who are un/under insured not residing in a facility.
- Create a process for referral and enrollment that is comprehensive, including physician orders to enroll at discharge in the electronic medical record.

SJRMC has also identified diabetes, as the high priority health issues in our communities on which we will focus our efforts. As such, SJPVH has maintained a steadfast community focused campaign to decrease uncontrolled diabetes through preventive health education interventions. 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

Other chronic diseases are also be addressed through the Stanford model evidenced based Chronic Disease Self-Management (CDSMP) curriculum. The goal for participants of the CDSMP is that upon completion of the program is to not require hospitalization or use of a hospital emergency department for a period of at least six months. Success will be measured by telephone interviews with graduates of the program.

## **Anticipated Impacts**

The hospital is committed to monitoring key initiatives and to collecting program metrics at least annually, to help assess and improve performance and impact. Specific goals and measurable objectives are described in the Program Digests that follow. The Health Communities committee, hospital executive leadership, Community Board, and Dignity Health receive and review program updates. In addition, the hospital evaluates impact and sets priorities for its overall community benefit program by conducting Community Health Needs Assessments every three years.

## **Planned Collaboration**

Anticipated collaborators for the above programs include: Camarillo Healthcare District, Kaiser, and Ventura County Health System.

This community benefit plan specifies significant community health needs that the hospital plans to address in whole or in part, in ways consistent with its mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in other community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report.



## PROGRAM DIGESTS

Senior Wellness Program	
<b>Significant Health Needs Addressed</b>	<ul style="list-style-type: none"> <li>• Diversity</li> <li>• Lack of financial resources and impact of poverty on healthcare access</li> <li>• Chronic disease prevention and education</li> <li>• Obesity, particularly adolescents</li> <li><input type="checkbox"/> Mental health services resources and access</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>• Disproportionate Unmet Health-Related Needs</li> <li>• Primary Prevention</li> <li><input type="checkbox"/> Seamless Continuum of Care</li> <li><input type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Program Description</b>	<p>The <b>Senior Wellness Program</b> has been an integral part of St. John’s Community Health Education Department. The Senior Wellness Program consists of programs that aim to provide seniors with tools to improve their health and wellness. Seniors can participate in the following programs: Energizer’s Walking Program; health related English and Spanish education and support groups; exercise classes; Chronic Disease Self-Management Workshops, six month Living With Diabetes Program; health screenings; adult immunizations and flu shot clinics. Free HbA1C screenings are offered to all participants who have diabetes. All of these services are bilingual and free to the community. St. John's provides coordination, staffing, facilities and funding for most of the programs, but collaborates with other organizations who contribute staff, facilities, publicity and a small amount of funding.</p>
<b>Planned Collaboration</b>	<p>Ventura County Area Agency on Aging - Publicity            RSVP Organization: Bone Builders Class            Alzheimer’s Organization: Classes and Support Groups            Brain Injury Center: Brain Injury Support Group            City of Oxnard, Senior Services and Special Populations            Ventura County Evidence-Based Health Programs Coalition            American Diabetes Association, Santa Barbara and Ventura Counties -            (One Talk: Type 1 Diabetes Support Group)            Ventura County Public Health Immunization Program</p>
<b>Community Benefit Category</b>	<p>A1-a Community Health Education – Lectures/Workshops            A1-c Community Health Education – Individual Health Education            A1-d Community Health Education – Support Groups            A1-e Community Health Education - Self-help            A2-d Community Based Clinical Services – Immunizations/Screenings</p>
FY 2015 Report	
<b>Program Goal / Anticipated Impact</b>	<ul style="list-style-type: none"> <li>• Monitor and manage hypertension and diabetes among seniors.</li> <li>• Prevent a medical crisis and hospitalization through early referral and self-management health education.</li> <li>• Improve health and wellness of seniors through supportive, safe healthy behavior programs.</li> </ul>
<b>Measurable Objective(s) with Indicator(s)</b>	<ul style="list-style-type: none"> <li>• 90% of program clients will NOT have a critical value on blood pressure screening.</li> <li>• 90% of program clients will NOT have a critical value on blood sugar screening.</li> <li>• Participants will display a 5 % increase in knowledge at health and disease management classes as</li> </ul>

	<p>demonstrated in pre and post-tests.</p> <ul style="list-style-type: none"> <li>• 75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the year.</li> <li>• Offer two Chronic Disease Self-Management Workshops.</li> </ul>
<b>Baseline / Needs Summary</b>	To improve and maintain their health, the senior population needs health knowledge and skills, as well as assistance in managing chronic illnesses and maintaining good health. Some need safe, supervised programs for physical activity. There is a need for preventive health management and services to reduce medical crisis, complications and hospitalizations. Diverse populations require programs designed based on their language, socio-economic and educational needs.
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Utilize 2014 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities.</li> <li>• Develop programs for clients to improve their health knowledge/skills and behaviors to manage their health and chronic illnesses and improve their health.</li> <li>• Implement and evaluate effectiveness of senior wellness programs.</li> </ul>
<b>Program Performance / Outcome FY 2015</b>	<ul style="list-style-type: none"> <li>• 100% of program clients did NOT have a critical value on blood pressure level (above 180/110) out of 2,694 blood pressure checks.</li> <li>• .001% (2) of program patients had a critical value on blood sugar levels (above 300 mg/dl) out of 1,724 blood sugar checks.</li> <li>• Senior Wellness Program participants displayed a 16% increase of knowledge of health and disease management as demonstrated in pre and post-tests.</li> <li>• 81% of Walking Program participants with diabetes achieved an HbA1C of 7% or less by the end of the fiscal year.</li> <li>• 3 Spanish Tomando Control Classes and 2 English Chronic Disease Self-Management classes were offered.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	Support for this program is included in St. John's operational budget. St. John's offers free use of hospital conference rooms to collaborators and the cost is applied cost to community benefit. St. John's Hospitals' volunteers collaborate with the community health education department staff to offer free health screenings, health information and immunizations, and assist with other aspects of the Senior Wellness Program.
<b>FY 2016 Plan</b>	
<b>Program Goal / Anticipated Impact</b>	<ul style="list-style-type: none"> <li>• Monitor and manage hypertension and diabetes among seniors.</li> <li>• Prevent a medical crisis and hospitalization through early referral and self-management health education.</li> <li>• Improve health and wellness of seniors through supportive, safe healthy behavior programs.</li> </ul>
<b>Measurable Objective(s) with Indicator(s)</b>	<ul style="list-style-type: none"> <li>• 90% of program clients will NOT have a critical value on blood pressure screening.</li> <li>• 90% of program clients will NOT have a critical value on blood sugar screening.</li> <li>• Participants will display a 5% increase in knowledge at health and disease management classes as demonstrated in pre and post-tests.</li> <li>• 75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the year.</li> <li>• Offer two Chronic Disease Self-Management Workshops.</li> </ul>
<b>Baseline / Needs Summary</b>	To improve and maintain their health, the senior population needs health knowledge and skills, as well as assistance in managing chronic illnesses and maintaining good health. Some need safe, supervised programs for physical activity. There is a need for preventive health management and services to reduce medical crisis, complications and hospitalizations. Diverse populations require programs designed based on their language, socio-economic and educational needs.
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Utilize 2016 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities.</li> </ul>

	<ul style="list-style-type: none"> <li>• Develop programs for clients to improve health knowledge/skills and behaviors to manage and improve their health and chronic illnesses.</li> <li>• Implement and evaluate effectiveness of senior wellness programs.</li> </ul>
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### Heart Failure (CHF) Program

<b>Significant Health Needs Areas Addressed</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Diverse needs from a diverse population</li> <li><input type="checkbox"/> Lack of Financial Resources</li> <li><input checked="" type="checkbox"/> Chronic Disease</li> <li><input type="checkbox"/> Obesity Rates</li> <li><input type="checkbox"/> Mental Health Services resources and access</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> <li><input checked="" type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<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.<sup>1</sup> 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.<sup>2</sup> 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>
<b>Program Description</b>	<p>St. John's Regional Medical Center &amp; 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 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>
<b>Planned Collaboration</b>	<p>Local physicians, cardiologists, health care agencies, Navi-Health, community health and faith community nurses.</p>
<b>Community Benefit Category</b>	<p>A1-a Community Health Education-Group Health Education and Individual Health Education  A1-d Community Health Education-Support Services  A2-d Community Based Clinical Services- Immunizations/Screenings  E3- In Kind Donations: Free use of Facilities for Classes and Support Groups</p>

### FY 2015 Report

<b>Program Goal / Anticipated Impact</b>	<ul style="list-style-type: none"> <li>• Participants in the Heart Failure Program will not be readmitted to any hospital/Emergency Department within 90 days of enrollment for Heart Failure complications.</li> <li>• The hospital will increase the number of patients enrolled in the CHAMP® program.</li> </ul>
<b>Measurable Objective(s) with Indicator(s)</b>	<ul style="list-style-type: none"> <li>• 90% of the participants enrolled in CHAMP® will not be re-admitted to any hospital within 90 days for Congestive Heart Failure Exacerbation.</li> <li>• Engage local physicians to increase patient participants in CHAMP®.</li> <li>• Refer to CHAMP® all appropriate patients with referrals.</li> </ul>
<b>Baseline / Needs Summary</b>	<p>FY 2013:</p> <ul style="list-style-type: none"> <li>• 67% of the HF appropriate patients were not re-admitted to any hospital within 30 days.</li> </ul>

	<ul style="list-style-type: none"> <li>98 participants were enrolled in CHAMP®.</li> </ul> <p>FY 2014:</p> <ul style="list-style-type: none"> <li>97% of the HF appropriate patients were not re-admitted to any hospital within 30 days for CHF exacerbation.</li> <li>216 participants were enrolled in CHAMP®.</li> </ul>																																				
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>Provide on-going education for staff and healthcare providers about the value of the HF Program.</li> <li>Work with the Mercy Health &amp; Vascular Institute to provided consistent telephone follow-up and education to all patients enrolled in CHAMP®.</li> <li>Cardiovascular team will conduct regular meetings to identify strategies to increase program enrollment.</li> <li>Identify HF program candidates and refer to the appropriate program level.</li> <li>Provide discharge planning, HF symptom management education, home health service evaluation and referral to the appropriate resources.</li> <li>Provide follow-up visits, assessments and education to HF participants.</li> <li>Refer and enroll patients to Living Well: Chronic Disease Self-Management Program and conduct program.</li> <li>Refer and enroll patients as appropriate to diabetes self-management program.</li> <li>Refer and enroll patients as appropriate to cholesterol classes.</li> <li>Refer and enroll patients to Healthy Heart (Heart Failure) management classes.</li> </ul>																																				
<b>Program Performance / Outcomes for FY2015</b>	<ul style="list-style-type: none"> <li>97.43 % of the participants enrolled in CHAMP® were not re-admitted to any hospital or emergency department within 90 days.</li> <li>216 community participants were enrolled in CHAMP®.</li> <li>All the appropriate patients were referred to CHAMP®.</li> <li>St. John's Case Managers provided initial evaluation, and referral to local county medical facilities</li> </ul> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th></th> <th>Reporting quarter outcomes</th> <th>Number of persons served/enrolled</th> <th>Number of Participants Admitted to the Hospital or ED within 90 days of the Intervention*</th> <th>% of Participants admitted to the Hospital or ED within 90 days of intervention</th> <th>Program Expense</th> </tr> </thead> <tbody> <tr> <td>1<sup>st</sup> Quarter</td> <td>April-June 2014</td> <td>58</td> <td>1</td> <td>1.72%</td> <td>\$11,286</td> </tr> <tr> <td>2<sup>nd</sup> Quarter</td> <td>July-Sept 2014</td> <td>51</td> <td>2</td> <td>3.92%</td> <td>\$10,758</td> </tr> <tr> <td>3<sup>rd</sup> Quarter</td> <td>Oct-Dec 2014</td> <td>46</td> <td>0</td> <td>0.00%</td> <td>\$11,088</td> </tr> <tr> <td>4<sup>th</sup> Quarter</td> <td>Jan-Mar 2015</td> <td>61</td> <td>2</td> <td>4.65%</td> <td>\$10,296</td> </tr> <tr> <td>FY2014 Total</td> <td></td> <td>216</td> <td>5</td> <td>2.57%</td> <td>\$43,428</td> </tr> </tbody> </table> <p style="text-align: center;">(including clinics) when indicated for those recruited within St John's Hospitals.</p>		Reporting quarter outcomes	Number of persons served/enrolled	Number of Participants Admitted to the Hospital or ED within 90 days of the Intervention*	% of Participants admitted to the Hospital or ED within 90 days of intervention	Program Expense	1 <sup>st</sup> Quarter	April-June 2014	58	1	1.72%	\$11,286	2 <sup>nd</sup> Quarter	July-Sept 2014	51	2	3.92%	\$10,758	3 <sup>rd</sup> Quarter	Oct-Dec 2014	46	0	0.00%	\$11,088	4 <sup>th</sup> Quarter	Jan-Mar 2015	61	2	4.65%	\$10,296	FY2014 Total		216	5	2.57%	\$43,428
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<b>Hospital's Contribution / Program Expense</b>	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 FY2015 was <b>\$43,428</b> .																																				
<b>FY 2016 Plan</b>																																					
<b>Program Goal / Anticipated Impact</b>	<ul style="list-style-type: none"> <li>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.</li> <li>Increase the number of patients enrolled in the CHAMP® program.</li> <li>Increase enrollment of underserved through outreach; collaborate with community; continue to maintain reduction in number of hospitals admissions and readmissions for enrolled participants.</li> </ul>																																				
<b>Measurable Objective(s)</b>	<ul style="list-style-type: none"> <li>90% of the participants enrolled in Heart Failure Program /CHAMP® will not be re-admitted to the</li> </ul>																																				

<b>with Indicator(s)</b>	hospital/ED within 90 days for CHF exacerbation.
<b>Baseline / Needs Summary</b>	<p>FY 2015:</p> <ul style="list-style-type: none"> <li>• 97.43% of the participants enrolled in CHAMP® were not re-admitted to the hospital within 90 days.</li> <li>• 216 participants were enrolled in CHAMP®.</li> <li>• All the appropriate patients were referred to CHAMP®.</li> <li>• 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.</li> <li>• 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.</li> </ul>
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Engage physicians to increase patient participants in CHAMP®.</li> <li>• Refer to CHAMP® all appropriate patients.</li> <li>• 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</li> <li>• Provide on-going education for staff and healthcare providers about the value of the HF Program.</li> <li>• Work with the Mercy Health &amp; Vascular Institute to provided consistent telephone follow-up and education to all patients enrolled in CHAMP®.</li> <li>• Cardiovascular team will conduct regular meetings to identify strategies to increase program enrollment.</li> <li>• Identify HF program candidates and refer to the appropriate program level.</li> <li>• Provide discharge planning, HF symptom management education, home health service evaluation and referral to the appropriate resources.</li> <li>• Provide follow-up visits, assessments and education to HF participants.</li> <li>• Refer and enroll patients to Living Well: Chronic Disease Self-Management Program and conduct program.</li> <li>• Refer and enroll patients to Healthy Heart educational classes.</li> <li>• Refer patients to Cholesterol and Diabetes educational classes as appropriate.</li> </ul>

Mobile Health Screenings Health Program	
<b>Significant Health Needs Areas Addressed</b>	<input checked="" type="checkbox"/> Priority Area 1: Diverse needs from a diverse population <input checked="" type="checkbox"/> Priority Area 2: Lack of Financial Resources <input checked="" type="checkbox"/> Priority Area 3: Chronic Disease <input checked="" type="checkbox"/> Priority Area 4: Obesity Rates <input type="checkbox"/> Priority Area 5: Mental Health Services resources and access
<b>Program Emphasis</b>	<p>Please select the emphasis of this program from the options below:</p> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	<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>
<b>Program Description</b>	<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"> <li>• Non-English proficient</li> <li>• Migrant/transient</li> </ul>

	<ul style="list-style-type: none"> <li>• Uninsured/under-insured</li> <li>• Limited transportation</li> <li>• Large families</li> </ul>										
<b>Planned Collaboration</b>	Local Physicians, Public Health, Community Health Care Agencies, Navi-Health, Community Health and Faith Community Nurses, Local Faith Communities, Schools, Health Care Providers										
<b>Community Benefit Category</b>	A1-a Community Health Education-Group Health Education and Individual Health Education A1-d Community Health Education-Support Services A2-d Community Based Clinical Services- Immunizations/Screenings E3- In Kind Donations: Free use of Facilities for Classes and Support Groups										
<b>FY 2015 Report</b>											
<b>Program Goal / Anticipated Impact</b>	<ul style="list-style-type: none"> <li>• Improve immunization rates for children and adults within our community.</li> <li>• Improve school readiness for children through prevention, vaccinations, and early interventions.</li> <li>• Improve early recognition and awareness of chronic disease risks among the adult population served with prevention, early detection, early interventions and increased immunization rates.</li> <li>• 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.</li> <li>• 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</li> <li>• Increase education and awareness on the importance of health screenings and immunizations to all populations served</li> </ul>										
<b>Measurable Objective(s) with Indicator(s)</b>	<ol style="list-style-type: none"> <li>1. Increased number of children and adults receiving health screenings.</li> <li>2. Increased number of children and adults receiving immunizations.</li> <li>3. Increased number of community events.</li> <li>4. Increased grant dollars secured for Mobile Health Screenings unit and Shots for Kids and Adults program.</li> <li>5. Increased number of persons getting health education</li> </ol>										
<b>Baseline / Needs Summary</b>	FY2014: <ul style="list-style-type: none"> <li>• Provided 1049 immunizations on adults (854 flu vaccines)</li> <li>• Provided 311 immunizations on children (189 flu vaccines)</li> <li>• Provided 109 TB (PPD) tests.</li> <li>• Provided 814 Body Mass Index screenings</li> <li>• Provided 919 Blood Pressure Screenings</li> <li>• Provided 954 Blood Glucose screenings</li> <li>• Provided 583 Blood hemoglobin (anemia) screenings</li> </ul> *numbers reflect corrected data excluding Medical Camp results										
<b>Intervention Actions for Achieving Goal</b>	Implementation strategies are: <ol style="list-style-type: none"> <li>1. 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.</li> <li>2. Enhance our work with other health care entities to implement a model continuum of care.</li> <li>3. Increase utilization of our wellness programs to create improved mechanisms that will enhance follow-up, and retention of participants.</li> <li>4. 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.</li> </ol>										
<b>Program Performance / Outcomes for FY2015</b>	FY2015: <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Number of Adult Immunizations</th> <th>Number of Children Immunizations</th> <th>Number of TB Tests Provided on Children</th> <th>Number of Adult Health Screenings</th> <th>Number of Children Health Screenings</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Number of Adult Immunizations	Number of Children Immunizations	Number of TB Tests Provided on Children	Number of Adult Health Screenings	Number of Children Health Screenings					
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				and Adults		
	1 <sup>st</sup> Quarter	40	36	23	270	8
	2 <sup>nd</sup> Quarter	1624	303	68	172	0
	3 <sup>rd</sup> Quarter	213	197	9	65	1
	4 <sup>th</sup> Quarter	20	31	9	539	21
	<b>FY2015 Total</b>	<b>1897</b>	<b>567</b>	<b>109</b>	<b>1046</b>	<b>30</b>
<b>Hospital's Contribution / Program Expense</b>	Support for this program was included in St John's Hospitals Operational Budget.					
<b>FY 2016 Plan</b>						
<b>Program Goal / Anticipated Impact</b>	<ul style="list-style-type: none"> <li>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.</li> <li>Increase the number of patients enrolled in the CHAMP® program.</li> <li>Increase enrollment of underserved through outreach; collaborate with community; continue to maintain reduction in number of hospitals admissions and readmissions for enrolled participants.</li> </ul>					
<b>Measurable Objective(s) with Indicator(s)</b>	<ol style="list-style-type: none"> <li>Increased number of children and adults receiving health screenings.</li> <li>Increased number of children and adults receiving immunizations.</li> <li>Increased number of community events.</li> <li>Increased grant dollars secured for Mobile Health Screenings unit and Shots for Kids and Adults program.</li> <li>Increased number of persons getting health education</li> </ol>					
<b>Baseline / Needs Summary</b>	FY2015: <ul style="list-style-type: none"> <li>Provided 1897 immunizations on adults (1733 flu vaccines)</li> <li>Provided 567 immunizations on children (400 flu vaccines)</li> <li>Provided 109 TB (PPD) tests.</li> <li>Provided 899 Body Mass Index screenings</li> <li>Provided 839 Waist Circumference Screenings</li> <li>Provided 910 Blood Pressure Screenings</li> <li>Provided 1057 Blood Glucose screenings</li> <li>Provided 788 Blood hemoglobin (anemia) screenings</li> <li>Provided 1095 referrals to Community Health Care providers for abnormal results follow up</li> </ul>					
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>Enroll participants in program, provide interventions and monitor their immunizations and health screenings results.</li> <li>Refer participants with abnormal screenings results to community health care providers based on their ability to pay and within geographic distance to participants.</li> <li>Utilize the Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of interventions.</li> <li>Increase immunization rates in targeted medically underserved areas.</li> <li>Promote health education and healthy living in the communities served.</li> <li>Provide a learning opportunity for Center of Employment Training medical assistant students and focus on barriers in caring for underserved children, adults and families, and the importance of collaborating to reduce health care disparities in our community.</li> <li>Educate adults and families about health insurance options.</li> <li>Explain to families the advantages of finding a permanent medical practice for their children immunizations and regular health screenings services.</li> </ul>					

## Hello! Health Living Well with Diabetes Self-Management Program

<b>Significant Health Needs Addressed</b>	<ul style="list-style-type: none"> <li>• Diversity</li> <li>• Lack of financial resources and impact of poverty on healthcare access</li> <li>• Chronic disease prevention and education</li> <li><input type="checkbox"/> Obesity, particularly adolescents</li> <li><input type="checkbox"/> Mental health services resources and access</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>• Disproportionate Unmet Health-Related Needs</li> <li><input type="checkbox"/> Primary Prevention</li> <li>• Seamless Continuum of Care</li> <li>• Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Program Description</b>	The Hello Health! Living Well with Diabetes self-management program provides free health screenings, including lab work (HbA1C, lipid panel), height/weight, and blood pressure readings, health education, individual counseling, and diabetes supplies (if needed).
<b>Planned Collaboration</b>	Planned collaboration is with community providers as well as departments within the hospital.
<b>Community Benefit Category</b>	Community Health Improvement A1. Community Health Education A2. Community-Based Clinical Services/Health Screenings.
<b>FY 2015 Report</b>	
<b>Program Goal / Anticipated Impact</b>	Increase individuals' health literacy and self-efficacy as related to diabetes for the population residing within St. John's primary service through a six-month evidenced-based health promotion/education bilingual program, Hello Health! Living Well with Diabetes or Self-Management Program (HLWD).
<b>Measurable Objective(s) with Indicator(s)</b>	<ul style="list-style-type: none"> <li>• By the third quarter of FY'15, the need for a Hello! Living Well with Diabetes Self-Management Program will be determined. The program would be facilitated through collaboration and peer educators.</li> <li>• Through an HbA1C lab test, 70% of individuals' in the HLWD program with an HbA1C <math>\geq 7.5</math> will decrease their HbA1C level by 5.0% after six-months.</li> <li>• 70% of the participants will show an increase of 10 points between their pre- and post- test knowledge test scores.</li> <li>• 50% of the participants will report an increase of 10% in their reported minutes per week of exercise by the conclusion of the six-month program.</li> <li>• Three diabetes health education outreach sessions will be held in Spanish in FY'15.</li> </ul>
<b>Baseline / Needs Summary</b>	According to the CHNA 2013, 73.5% of the population in Oxnard identified themselves as Hispanic/Latino. According to the American Diabetes Association Hispanics are 1.7 times more likely to be diagnosed with diabetes than whites. In addition, 67% of the population in Oxnard reported they do not speak English at home. A Latino CHNA identified that 40% of the participants surveyed reported not having health insurance.
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Four bilingual Hello Health! Living Well with Diabetes lab and education events were held, one each quarter.</li> <li>• Eight (4 English; 4 Spanish) follow-up classes were held one to two weeks after the HHLWD lab events.</li> <li>• A six-week English diabetes pilot program was completed to gauge community interest. After participants understand the subject matter, interest wanes.</li> <li>• Six diabetes educational classes were conducted in Spanish at different churches and locations within Oxnard.</li> </ul>
<b>Program Performance / Outcome</b>	<ul style="list-style-type: none"> <li>• 20 participants had an HbA1C <math>&gt; 7.5</math> when they began the program, of which, 70% (14) reduced their HbA1C by 5%.</li> <li>• 30 participants reported on exercise, with 53.3% (16) of participants report an increase in</li> </ul>



	<p>physical activity. 7 participants (n=30) reported maintaining their level of physical activity.</p> <ul style="list-style-type: none"> <li>• 26 participants completed the pre- and post- test, of which 73% (n=19) participants increased their pre- and post-test results by 10 points.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	This program is part of St. John's Regional Medical Center's operating budget.
<b>FY 2016 Plan</b>	
<b>Program Goal / Anticipated Impact</b>	Through better collaboration a new report generated by the Electronic Medical Record and improved marketing, this program will reach out to more citizens of the PSA.
<b>Measurable Objective(s) with Indicator(s)</b>	<ul style="list-style-type: none"> <li>• Through an HbA1C lab test, 70% of individuals' in the HLWD program with an HbA1C <math>\geq 7.5</math> will decrease their HbA1C level by 5.0% after six-months.</li> <li>• 70% of the participants will show an increase of 10 points between their pre- and post- test knowledge test scores.</li> <li>• 50% of the participants will report an increase of 10% in their reported minutes per week of exercise by the conclusion of the six-month program.</li> <li>• Five diabetes health education outreach sessions will be held in Spanish in FY'15.</li> <li>• Develop a pre-diabetes track in the program and offer pre-diabetes programs in English and Spanish.</li> </ul>
<b>Baseline / Needs Summary</b>	It is reported that 49% of all Californians are pre-diabetic yet 9 out of 10 are unaware of this. Unaddressed is this population becomes diabetic it will likely overwhelm the healthcare system, locally and state wide.
<b>Intervention Actions for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Through random testing at health fairs &amp; patients identify those at risk or who are diabetic</li> <li>• Offer educational opportunities in the community to assist people in making healthier life style choices.</li> </ul>

## ECONOMIC VALUE OF COMMUNITY BENEFIT

	<u>People Served</u>	<u>Total Expense</u>	<u>Offsetting Revenue</u>	<u>Net Benefit</u>	<u>% of Expense</u>
<b><u>Benefits for Living in Poverty</u></b>					
<b>Financial Assistance</b>	1,193	2,180,002	69,685	2,110,317	0.7
<b>Medicaid</b>	32,044	97,798,915	72,055,368	25,743,547	8.4
<b>Community Services</b>					
A Comm. Health Improvement Svcs	22,068	271,621	20,309	251,312	0.1
B Health Professions Education	77	2,856	0	2,856	0.0
E Financial and In Kind Contributions	45,779	509,115	41,707	467,408	0.2
G Community Benefit Operations	2	146,029	0	146,029	0.0
<b>Totals for Community Services</b>	<b>67,927</b>	<b>930,319</b>	<b>62,016</b>	<b>868,303</b>	<b>0.3</b>
<b>Totals for Living in Poverty</b>	<b>101,164</b>	<b>100,909,236</b>	<b>72,187,069</b>	<b>28,722,167</b>	<b>9.4</b>
<b><u>Benefits for Broader Community</u></b>					
<b>Community Services</b>					
A Comm. Health Improvement Svcs	16,694	410,754	17,232	393,522	0.1
E Financial and In Kind Contributions	8	1,753	0	1,753	0.0
G Community Benefit Operations	251	8,393	0	8,393	0.0
<b>Totals for Community Services</b>	<b>17,212</b>	<b>459,227</b>	<b>17,232</b>	<b>441,995</b>	<b>0.1</b>
<b>Totals for Broader Community</b>	<b>17,212</b>	<b>459,227</b>	<b>17,232</b>	<b>441,995</b>	<b>0.1</b>
<b>Total Community Benefit</b>	<b>118,376</b>	<b>101,368,463</b>	<b>72,204,301</b>	<b>29,164,162</b>	<b>9.5</b>
<b>Medicare</b>	<b>14,825</b>	<b>107,118,154</b>	<b>74,348,288</b>	<b>32,769,866</b>	<b>10.7</b>
<b>Total with Medicare</b>	<b>133,201</b>	<b>208,486,617</b>	<b>146,552,589</b>	<b>61,934,028</b>	<b>20.3</b>

The uncompensated costs of providing services through financial assistance/charity care, Medicaid, Medicare and other means-tested programs are calculated utilizing a cost accounting system.

## **APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTER**

### **Community Board Members**

Rober Azelby (Senior Executive for Amgen)  
Sr. Amy Bayley RSM (Sister of Mercy Sponsor)  
Joe Burdullis (retired CEO in the Agriculture industry)  
Gary Deutsch MD (Medical Staff)  
Mary Fish (Retired Director of Surgery Center)  
Joe Hernandez (CEO of JHC Benefits)  
Andrew Jeffers MD (Chief of Medical Staff)  
Lynn Jeffers MD (Medical Staff)  
Ann Kelley MD (Chair & 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)  
Maureen Sheldon Esq. (Attorney)  
Donald Skinner (Retired President of a Technology Corp.)  
Gabriel Soumakian (High School Superintendent)  
Carl Wesley (President, General Contracting firm)  
Celina Zacarias (Director, Cal-State Univ. Channel Islands)  
Jerry Zins, (Chair, St. John's Foundation & CEO of a private wealth management firm)

### **Healthy Communities Members**

Lynn Jeffers MD  
Ann Kelley MD  
Gabriel Soumakian  
Celina Zacarias (Chair)

## **APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS**

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

### **Dignity Health Community Grants Program**

In FY15 St. John's Hospitals awarded two grants to accountable care communities ( i.e. three or more not for profit community organizations). One such collaboration addressed homeless and healthcare issues and the other sought to address obesity in the un/under insured population of Ventura County.

Among the community building activities is the Health Ministry Department's 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 SJRMC's commitment to the environment of our communities by reducing the hospital's ecological impact. In FY 15 this committee focused on reducing water usage, composting recycling. For the near future the focus will include an ecologically sound design for the new patient addition. For a community whose economy includes a significant agricultural sector, efforts in ecology are efforts to improve the local economy.

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 2015:

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

St. John's hospitals are the largest healthcare employer in Ventura County. SJRMC employs 1305 people whose average salary is \$42 per hour. The estimated FY2015 economic benefit across 10 incorporated cities in Ventura County (where most of our employees live) is more than \$84,000,000.