



Dignity Health
St. John's Pleasant Valley Hospital
Community Health Implementation Strategy
2016 – 2018

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EXECUTIVE SUMMARY

Though the communities served include all of Ventura County, the Primary Service Area of Dignity Health St. John's Pleasant Valley Hospital (SJPVH) is the City of Camarillo including zip codes 93010, 93012 and Somis, zip code 93066. This represents a population of 70,025. The Secondary Service Area is Eastern Oxnard, zip code 93030.

The significant community health needs that form the basis of this document were identified in the SJPVH's most recent Community Health Needs Assessment (CHNA), which is publicly available at www.dignityhealth.org/stjohnspleasantvalley/document/community-benefit-reports/2016-chna. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The significant community health needs identified are:

Tier I priorities-

- Obesity & Overweight
- Lack of Mental Health Resources
- Family Caregiver Support & Respite

Tier II priorities-

- Diabetes & Prediabetes
- Cardiovascular Health
- Cancers
- Arthritis

Note—Tier levels are determined by urgency of the identified health needs balanced with resources currently available/being used in the Primary Service Area (PSA).

For FY17 & 18, SJPVH plans to address these needs both directly and through greater collaboration between the hospitals in Ventura County and Ventura County Public Health and Kaiser. During the CHNA process the community health leaders of the not-for profit hospitals in Ventura County (the two St. Johns, Community Memorial Hospital, Simi Valley Adventist Hospital) and Ventura County Medical Center began meeting with Ventura County Public health and the regional leader for Kaiser's community health program. From these quarterly meetings we have resolved to collaborate in addressing identified health needs where possible based on unique resources of each facility/organization and pooling other resources.

- **Tier I—**

- **Obesity & Overweight** will be addressed through increased education.
- **Lack of Adequate Mental Health Resources** is a need for which SJRMC lacks resources. We look to, and will support where possible, Ventura County Behavioral Health in addressing this need.
- **Family Caregiver Support & Respite** is a need for which SJPVH lacks sufficient resources. This need is currently being addressed by other community resources/organizations (e.g. Camarillo Health Care District) with whom SJPVH will explore collaboration opportunities.

- **Tier II—**

- **Diabetes & Prediabetes** will be addressed through education using a collaborative evidenced based approach.
- **Cardiovascular Health** is being addressed through SJPVH with CHAMP® (Congestive Heart Active Management Program) and our “Know Your Numbers” health screening events.
- **Cancers** are being addressed through the multiple programs of St. John’s Cancer Center of Ventura County.
- **Arthritis** is being addressed collaboratively with the Arthritis Foundation of Ventura County

This document is publicly available at www.dignityhealth.org/community-benefit-reports/2016 and will be distributed to City, County, State and Federal government leaders in the PSA, community human services agencies and collaborating health care partners as well as distribution to SJRMC staff, volunteers and physicians.

Written comments on this report can be submitted to the St. John’s Regional Medical Center Community Health Office, 1600 N. Rose Ave., Oxnard, CA 93030, or by e-mail to george.west@dignityhealth.org.

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

Pleasant Valley Hospital was founded in 1974 by a group of Camarillo community leaders and physicians who believed that the young City of Camarillo needed a hospital of its own. In 1993 it merged with St. John's Regional Medical Center in Oxnard, becoming St. John's Pleasant Valley Hospital (SJPVH), one ministry of healing with two hospital campuses, both sponsored by the Sisters of Mercy. SJPVH provides emergent, acute and intensive care, with extensive surgery services, outpatient hyperbaric care and a 99 bed sub-acute facility. SJPVH is Primary Stroke Certified by the Joint Commission, and Healthgrades rates SJPVH as among the top 100 hospitals in the USA for: Stroke Care, Pulmonary Care, GI Care, General Surgery and Critical Care.

Rooted in the Sisters of Mercy heritage as carried forward by Dignity Health's mission, vision and values, SJPVH is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board, staff, physicians and volunteers.

The board and committee are composed of community members who provide oversight and direction for the hospital as a community resource. SJPVH continues the Sisters of Mercy heritage of healing and community service in the Catholic social tradition with a 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. This is done through multiple programs tailored to an identified need and collaborations with other community organizations.

The Chair of the Community Board also serves as Chair for the Healthy Communities Committee of the Board. That committee is composed of Community Board members, Foundation Board members and interested community members. As a group they oversight responsibility for the CHNA process, contribute to strategies for meeting the identified health needs of the community, and oversee programmatic outcomes in addition to seeking additional resources, exploring potential collaborations and identifying opportunities. This includes, but is not limited to, review of this triennial Implementation Strategy, the annual Community Benefits Report and Plan, monitoring on a monthly basis reports of programs offered by SJPVH and dialoguing with community health program leaders and Executive leadership. Appendix A includes a roster of board and committee members, with affiliations;

The key staff members of SJPVH who are responsible for and dedicated to planning and carrying out the community benefit program include:

- George West, Vice President Mission Integration who is the executive leader accountable for all community health programs;
- Sr. Suzanne Soppe, Sister Sponsor and Lead Community Health Educator, who in addition to educating community members provides continuity and Sister Sponsor oversight of the community education and outreach activities. Sr. Soppe has been instrumental in the successful launch of DEEP®;
- Gabriel Guillen RN, Supervisor Community Health Education Dept. who is responsible for Community Health Education programs/classes, health fairs/screenings, CHAMP® and the immunization program.
- Lydia Kreil, Supervisor, Health Ministries Dept. and Healthy Beginnings Program, manages the outreach activities that address the social determinants of poor health. These include the community food pantry, community clothes

closet, basic needs fund & counseling. Ms. Kreil is also responsible for tracking and reporting Community Benefits.

- Alicia Zaragoza RN, manager of the St. John's Cancer Center of Ventura County, is responsible for the daily activities of the Cancer Center including support groups, classes, lectures, symposia and is the Cancer Nurse Navigator.

SJPVH's community benefit program includes financial assistance provided to those who are unable to pay the cost of medically necessary 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 System has a long history of investing in community capacity to improve health, especially with regards to affordable housing as a social determinant of health, through Dignity Health's Community Investment Program. These efforts include the following housing projects:

- With the Sisters of Mercy through Mercy Housing:
 - Casa San Juan, Oxnard
 - Casa Merced, Oxnard
- With Cabrillo Economic Development Corp.:
 - Rodney Fernandez Gardens, Santa Paula
 - Valle Naranjal Farmworker Family Apartments, Piru

DESCRIPTION OF THE COMMUNITY SERVED

Community is defined as the resident population within the hospital's service area. While Dignity Health St. John's Pleasant Valley Hospital serves all of Ventura County, the hospital is located in and serves primarily Camarillo. Camarillo is a suburban community located in the west end of Ventura County. Camarillo had a mixed economy with significant agricultural and industrial elements, a regional retail shopping center, and a high-tech sector. SJPVH's Primary Service Area (PSA) was determined by analysis of the highest percent of discharges from the hospital for the year. SJPVH's Community is therefore determined to be the people residing in the zip codes of Camarillo 903010, 93012 and Somis 93066. The Secondary Service Area is Oxnard 93030. As part of our commitment to mission in raising the common good and improving the quality of life for our communities, SJPVH not only focuses on the needs of its PSA but also takes into account the needs throughout Ventura County.

The PSA for SJPVH 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 nearly 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 (data provided from the US Census).

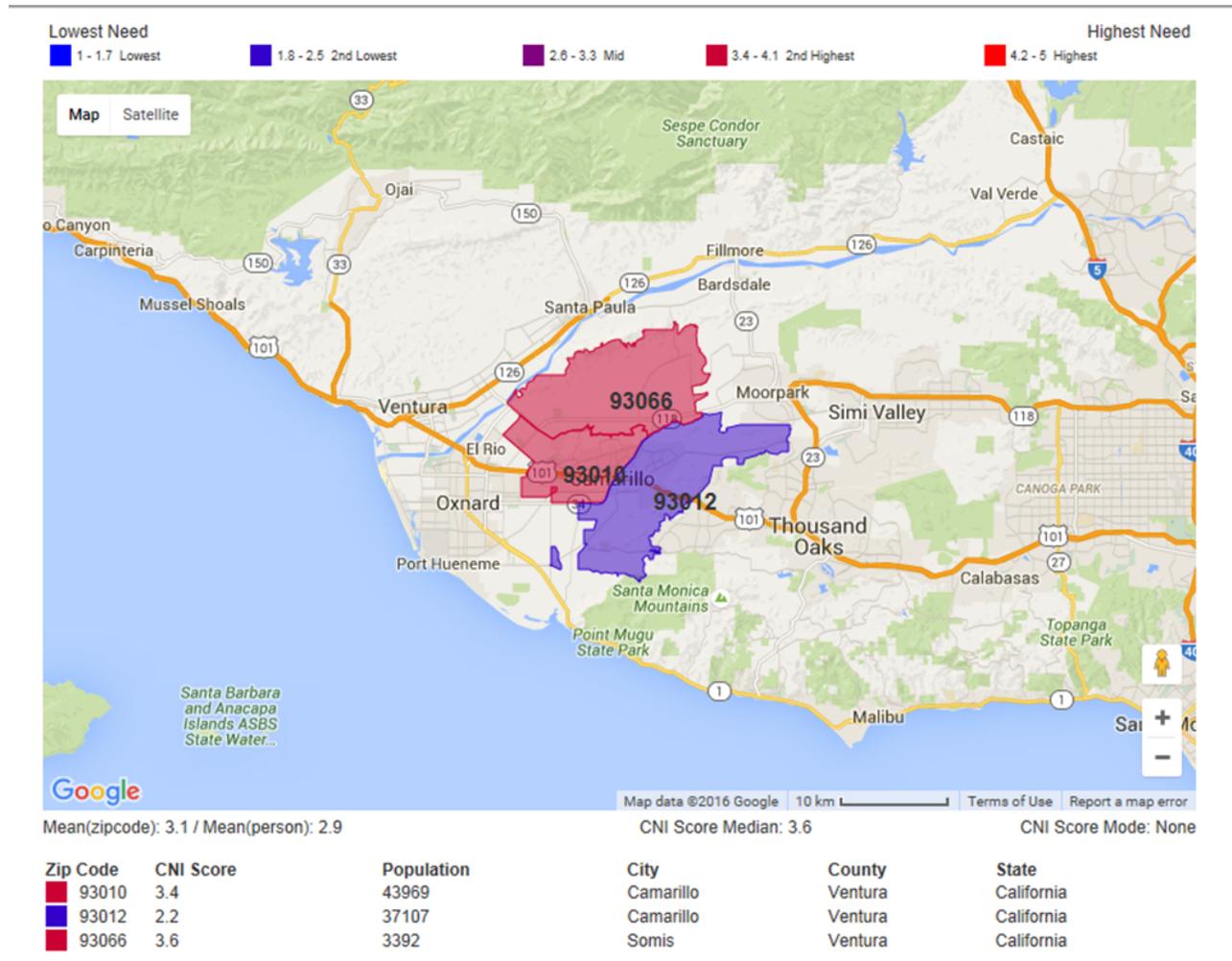
Community Demographics

- Total Population – the population for Ventura County is 835,981, with 70,025 in the PSA.
- Age Groups –27.2% of the population is under the age of 18 with 20.87% over the age of 60.
- Gender Diversity – 51.5 of the population is female, 49.5% male.
- Race/Ethnic Diversity –61.9% self identifies as Non-Latino Caucasian 23.4% of the population self identifies as Latino, 10.9% Asian, 2.1% Black and all others comprise 1.7%
- Adult Education – only 7.7% do not have at least a High School Diploma.
- Poverty Status – the poverty rate for the service area is 5.9%
- Unemployment – among the cities in the service area, the unemployment rate is 4.2%.
- Income – Median household income in 2016 was \$83,892.
- Primary Language and Linguistic Isolation – English is the primary languages in the PSA only 22.8% in reporting English is not spoken in the home (compared to a much larger percentage for Oxnard and other areas in Ventura County).
- Insurance status – 11.1% of the population are uninsured

The hospital serves an area federally designated as a Medically Unserved Area (MUA). SJPVH 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.

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community.

Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



NOTE: Based on the Community Needs Index, 93010 is on the low margin of “2nd Highest Need” and 93066 is in the Mid-range of “2nd Highest Need” and 93012 is in the “2nd Lowest Need” range.

Implementation Strategy Development 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 Community Board Healthy Communities Committee and other stakeholders in the development of the annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment Process

The 2016 CHNA, as adopted in June of 2016, was completed through a culmination of primary and secondary data sources. Each data source and the process utilized for assessment and collection is described in the following subsections. To compliment primary data, community health needs survey, key stakeholder focus groups, community leader interviews, secondary data including U.S. Census and well established state and county wide public health was collected and synthesized for this report.

Primary data sources can be best described as first hand evidence by participants or observers concerning a specific topic. This CHNA reveals primary data through a health behavior survey, in efforts to gain thorough understanding of the medically underserved, low-income, and minority populations most often served.

The initial step in conducting the Community Health Needs Assessment was through the development of a health needs assessment survey based on questions from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey (BRFSS). The survey collection used a convenience sampling approach where locations were selected to best represent the PSA. To secure confidentiality, surveys were placed in a sealed box or envelope.

Based on the population of the PSA, it was determined at least 384 surveys would indicate a representative sample. Data was then interpreted by coding survey responses and entered into an Excel spreadsheet. The compiled data was reviewed for accuracy and thereon inputted into analytical software. Survey responses were analyzed as compared to various independent variables, including place of residence, educational attainment, race/origin, and age.

In addition to our health behavior survey and to supplement the quantitative findings, key informants were invited to participate in a group and/or interview to further assess the underlying drivers for health outcomes, current community efforts, and obstacles to health. Key informant interviews with representation from Ventura County Public Health Department, Camarillo elected officials, a former Somis public servant and focus groups with those having special knowledge and whose work focuses on health needs, health disparities, and vulnerable populations, provided vital information that increased the understanding of the health needs of the PSA.

The stakeholder focus group was held on May 3, 2016 at St. John's Regional Medical Center. Attending included individuals from community organizations including health professionals, social service

providers, and other community leaders. The stakeholder focus group was given a Likert scale survey on the services provided and top health needs.

The 2016 CHNA utilized the following secondary data sources, and where possible, was compared to data collected during the community health survey providing a comparison of service area data to county, state, or national levels:

- a) United States Census Bureau
- b) Centers for Disease Control and Prevention – Behavioral Risk Factor Surveillance System
- c) California Department of Public Health
- d) Healthy People 2020
- e) Health Matters in Ventura County

Based on the multitude of primary and secondary data sources evaluated and considered, there appears to be no evidence of information gaps that limit the ability of this CHNA to assess the community's health needs.

CHNA Significant Health Needs

St. John's leadership adopted a tiered approach to prioritize identified community health needs as follows:

- Tier I community needs are those that are the most urgent and not being addressed due to a lack of community resources to address the need.
- Tier II community needs are less urgent but that are not being fully addressed by existing community resources.

The prioritized health needs from the 2016 CHNA and plans to address those needs are summarized as follows:

Tier I—

Obesity & Overweight which will be addressed through increased education, especially of youth, to change life style behavior patterns that result in these conditions.

Lack of Mental Health Resources is a need for which SJPVH lacks resources. We look to, and will support where possible, Ventura County Behavioral Health in addressing this need. Future Dignity Health Community Grants (2017 & 2018) are being considered as a resource to initiate a collaborative approach to addressing this need.

Family Caregiver Support & Respite is a need for which SJPVH lacks sufficient resources. This need is currently being addressed by community resources/organizations (e.g. Camarillo Health Care District). SJPVH will explore future collaborations opportunities with these organizations.

Tier II—

Diabetes & Prediabetes will be addressed through greater collaborative education using evidenced based DEEP® (Diabetes Education & Empowerment Program). Sponsored by the Health Services Advisory Group SJRMC was first in the county to offer this program, which shows great promise (in participant enrollment and retention). This program is our first collaboration with Community Memorial Health System staff (one of the educators in the classes held at SJRMC is a CMHS Nurse Supervisor and diabetes CNE).

Cardiovascular Health is being addressed through CHAMP® (Congestive Heart Active Management Program) and our “Know Your Numbers” health screening events. Future plans are to increase CHAMP® access by expanding use of this resource through the Dignity Health Medical Foundation and other affiliated providers.

Cancers are being addressed through the multiple programs of St. John’s Cancer Center of Ventura County. These include education/prevention seminars and lectures, support groups, a nurse navigator program and a cancer dietician. Breast Cancer Symposium will be held at Spanish Hills Country Club and a Cancer Lecture Series will be held at Padre Serra Parish in Camarillo. For 2017 we will introduce mobile skin cancer screenings through our Mobile Wellness Vehicle.

Arthritis which is being addressed collaboratively with the Arthritis Foundation of Ventura County through an exercise program & support group held on the SJRMC campus. The Senior Wellness Program held weekly at the Boys and Girls Club of Oxnard also provides supervised opportunities to improve physical mobility/flexibility for seniors suffering from arthritis.

Creating the Implementation Strategy

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

- **Focus on Disproportionate Unmet Health-Related Needs:** Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Emphasize Prevention:** Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Contribute to a Seamless Continuum of Care:** Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Build Community Capacity:** Target charitable resources to mobilize and build the capacity of existing community assets.
- **Demonstrate Collaboration:** Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.

Program Design & Implementation Process

Community Health staff explored current resources, including fiscal and personnel limitations (number of staff and education), available off-the-shelf outcomes/evidenced based programs and community resources/collaborations in determining what programs could best address the needs described above. Planning the programs is taken on as a team under the leadership of Vice President of Mission Integration and Sisters of Mercy Sponsors, and is presented to the Healthy Communities Committee for input and oversight.

Examples of this process:

- The Health Services Advisory Group (HSAG) offered to train trainers in the evidenced based DEEP® Program. Community Health Education staff explored the program and found the material and approach more engaging than our prior evidence based program. The Community Health Education team was trained and offered one test class in English. Our initial offering of DEEP® was successful and roll-out is now our diabetes education mainstay through 2018.

- CHAMP® has been a low labor intensive contracted activity with proven result in empowering those who suffer from Heart Failure in order to avoid unneeded use of healthcare resources. Results continue to show remarkable results, as a result Community Health Leadership in collaboration with the St. John's physician Cardiology Committee decided to continue his program through 2018 with expansion to Dignity Health Medical Foundation so those who are within the Dignity Health family of care can benefit from this program.
- A Senior Wellness Program focuses on senior education, activity and health monitoring. Initiated by a Sister Sponsor, and partially grant funded, continues to provide excellent outcomes for participants in health awareness and maintenance.

The health needs of the communities of Camarillo and Somis continue to grow and to meet those needs Dignity Health has committed to build a new state of the art patient wing at SJPVH which will include modernized surgery facilities and a diagnostic cath lab. Leadership also includes in its strategy a Dignity Health Care Corridor in Ventura County. This will include imaging, physical therapy, women's centers and at least one new community clinic affiliated with Dignity Health by 2018.

Planning for the Uninsured/Underinsured Patient Population

St. John's Pleasant Valley Hospital seeks to deliver compassionate, high quality, affordable health care and to advocate for those who are poor and disenfranchised. In furtherance of this mission, the hospital offers financial assistance to eligible patients who may not have the financial capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C.

The hospital notifies and informs patients about the Financial Assistance Policy by offering a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process. At the time of billing, each patient is offered a conspicuous written notice containing information about the availability of the Policy.

Notice of the financial assistance program is posted in locations visible to the public, including the emergency department, billing office, admissions office, and other areas reasonably calculated to reach people who are most likely to require financial assistance from the hospital. The hospital provides brochures explaining the financial assistance program in registration, admitting, emergency and urgent care areas, and in patient financial services offices.

The Financial Assistance Policy, the Financial Assistance Application, and plain language summary of the Policy are widely available on the hospital's web site, and paper copies are available upon request and without charge, both by mail and in public locations of the hospital. Written notices, posted signs and brochures are printed and available online in appropriate languages.

Our Financial Assistance Policy is posted for the public at <http://www.dignityhealth.org/stjohnspleasantvalley/patients-and-visitors/patients/billing-and-payment-information/payment-assistance>.

2016-2018 Implementation Strategy

This section presents strategies, programs and initiatives the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It includes summary descriptions, anticipated impacts, planned collaboration, and detailed “program digests” on select initiatives.

The strategy and plan specifies planned activities consistent with the hospital’s mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital’s limited resources to best serve the community.

STRATEGY AND PROGRAM PLAN SUMMARY

- **Obesity & Overweight**
 - Increased education, especially of youth, to change life style behavior patterns that result in these conditions*
 - Health Fairs when BMI & Waster Measurement screenings indicate education is appropriate*
 - Senior Wellness & Walking Program*
- **Diabetes & Prediabetes**
 - DEEP® (Diabetes Education & Empowerment Program). This program is our first collaboration with Community Memorial Health System staff (one of the educators in the classes held at SJRMC is a CMHS Nurse Supervisor and diabetes CNE)*
- **Cardiovascular Health**
 - CHAMP® (Congestive Heart Active Management Program)*
 - Expanded to include Dignity Health Medical Foundation & other affiliated physician organizations/collaborations*
 - “Know Your Numbers” offered quarterly to the community*
 - 1:1 health education as needed*
- **Cancers**
 - Cancer Center of Ventura County at St. Johns*
 - Education/prevention seminars and lectures
 - Support groups
 - Cancer nurse navigator
 - Cancer dietician specialist services
 - Mobile skin cancer screenings through our Mobile Wellness Vehicle.
- **Arthritis**
 - Senior Wellness Program*
 - Structured Activity monitored by a health educator
 - Health Screenings
 - Collaboration with the Arthritis Foundation of Ventura County*
 - Move Free classes

Anticipated Impact

The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Healthy Communities Committee of the community board, hospital executive leadership, Community Board, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

During the CHNA process the community health leaders of the not-for profit hospitals in Ventura County (the two St. Johns hospitals, Community Memorial Hospital, Simi Valley Adventist Hospital) and Ventura County Medical Center began meeting with Ventura County Public Health Dept. and the regional leader for Kaiser’s community health programs. From these quarterly meetings we have resolved to collaborate in addressing identified health needs where possible based on unique resources of each facility/organization and pooling other resources. In addition, we look to collaborate to complete a comprehensive CHNA when it is next due for the not-for-profit facilities in 2019.

SJPVH looks to collaborate more with the Dignity Health Medical Foundation in Ventura county and the SCICN-Ventura (Southern California Integrated Care Network—Ventura). This unfolding collaboration will create portals for health consumers to enter the Dignity Health family of care services, whether physician, hospital or community health event. In entering that portal the planned outcome is for a comprehensive health management of each individual’s needs.

Program Digests

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. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

| Senior Wellness Program | |
|---|--|
| Significant Health Needs Addressed | <ul style="list-style-type: none"> ✓ Significant Health Need: Obesity & Overweight Significant Health Need: Diabetes and Prediabetes ✓ Significant Health Need: Cardiovascular Health □ Significant Health Need: Cancers □ Significant Health Need: Arthritis |

| | |
|--|--|
| Program Emphasis | <ul style="list-style-type: none"> √ Disproportionate Unmet Health-Related Needs √ Primary Prevention □ Seamless Continuum of Care □ Build Community Capacity □ Collaborative Governance |
| Program Description | <p>The Senior Wellness Program continues as 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 Well 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> |
| Community Benefit Category | <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 2017 Plan | |
| Program Goal / Anticipated Impact | <ul style="list-style-type: none"> • Monitor and manage hypertension and diabetes among seniors. • Prevent a medical crisis and hospitalization through early referral and self-management health education. • Improve health and wellness of seniors through supportive, safe healthy behavior programs. |
| Measurable Objective(s) With Indicator(s) | <ul style="list-style-type: none"> • 90% of program clients will NOT have a critical value on blood pressure screening. • 90% of program clients will NOT have a critical value on blood sugar screening. • Participants will display a 5 % increase in knowledge at health and disease management classes as demonstrated in pre and post-tests. • 75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the year. • Offer two Chronic Disease Self-Management Workshops. |
| Baseline / Needs Summary | <p>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.</p> |

| | |
|--|--|
| Intervention Actions For Achieving Goal | <ul style="list-style-type: none"> • Utilize 2016 Community Needs Assessment to plan, organize and coordinate • Increased outreach to DUHN communities. • Develop programs for clients to improve health knowledge/skills and behaviors to • Manage to improve their health and chronic illnesses. • Implement and evaluate effectiveness of senior wellness programs. |
| Planned Collaboration | <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> |

Heart Failure (HF) Program (CHAMP®)

| | |
|--|--|
| CNHA Significant Health Needs Areas Addressed | <ul style="list-style-type: none"> <input type="checkbox"/> Significant Health Need: Obesity & Overweight <input type="checkbox"/> Significant Health Need: Diabetes and Prediabetes <input checked="" type="checkbox"/> Significant Health Need: Cardiovascular Health <input type="checkbox"/> Significant Health Need: Cancers <input type="checkbox"/> Significant Health Need: Arthritis |
| Program Emphasis | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance |
| Program Description | <p>St. John’s Regional Medical Center & St. John’s Pleasant Valley Hospital are committed to give all persons with heart failure and their family members within our community the knowledge and support necessary to help them maintain the highest quality of life and reducing their risk of being readmitted to any hospital or emergency department. St John’s Hospitals identifies and recruits 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 and all emergency departments. In addition, the HF program participants are referred to the following free services and open to the public: Chronic Disease Self-Management Program, Diabetes Empowerment</p> |

| | |
|--|--|
| | Education Program, Hello Health, Living well with Diabetes Self-Management Program and other health educational classes and programs available based on the participant's needs. |
| Community Benefit Category | Community Health Improvement A1-a Community Health Education-Lectures/Workshops Health Education A1-c Community Health Education – Individual Health Education A1-d Community Health Education-Support Services A2-d Community Based Clinical Services- Immunizations/Screenings A1-e Community Health Education - Self-help E3- In Kind Donations: Free use of Facilities for Classes and Support Groups |
| FY 2017 Plan | |
| Measurable Objective(s) with Indicator(s) | <ul style="list-style-type: none"> • 98% of the participants enrolled in Heart Failure Program /CHAMP® will not be re-admitted to the hospital/ED within 90 days for CHF exacerbation. • 5% increase in participants during fiscal year • 85% of participants will be on ACE inhibitors or ARBs • 85% of participants will be on Beta Blockers |
| Intervention Actions for Achieving Goal | <ul style="list-style-type: none"> • Utilize the 2016 Community Health Needs Assessment to assess, plan, create interventions and evaluate interventions to decrease the impact of heart disease within our communities. • Engage local physicians to increase patient participants in CHAMP®. • Refer to CHAMP® all appropriate patients within our hospitals and within our community. • Enhance the telephone based monitoring program by offering Tele-Health electronic monitoring services to prevent hospital readmissions within 6 months of enrolling in the CHAMP® Program • Provide on-going education for staff and healthcare providers about the value of the HF Program. • Work with the Mercy Health & Vascular Institute to provided consistent telephone follow-up and education to all patients enrolled in CHAMP®. • Cardiovascular team will conduct regular meetings to identify strategies to increase program enrollment. • Identify HF program candidates and refer to the appropriate program level. • Provide discharge planning, Heart Failure sign and symptom management education, home health service evaluation and referral to the appropriate resources. • Refer and enroll patients to Living Well: Chronic Disease Self-Management Program • Refer and enroll patients to other health educational classes as appropriate. |
| Planned Collaboration | Local physicians, cardiologists, health care agencies, Navi-Health, community health and faith community nurses. |

Mobile Health Screenings and Immunization Health Program

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| 2CHNA Significant Health Needs Areas Addressed | <ul style="list-style-type: none"> ✓ Significant Health Need: Obesity & Overweight ✓ Significant Health Need: Diabetes and Prediabetes ✓ Significant Health Need: Cardiovascular Health ✓ Significant Health Need: Cancers ☐ Arthritis |
| Program Emphasis | <ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ☐ Seamless Continuum of Care ✓ Build Community Capacity ☐ Collaborative Governance |
| Program Description | <p>The St John’s Mobile Health Screenings and the Flu Vaccination Clinic is a portable program targeting children and adults in Ventura County targeting primarily the poor and underserved, the working poor with no insurance and the Latino population. The mobile unit targets locations in areas of greatest need as identified in the 2013 <i>Latino Community Health Needs Assessment</i>, are accessible to those least likely to receive health screenings and immunizations from mainstream health care including:</p> <ul style="list-style-type: none"> • Non-English proficient • Migrant/transient • Uninsured/under-insured • Limited transportation • Large families |
| Community Benefit Category | <p>A1-a Community Health Education-Group Health Education A1-b Community Health Education-Individual Health Education A1-d Community Health Education-Support Services A2-d Community Based Clinical Services- Immunizations/Screenings</p> |
| FY 2017 Plan | |
| Program Goal/Anticipated Impact | <ol style="list-style-type: none"> 1. Contribute to improvement of consumer healthcare literacy. 2. Empowerment of individuals to maintain their own health. 3. Educate re. access to healthcare 4. Influenza prevention for those without easy access to immunizations. |
| Measurable Objective(s) with Indicator(s) | <ol style="list-style-type: none"> 5. Increased by 5% the number of children and adults receiving free health screenings. 6. Increased by 5% the number of children and adults receiving immunizations. 7. Increased by 5% the number of community events, health fairs and immunization clinics. 8. Increased grant dollars secured for Mobile Health Screenings unit and Shots for Kids and Adults program. 9. Increased by 5% the number of persons getting health education |
| Intervention Actions for Achieving Goal | <ul style="list-style-type: none"> • Provide all CDC mandatory immunizations and catch up immunizations to those children under the age of 18 years of age free of charge. • Provide teenagers with HPV vaccine free of charge up to age 26 years of age. |

| | |
|------------------------------|--|
| | <ul style="list-style-type: none"> • Enroll participants in the immunization program, provide interventions and monitor their immunizations schedules for follow up visit and schedule compliance. • Provide individual health education with any immunization and health screenings exam. • Provide Community-based clinical services, such as health services and screenings for uninsured and underinsured persons. • Use health prevention activities designed to detect the early onset of illness and disease and can result in a referral to any community medical resource for abnormal screenings results based on participant’s ability to pay and within the geographic distance to participants to reduce barriers to access of health care. • Utilize the 2016 Community Health Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of interventions. • Increase immunization rates in targeted medically underserved areas. • Promote health education and healthy living in the communities served. • Educate adults and families about health insurance options. • Educate parents on advantages of finding a permanent medical practice for their children to maintain regular immunizations and regular medical, dental and vision health screenings. • Provide a clinical and educational opportunity for undergraduate/vocational nursing/medical students to advocate for social justice, health equity and human rights with special focus on mitigating health delivery barriers and improve the continuum of care while caring for women, children, adults and families, especially those living in poverty, and other vulnerable populations. • Educate health professionals on the importance of shared vision and collaboration to reduce health care disparities within our community while addressing root causes of health problems such as poverty, homelessness and environmental hazards. • Advance increased general knowledge • Improve access to affordable health care services • Enhance Population Health especially those at-risk populations such as underinsured and uninsured persons. • Increase the community’s capacity to promote the health and well-being of its residents by offering the expertise and resources of medical professionals in these health events. |
| Planned Collaboration | Local Physicians, Public Health, Community Health Care Agencies, Navi-Health, Community Health and Faith Community Nurses, Local Faith Communities, Schools, Health Care Providers |

| Diabetes Program (DEEP®) | |
|--|--|
| Significant Health Needs Addressed | <input type="checkbox"/> Significant Health Need: Obesity & Overweight <input type="checkbox"/> Significant Health Need: Access to Health Care <input checked="" type="checkbox"/> Significant Health Need: Diabetes and Prediabetes <input type="checkbox"/> Significant Health Need: Cardiovascular Health <input type="checkbox"/> Significant Health Need: Cancers <input type="checkbox"/> Significant Health Need: Social Determinants of Poor Health |
| Program Emphasis | <input type="checkbox"/> Focus on Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Emphasize Prevention <input type="checkbox"/> Contribute to a Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Demonstrate Collaboration |
| Program Description | A six session class to educate and empower those with diabetes or prediabetes so that they and their families can control their disease process to the extent that they arrest diabetes or prevent further deterioration of their health. |
| Community Benefit Category | A1-a Community Health Education – Lectures/Workshops A1-c Community Health Education – Individual Health Education A1-e Community Health Education - Self-help |
| FY 2017 Plan | |
| Program Goal / Anticipated Impact | Those that complete the classes will be empowered to control their diabetes and avoid unnecessary use of medical resources. |
| Measurable Objective(s) with Indicator(s) | Pre-test vs post-test of participants will show a 50% increase in knowledge. Class attendance erosion will be less than 80% |
| Intervention Actions for Achieving Goal | Offer at least 4 classes in English and 4 in Spanish Six session per class, attendees must complete 5 of 6 sessions Multi-media and hands on education with live Q& A tailored to each participant. |
| Planned Collaboration | One of the Bi-lingual Instructors is an nurse educator employee of Community Memorial Health System |

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

Sr. Amy Bayley RSM
Sister Sponsor

Laura McAvoy
Attorney

Gary Deutsch MD
Medical Director, Identity Medical Group

Henry Montes M.D.
Radiation Oncologist

Mary Fish
Retired, Director of Surgery Center

Sandy Nirenberg
Exec. Director, Camarillo Hospice

Joe Hernandez
President, JHC Benefits

Sr. Joan Marie O'Donnell RSM
Sister Sponsor

Stephen Huber
CEO, S.H. Huber and Associates

Michael Powers
Ventura County Executive Officer

Vance Kalcic M.D.
Chief of Staff

Billie Jo Rodriguez
St. John's Healthcare Foundation Chair

Ann Kelley M.D.
Oncologist / Hemotologist

Donald Skinner
Retired, President, Zebra Technologies

Tom Laubacher
Laubacher Insurance Agency

Carl Wesely, Community Board Chair
Chairman, Wesely Thomas Construction

Darren Lee
President & CEO of St. Johns Hospitals

George Yu M.D.
Pulmonologist

HEALTH COMMUNITIES COMMITTEE MEMBERS:

Carl Wesley, Chair

Joe Hernandez

Stephen Huber

Dr. Henry Montes

Sandy Nirenberg

Colleen Nevins, Community Member and Dir. CSUCI Nursing Program

Toni Ow, Community Member

Sergio Magdelano RN, Community Member

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

Through the **Dignity Health Community Grants Program** a \$75,000 grant was awarded a \$75,000 grant to an Accountable Care Community Collaboration **to address obesity** by providing education and counseling. Although goals were achieved in terms of the number of clients seen the quantifiable benefit cannot be determined.

The Cancer Center of Ventura County at St. John's is another ministry that cannot quantify its outcomes because its purpose is support. Support of those diagnosed with cancer, their families, survivors and those who have suffered a loss. The work of support in FY 16 was exceptional:

- Exercise Class contacts 778
- Cancer Information contacts 1,387
- Free mammograms & Ultrasounds 162
- Cancer nutrition Counseling contacts 1,035
- Cancer Nurse Navigator clients 379
- Relaxation Therapy contacts 690
- Support Group Counseling 1,090

This ministry provides valuable free services to those who are dealing with life threatening disease. And, though it may not have direct correlation to cancer survival, it does provide necessary support not otherwise available, offering hope and Humankindness®.

St. John's Hospitals offer opportunities for **health care profession education** to the following organizations/institutions:

- California State University Channel Islands (Nursing)
- Oxnard College (LVN training)
- Ventura College (Nursing & CNA)
- Center for Employment Training (medical assistant and front office)
- C.O.P.E Health Scholars (internships for those exploring careers in health)
- PathPoint Services (developmentally challenged citizens training)

These programs offer supervised exposure and training to potential future healthcare workers and those enrolled in a program that leads to a health career. The benefits to the community of providing more trained health care professionals (or in the case of PathPoint—an opportunity to learn a rewarding trade) is significant but cannot be quantified.

St. John's has an active **Ecology Program**. That program has improved recycling and reduced land-fill trash significantly. The program has also moved to install charging stations at both facilities and ensures that replacement equipment has a less of an environmental footprint. While these activities cannot be quantified they fulfill our responsibility to be a good steward of the environment and a good neighbor to our community.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.