Community Health Needs Assessment

St. John's Regional Medical Center

Oxnard, CA

Dignity Health.
St. John's Regional Medical Center

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Appendices

Acknowledgements

Conducting a Community Health Needs Assessment would not have been made possible without the help and cooperative efforts of various community organizations and members of Oxnard, CA.

Dignity Health, St. John's Regional Medical Center would like to give a special thanks to the following who took time to provide community insight or assistance with the survey collection process, data analysis, or technical input.

Executive Summary

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by St. John's Regional Medical Center. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California of Senate Bill 697) that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

St. John's Regional Medical Center serves all of Ventura County, and is located in Oxnard. Oxnard is a suburban community located in the west end of Ventura County comprised of significant agricultural and industrial subdivisions, commercial and recreational harbors, and an active Navy base with an air station. While SJRMC targets its attention to its primary service area (PSA), it does not exclude the needs of those residing elsewhere, following its commitment to raise the common good and improve the quality of life for our communities.

Conducted every three years, most recently in 2016, the Community Health Needs Assessment for St. John's Regional Medical Center took initial planning in 2015. St. John's Regional Medical Center and St. John's Pleasant Valley Hospital decided to conduct primary data simultaneously to help make determinations of health priorities that could be addressed county wide. Quantitative primary data was gathered through a health needs assessment survey tool with select questions from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey Questionnaire (BRFSS).

The survey tool consisted of 32 questions with 7 additional demographic questions, available both in Spanish and English, and was handed out to community members of Oxnard, CA. Using a convenience sampling method, surveys were disseminated through a time period of 2 months. A number of locations within Oxnard were contacted to request permission to distribute surveys.

In addition, input from persons representing the broad interests of the community was gathered through community networking meetings, stakeholder forums, and phone call interviews. Those representing the community consisted of members of various entities within Ventura County. Invitations were sent to public and private organizations specializing in health and human services to participate in a focus group at St. John's Regional Medical Center. Telephone interviews with civic leaders were also conducted to gather additional views and observations of health needs of the Oxnard community.

Through the CHNA process, a prioritized list of significant of significant health needs was identified during primary and secondary evaluation, including:

1. Obesity and Overweight
2. Access to Healthcare
3. Youth Health Education
4. Homeless Health Issues
5. Lack of Mental Health Resources
6. Diabetes and Pre-diabetes
7. Cardiovascular Health
8. Cancer

While potential resources are available to address the identified needs of the community, the needs are too significant for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local business leaders and other institutions.

The conclusions of this CHNA report were adopted by the St. John's Regional Medical Center community board in June, 2016. This report is widely available to the public on the hospital's web site, and a paper copy is available for inspection upon request at St. John's Regional Medical Center's Community Health Education Department. Written comments on this report can be submitted to the Community Health Education Department, 1600 N. Rose Ave, Oxnard, CA 93030 or by email stjohnshealthed@dignityhealth.org.

Assessment Purpose and Organizational Commitment

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Dignity Health's St. John's Regional Medical Center. In the past, St. John's Regional Medical Center developed community health needs assessment reports solely on secondary quantitative data to make decisions on how to best address the unmet health needs. This year, St. John's Regional Medical Center decided to conduct primary research, to include in their community health needs assessment report, in conjunction to secondary data.

The priorities identified in this report help guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California of Senate Bill 697) that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

Founded in 1912, the Sisters of Mercy, with community leaders' support, established St. John's Hospital near the coastal plain of Oxnard as a six-room wooden structure. Today, St. John's Regional Medical Center (SJRMC) is a 265-bed facility located on a 48-acre campus in northeast Oxnard. SJRMC serves a community that has a land use mix of residential, agricultural and industrial, including a large Navy base and a vacation harbor area.

Grounded in a longstanding commitment to deliver compassionate, high quality, and affordable health services, 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 and a Stroke Center, it is also serves as home to St. John's Cancer Center of Ventura County, St. John's Regional Spine Center, and St. John's Center Surgical Weight Loss Center. St. John's Hospitals have the only 24/7 Critical Care Intensivist Physician program in Ventura County.

St. John's Regional Medical Center continues the Sisters of Mercy heritage of healing and community service in the Catholic social tradition. SJRMC 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.

Our Mission

Rooted in Dignity Health's mission, vision, and values, St. John's Regional Medical Center is 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 expectation through teamwork and innovation.

Community Definition

St. John's Regional Medical Center serves communities within Ventura County, and has a defined primary service area (PSA) including Oxnard (93030, 93033), El Rio CDP (93036), Channel Islands CDP (93035), and Port Hueneme City (93041). The PSA for SJRMC is comprised approximately of 27% of the population of Ventura County. Dignity Health St. John's Regional Medical Center, therefore defines the community served as those individuals residing within its hospital service area and does not exclude low income or underserved populations.

The city of Oxnard is 26.2 square miles, and is located with the shore of the Pacific Ocean as its southwesterly border. Oxnard, California is the largest city within the Oxnard Plain in Ventura County. The Oxnard Plain, Ventura County, California is a historically agricultural area with an expanding population and is still a home to a two billion dollar agricultural industry.

The population of Oxnard City grew from 197,899 in 2000 to 205,437in 2014. The majority of the population best describe themselves as Hispanics. A little over half of residents report being a high school graduate. 16.0% of residents report living below poverty level and quarter report not having health insurance.

El Rio, located on the northeast side of Oxnard, has a population estimate of over 7,000, with a majority of the population being Hispanic. In El Rio, 20.9% of residents live below poverty level and 34.0% report not having health insurance. Port Hueneme City has a population of over 22,000, with a majority of Hispanics residing here. Similarly to Oxnard City, 22.8% of Port Hueneme residents report not having health insurance and 18.3% live below poverty level. Appendix A provides a detailed population summary.

The demographics of a community significantly impact its health profile. Different ethnic, age, and socioeconomic groups may have unique needs and take varied approaches to health.

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

Based on the Community Need Index, Oxnard, in zip codes 93030, 93033, 93035, and 93036, has a median score of 4.2. Showing the highest need include zip codes 93030, 93033, and 93041. The following Figure 1 depicts the CNI scores for SJRMC service area.

Figure 1. *Community Needs Index*

Zip Code	CNI Score	Population	City	County	State
93030	4.2	63073	Oxnard	Ventura	California
93033	4.4	83515	Oxnard	Ventura	California
93035	3.6	28337	Oxnard	Ventura	California
93036	3.8	44017	Oxnard	Ventura	California
93041	4.4	24194	Port Hueneme	Ventura	California
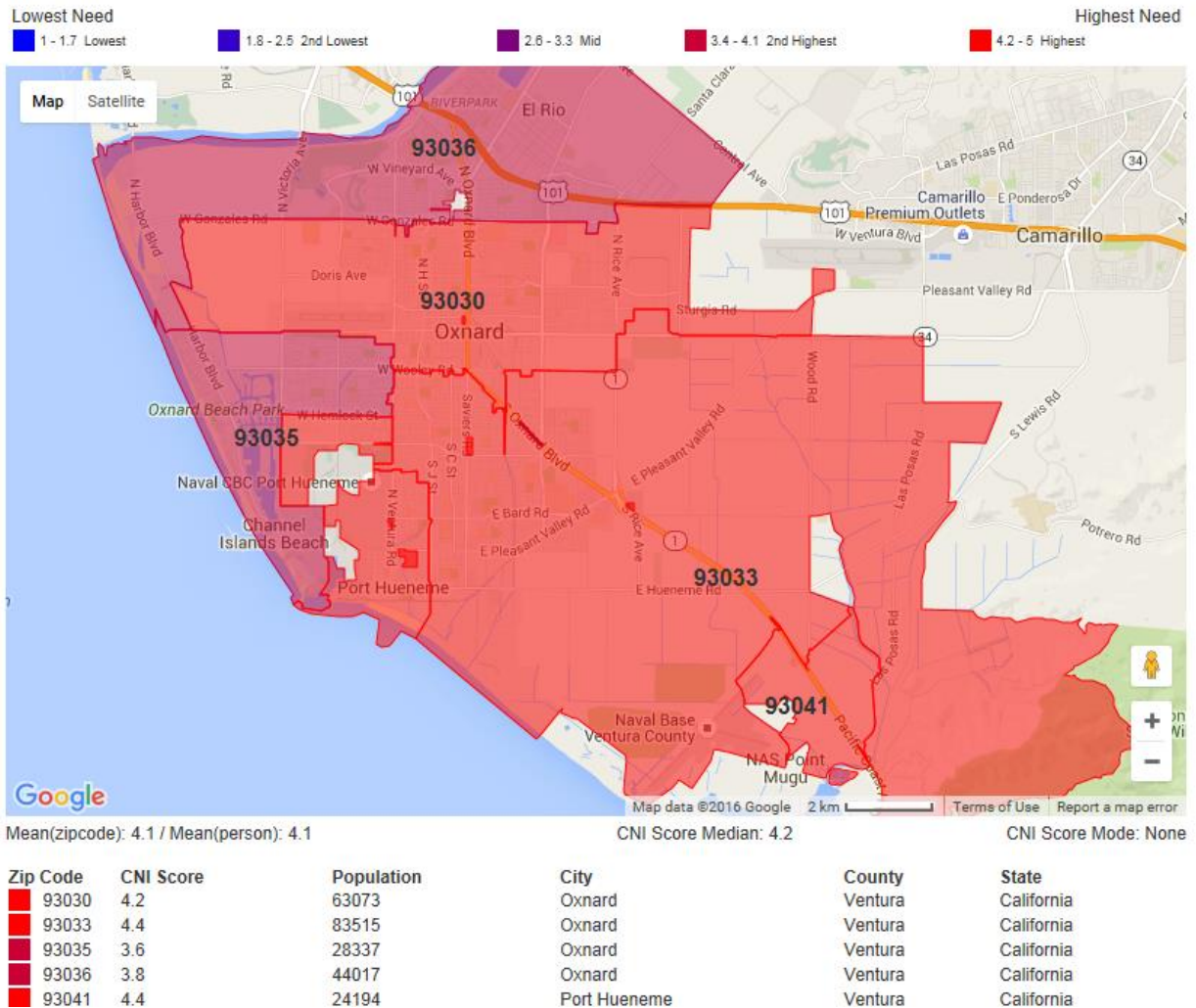
Assessment Process and Methods

The CHNA 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. A community health needs survey, key stakeholder focus groups, community leader interviews, and secondary data including U.S. Census and well established state and county wide public health information was collected and synthesized for this report.

Primary Data Sources

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.

Health Behavior Survey and Analysis

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). This survey was piloted in the 2014 Latino Community Health Needs Assessment (available on the Dignity Health webpage). The final survey consisted of 32 questions with 7 additional demographic questions. The survey included questions on health status; health related quality of life, health care access, and both chronic and non-chronic health conditions (i.e. hypertension, diabetes, cholesterol, cancer diagnoses, women and men's health, and more). A copy of the survey can be found in Appendix B.

The survey collection used a convenience sampling approach where locations were selected to best represent the Oxnard community, including churches, senior centers, low income housing, and farmers markets (locations found in Appendix C). Prior to collecting surveys, permission was requested from an individual of decision making authority. The survey was made available both in Spanish and English. Participants were given a brief explanation: completing the survey was voluntary and anonymous; it did not ask for their name, address, or telephone number and that results from the survey would help SJRMC better understand the community needs and types of services to offer or increase in the community. It was also stated to them that the survey would take approximately five minutes of their time and could be self-completed or if

they needed assistance a St. John's employee or volunteer would conduct a one on one interview. To secure confidentiality, surveys were placed in a sealed box or envelope.

Based on the population of Oxnard City, it was determined at least 384 surveys would indicate a representative sample. Between January 5, 2016 and March 31, 2016, a total of 806 surveys were collected.

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 SPSS (Version 21.0). Surveys omitted were those where age was not provided and or were not at least 70% complete or the participant did not reside or adjacent to SJRMC primary service area.

Survey responses were analyzed using descriptive statistics such as frequencies, percentages, means, modes, and cross tabulations. Survey responses were analyzed as compared to various independent variables, including place of residence, educational attainment, race/origin, and age.

Community Stakeholder Focus Group and Key Informant Interviews

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, Oxnard Police Department, Port Hueneme City Council 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 Oxnard community.

The community 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 (found in Appendix G) on the services provided and top health needs in Ventura County. A nominal group process was then used to identify the top perceived health needs within the community. They were also asked the following questions:

1) What are our communities' strengths and what is working well?
2) What are our challenges and weaknesses as a community? and
3) What challenges may we face, and how can we overcome these obstacles?

Key informant interviews took place in the month of May 2016 and were asked the same questions, in addition to what they perceived as the top health needs in the community.

Community Leader Interviewees

> Ventura County Public Health Department Director, Rigoberto Vargas

> Oxnard Police Department Chief, Jeri Williams

> Port Hueneme City Councilman, Jim Hensley

Notes were taken during the focus group and interviews to capture the bulk of the conversation. Interview notes were then condensed and summarized. A summary of community focus groups attendees and interview notes can be found in Appendix D-F.

Written Comments Received about SJRMC's June 2013 CHNA

There were no known written comments received on the previous CHNA and Implementation Strategy prepared and adopted in June 2013.

Secondary Sources

Questions in the health behavior survey were based upon the Centers for Disease Control and Prevention BRFSS, which is a secondary data source. A secondary data source is best described as information that has been collected by others, is typically readily available and is inexpensive to obtain. Many times secondary data covers a population from a larger geographic area than the area being analyzed, such as state and national level data. While secondary data has typically been validated, it may have been collected prior to actual publishing.

This 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. The assembled data, information,

and analyses provide a comprehensive identification and description of significant community needs.

St. John's Regional Medical Center did not contract with outside consultants or organizations for the 2016 CHNA. However, a renewed, county wide, interest arose in joint assessment activity, and a closer collaboration will be evaluated for the 2019 CHNA with Ventura County Public Health, Community Memorial Hospital, Kaiser Permanente, and Simi Valley and Moorpark.

Assessment Data and Findings

This Community Health Needs Assessment was initiated and serves the purpose of identifying and responding to the health needs of the Oxnard community. The primary data source for this CHNA was a community health survey designed to gain a perspective of each individual's social determinants as well as their health behavior and health conditions. The community health survey questions have been categorized and will be presented based upon similar indicators of health and compared to secondary data sources, as well as Healthy People 2020 found in Appendix H. In addition, qualitative data collected during stakeholder interviews will be included.

The community health survey results to each question for SJRMC are provided in Appendix B.

Survey Participants

Demographics

During the period of January 5 to March 31, 2016, 806 participants between the ages of 18 and 93 completed the health behavior survey. Over half (n= 489; 60.7%) of surveys were completed in Spanish.

Figure 2. *Health Survey Participants' Place of Residence*
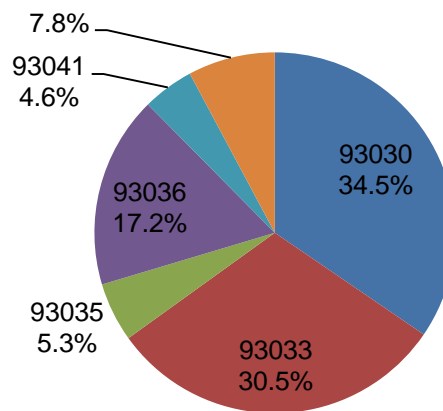
A breakout of survey participants' place of residence is displayed in Figure 2. Those residing in "other" include persons who reported living outside of SJRMC's primary service area.

Of the respondents, 65.6% were female (n=491) and 34.4% were male (n=257). Over half of the respondents were over the age of 46 (n=431; 53.4%), 36.5% were between the ages of 26 to 45 (n=156) and a smaller percentage represented those between the ages 18 to 25 (n=78; 9.7%). The average age is 49.

When survey participants were asked about their race or origin, more than half identified themselves as Hispanic (n=550; 68.7%), 6.2% identified themselves as Indigenous Indian (from Oaxaca or Guerrero) (n=50), followed by smaller percentage of those

identifying as Asian, Caucasian, American Indian or Alaska Native, Pacific Islander, Black or African American.

Educational attainment varied among race and ethnic groups. Over half of participants reported achieving only a high school diploma (n=495; 62.3%) and only 12.6% (n=101) of respondents reported attaining a bachelor's degree or higher. Hispanics, including persons from Oaxaca and Guerrero, had higher percentages of lower levels of education, while Caucasians and Asian's received more than a high school diploma. Table 2 provides an overview of education compared with race and ethnicity.

Figure 3. *Educational Attainment by Ethnic Group*
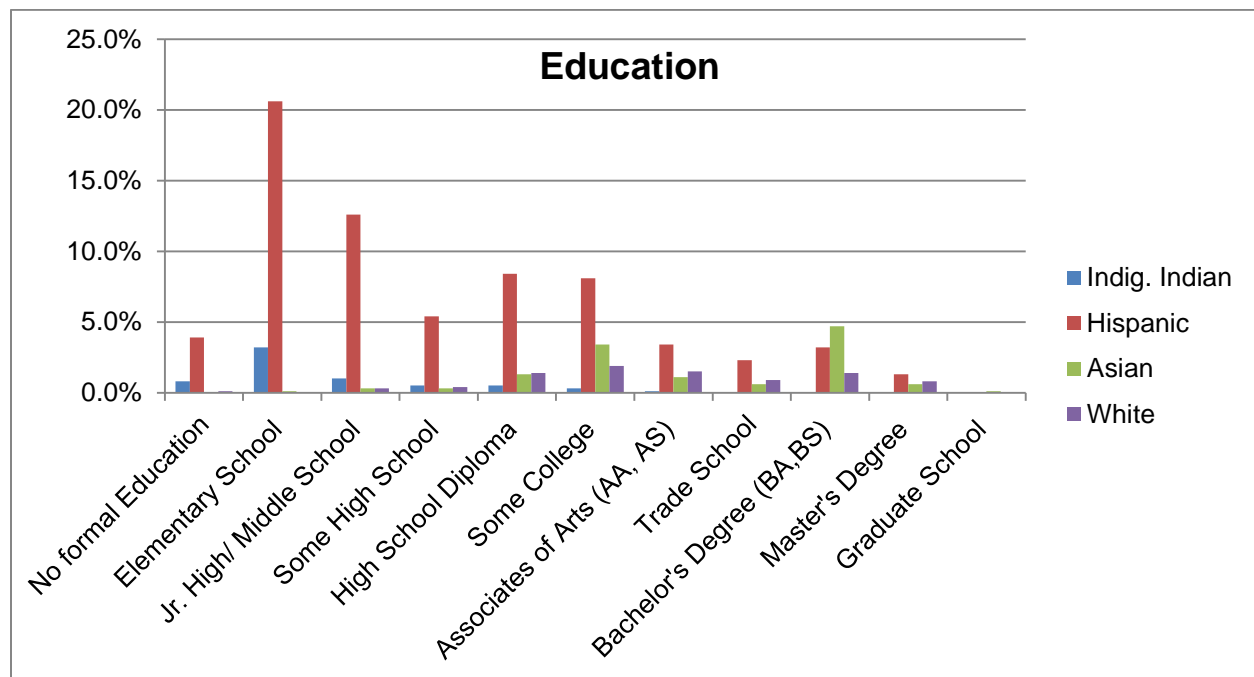
Close to half of Oxnard participants reported being employed (n=312; 41.3%). The most commonly reported employment type amongst Hispanics (including those from Oaxaca and Guerrero) was agriculture (27.7%; n=59). Homemakers was reported most among Hispanic women (n=109; 14.5%) and the retiree group varied amongst Hispanics (9.2%; n=69), Asians (6.8%; n=51), and Caucasians (4.4%; n=33). Several students reported that while attending school full time, also held a job, such as in customer service, teacher's aide, and babysitting.

To further understand health survey participant's household status, they were asked the number of children and number of adults in the household. Of those participants who have at least one child in the household, an average of 4 children (n=434) was reported. Similarly, the average number reported of adults in a household were 5 (n=796).

When asked about safety, overall, Oxnard residents, respond to feeling often safe or always safe (n=617; 81.6%). According to the 2015, State of the Region Report by the Ventura County Community Foundation, a safer community may be due to more police and better policing methods on the street.

Health Related Quality of Life

The communities health related quality of life was measured and compared to state and national levels.

Nearly 70% (n=555) of survey participants rated their health as good, very good, or excellent. However, there were still 30.5% (n=243) of those responding to their overall health as poor or fair.

Figure 4. *Health Related Quality of Life*

Community Health Benchmark		CDC BRFSS, 2014	
	SJRMC (N=798)	CA Rate	US Rate
Poor	4.8%	4.6%	4.3%
Fair	25.7%	13.5%	12.1%
	30.5%	**18.1%**	**16.4%**

In comparison to state and national levels, the percentage of those responding to fair and poor overall health is higher in Oxnard residents. Rating their health as very good or excellent is also far lower than the CDC's BRFSS state and national level. Although quality of life can have a different meaning to everyone, health related quality of life encompasses aspects that include physical, mental health, emotional, and social functioning.

To further understand the community's health related quality of life, survey participants were asked how many days in the past 30 days was their mental health not good (which included stress, depression, and problems with emotions), of those responding at least one day, the average number of days was 12.

As mentioned, mental health is essential to a person's well-being and their ability to live a healthful and productive life. When mental health is at risk, it can also have a serious impact on physical health and effects on chronic disease such as diabetes, heart disease, and cancer.

Access to Health Care

While access to comprehensive health care is important for the achievement of health equity and for increasing the quality of a healthy life for everyone, disparities in access to health services affect individuals and society. Although, efforts are continually made

to help more people access affordable, quality health care, limitations to health care access can greatly impact people's ability to reach their full potential, negatively affecting their quality of life.

When survey participants were asked about their health insurance status, 76% (n=599) reported having some kind of health insurance (including Affordable Care Act and restricted or emergency health insurance), however, still nearly a quarter of survey participants are without any form of health insurance (n=189; 24.0%). The percentage of persons without health insurance is 10 percentage points above CDC's 2014 BRFSS state and national level.

Figure 5. *Access to Health Insurance*

Community Benchmark		CDC BRFSS, 2014	
	SJRMC (N=788)	CA Rate	US Rate
Health Insurance Coverage (of any kind)	76.0%	85.2%	87.6%
No Health Insurance	24.0%	14.8%	12.5%

Among survey participants, Hispanics working in agriculture and homemakers, who also report lower levels of education, compared to all other ethnic groups and employment status, report the highest percentage of no health insurance. Additionally, the most common age groups without health insurance are those between the ages of 26 to 45.

Figure 6 & 7. *Ethnic and Age Groups without Health Insurance*
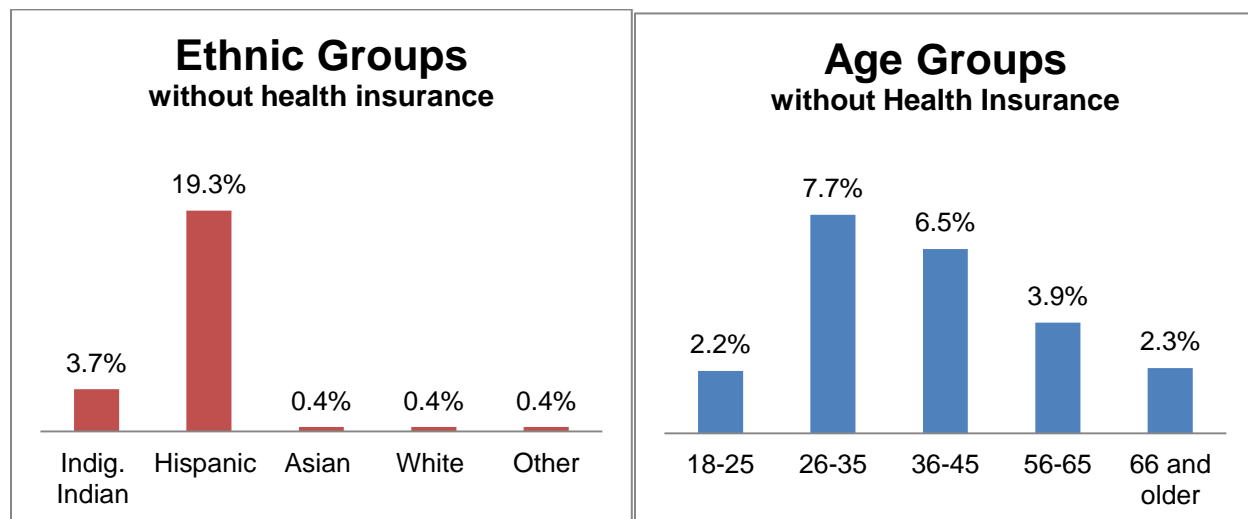
A person's inability to access health services has a complex effect on every aspect of a person's health. People without medical health insurance are likely to lack a source of

medical care, such as a primary care physician, and skip routine medical care due to the cost, making them susceptible to serious and disabling health conditions.

Survey participants were also asked how long it has been since they last visited a doctor for a routine checkup and dentist or dental clinic. Despite the majority of respondents having yearly routine checkups, a lesser amount of dental visits is reported compared to that of a doctor visit. Table 8 represents this difference.

Figure 8. *Comparison of Doctor Visits and Dental Visits*
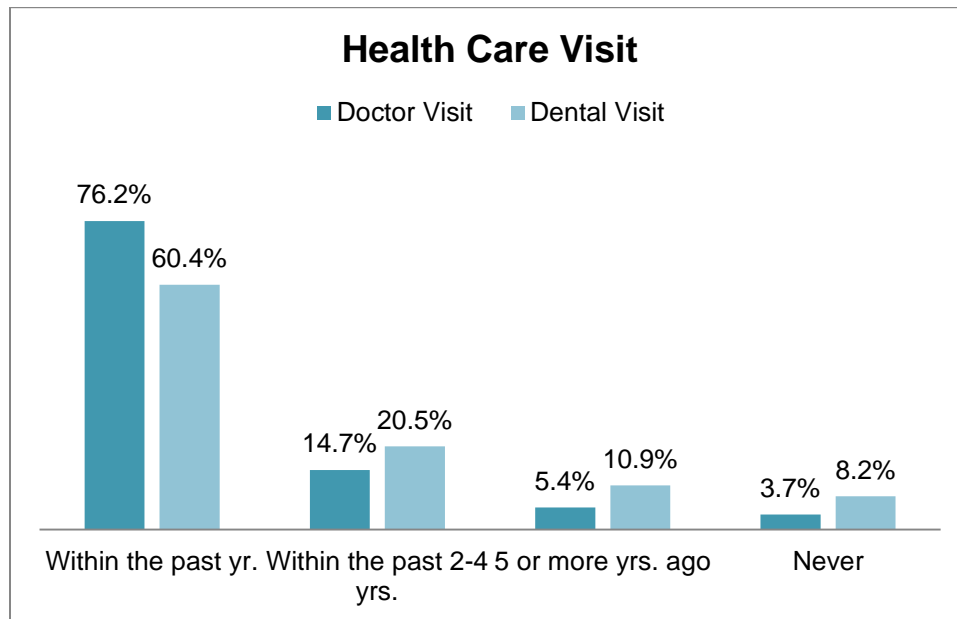
When people do finally access health care services, they may often be troubled with extensive medical bills and out of pocket expenses. Participants were asked if there was a time in the last 12 months when they needed to see a doctor but could not because of the cost, almost one fourth of respondents said 'yes' -they were not able to see a doctor (n=177; 22.5%), exceeding the CDC's BRFSS state and national levels.

In addition to medical cost, extensive medical bills, or out of pocket expenses participants may be troubled with, 34.9%% (n= 184) of participants reported delaying medical care because they had to wait too long for an appointment, they had a work conflict, or they had no way of getting to the doctor. All these reasons in delaying medical care make a person more susceptible to visit the emergency room (ER). Of those who responded at least one time (n=145), the average number of visits to the ER, in the last 12 months, was 5 times.

Making the Healthy People 2020 goal (100% of people with health insurance) is imperative. Increasing access to both routine medical care and medical insurance can

help our community by preventing disease and disability, detect and treat illness and health conditions early, and increase the quality of life of our residents.

Cancer Screening

Cancer, being the second leading cause of death, has major impact in the United States. By the end of 2016, it is estimated that over one million new cases of cancer will be diagnosed and nearly half will die from the disease. Cancer affects both men and women of all ages, races, and ethnicities.

Participants in the Oxnard community were asked if they had ever had a cancer diagnosis, 7.8% said yes (n=61). Among the most common cancer types reported by participants, breast, skin, prostate, uterine, colon, cervical, and lung were most noted.

According to the American Cancer Society, breast cancer is the second leading cause of death in women. About 1 in 8 women in the United States develop invasive breast cancer during their lifetime. Overall, approximately all female survey participants received the age appropriate breast cancer screening within the past two year (n=177; 82.3%).

Cervical cancer, in the past, was one of the most common causes of cancer death for American women, but over the years the death rate has decreased by the increased use of the Pap tests. In Oxnard City, however, 71.6% (n=333) of women over the age of 21 reported having a pap test in the past 3 years, leaving a little over a quarter who have not.

Prostate cancer is one of the leading causes of cancer death among men of all races. Among Oxnard men over the age of 40, only 54.7% reported being screened for prostate cancer. Similarly, only 59.5% of survey respondents over the age of 50 stated having had a colonoscopy. Although, deaths from colorectal cancer have decreased with the use of colonoscopies, prostate cancer screening and colonoscopies have lower percentages than the above cancer screenings.

Cardiovascular Health

Heart disease and stroke are among the top five leading causes of death and most costly health problems in the United States. Heart disease and stroke can cause severe illness and disability and decreased quality of life. However, they are also among the most preventable conditions.

Among survey participants, females had a higher percentage than men of having had a stroke, inversely to more males having had a heart attack than their female

counterparts. Heart attack and stroke was most frequently reported among Hispanics and Caucasians above the age of 46.

Figure 9. *Difference in heart attack and stroke by gender*
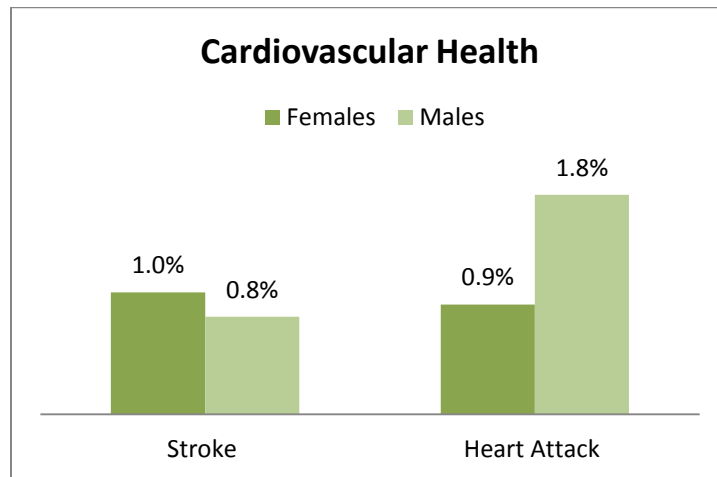
Some of the leading and modifiable risk factors of heart disease and stroke include high blood pressure, high cholesterol, and cigarette smoking. In Oxnard, when asked about smoking, 10.9% (n=84) of survey respondents stated someone in the household smoked. Although the survey question pertained to anyone in the household, second hand smoke also increases the risk of heart attack and stroke in non-smokers.

High blood pressure and or high cholesterol can also increase the chance of developing heart disease and heart attack. Among survey respondents, percentage rates in cardiovascular health including high blood pressure and high cholesterol are higher than or almost as high as state and national levels compared to that of the CDC's BRFSS.

Figure 10. *Heart Attack and Stroke Indicators*

Community Benchmark		CDC BRFSS, 2014	
	SJRMC	CA Rate	US Rate
High Blood Pressure (n=256)			
	32.8%	28.7%	31.4%
High Cholesterol (n=254)			
	32.6%	37.7%	38.4%

Disparities in cardiovascular health can vary. Both high blood pressure and high cholesterol was more prevalent among females over the age of 46. In Oxnard, Hispanics were among the highest who reported having high blood pressure and high cholesterol followed by Asians and Caucasians.

Figure 11. *Heart Attack and Stroke Indicators among Ethnic Groups*
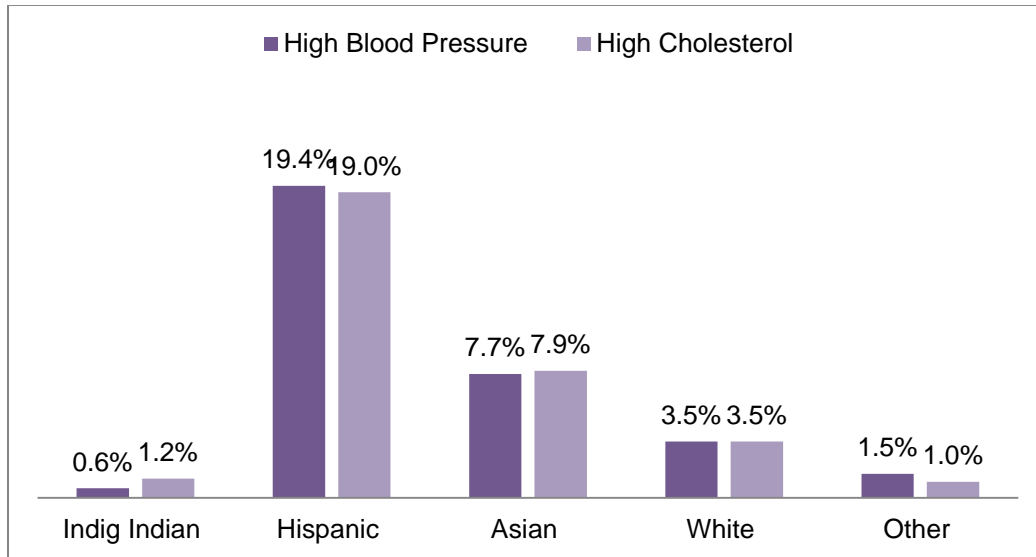
Amongst those with high blood pressure, 14.8% (n=37) reporting not having any form of health insurance. Equally to 14.8% (n=37) of respondents with high cholesterol reported not having form of health insurance.

The risk of developing cardiovascular disease could be reduced with improvements were made in the control of high blood pressure and cholesterol and diet and physical activity.

Chronic Disease

Along with high blood pressure and high cholesterol, diet and physical inactivity are significant contributors to chronic conditions.

Diabetes, for example, was the seventh leading cause of death in the United States in 2010. Currently 29.1 million (9.3%) of the U.S. population have diabetes.

Pre-diabetes affects approximately 86 million American adults and 9 out of 10 people with prediabetes do not know they have it.

Survey participants were asked if they had been ever told by a doctor that they have diabetes. Figure 12 demonstrates the diabetes percentage of Oxnard residents compared to that of CDC's BRFSS.

Figure 12. *Percent of Individuals with Diabetes*

Community Benchmark		CDC BRFSS, 2014	
	SJRMC (n=777)	CA Rate	US Rate
Diabetes (n=140)	18.0%	10.3%	10.0%
Pre Diabetes or Borderline diabetes (n=41)	5.3%	2.6%	1.3%

More females (n=92; 12.7%) than males (n=35; 4.8%) reported having diabetes; Hispanics (n=93; 12%) had higher percentages than Asians (n=25; 3.2%) and Caucasians (n=11; 1.4%). Most were above the age of 46 (n=120; 15.5%).

While 74.9% (n=582) reported not having diabetes, it is uncertain if participants are underreporting, do not know they have diabetes, or do not have the adequate resources to access health care. It is estimated that 8.1 million (27.8%) of people with diabetes in the United States are undiagnosed. That means about 1 out of 4 people do not know they have diabetes.

In addition to the higher rate of diabetes than that of state and national levels (CDC's BRFSS), 5.3% (n=41) report having borderline or prediabetes. Prediabetes is treatable, but without intervention, it is likely to develop into type 2 diabetes within 10 years.

Modifiable Risk Factors

The risk of death for adults with diabetes is 50% higher than for adults without diabetes. Medical costs are also twice as high. Despite the impactful effects of diabetes; diabetes and other chronic conditions; however, may be prevented by healthful eating and regular physical activity.

Body Mass Index (BMI)

Being overweight or obese increases the risk of many diseases and health conditions including heart disease, type 2 diabetes, cancer, hypertension, and more. In Ventura County, reducing the 25.3% rate of adults with obesity to 21.6% has not been met. More specifically, participants from Oxnard were asked to report their height and weight to then calculate their BMI. The table below shows that, in fact, almost three fourths of participants are overweight and obese.

Figure 13. *Percent of Individuals with High BMI Scores*

Community Benchmark		CDC BRFSS

	SJRMC	CA Rate	US Rate
Overweight (n=248)	38.2%	35.0%	25.4%
Obese (n=196)	30.2%	24.7%	29.6%
High BMI - Total	**68.4%**	**59.7%**	**55.0%**

Hispanics, including those from Oaxaca and Guerrero, (n=345; 53.3%), among other ethnic groups reported BMIs exceeding the normal range. Adults aged 26-35 had the second highest percentage of a high BMI. Figure 14 depicts age groups with a high BMI.

Figure 14. *Age Groups with High BMI Scores*
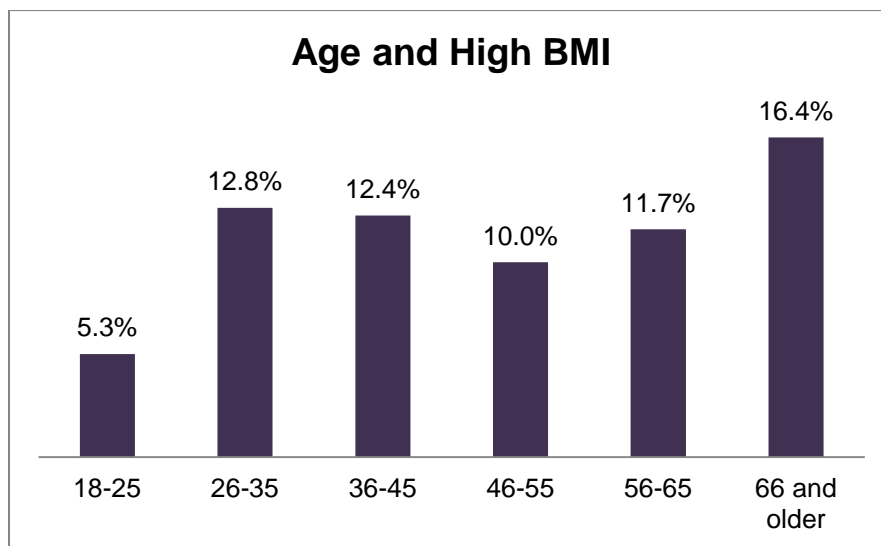
Physical Activity

66.0% (n=518) of survey respondents reported participating in physical activity or exercises, such as walking, running, or any other fitness activity at least three times a week. 32.1% (n=252) however, reported no physical activity. The benefits of physical activity are incredible; from controlling your weight, decreasing your risk of chronic diseases, and even some cancers, to improving your mental health and increasing your chances of living longer. 5.8% (n=44) of participants with diabetes, also report they do not participate in any form of physical activity.

Furthermore, 14.6% (n=92) of persons with diabetes and 24.0% (n=152) of those with high blood pressure and high cholesterol have a high BMI. Figure 15 however, shows those who report they do not have diabetes, high blood pressure, or high cholesterol, but have high BMI scores.

Figure 15. *High BMI but no reported Chronic Condition*

No Chronic Condition but High BMI

48.2%
38.2%
41.3%

No Diabetes   No HBP   No High Cholesterol
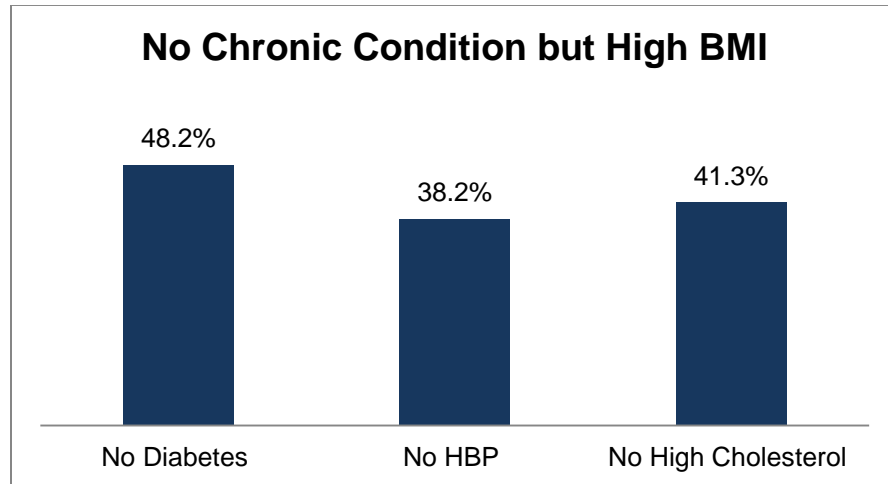
A high BMI score puts individuals at risk of developing diabetes, high blood pressure or high cholesterol. It is also possible that individuals may be undiagnosed, at borderline, and or unaware that they may and can potentially suffer from a chronic condition.

Healthful Eating

When asked about healthful eating, participants reported an average of 2 servings of fruit; equally to 2 servings of vegetables per day. Still there were 40 participants who stated eating 0 fruits a day and 48 participants eating 0 vegetables. An average of 9 sugary drinks or soda per week was reported amongst participants.

Eating a diet rich in vegetable and fruits, like physical activity, may reduce the risk of a number of chronic conditions.

Other Chronic Conditions

Figure 16, represents other chronic conditions reported from Oxnard residents.

Figure 16. *Other Chronic Conditions*
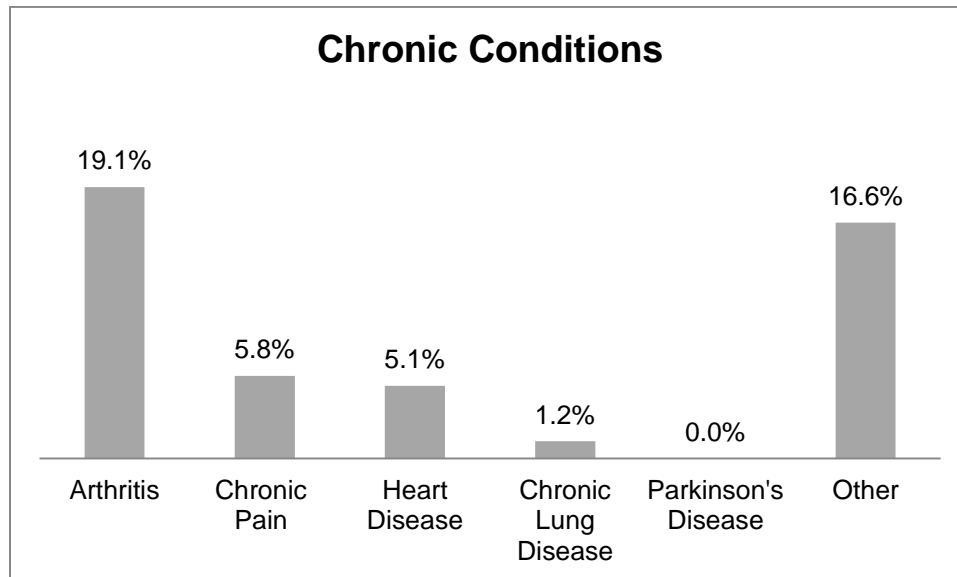
Among these, arthritis, chronic pain and heart disease were most often reported. "Other" had a high percentage of 16.6% (n=134). Asthma, anxiety, back pain, glaucoma, migraines, osteoporosis, depression and fibromyalgia were among other chronic conditions reported.

More females, than males report arthritis, chronic pain, and heart disease. Arthritis and chronic pain hinders an individuals' ability to work, activities of daily living, thus affecting their overall quality of life. Oxnard residents are nearly reaching that of the state level as compared to CDC's BRFSS.

Figure 17. *Percent of Individuals with Arthritis*

Community Benchmark	SJRMC	CDC BRFSS	
Arthritis (n=154)	19.1%	CA Rate	US Rate
		20.4%	26.0%

Increasing health awareness plays an important role in preventing disease, improving health, and enhancing quality of life. Oxnard residents stated they access community

health related resources, such as health and wellness programs, support groups, etc., mostly through friends and family (n=503; 71.6%) and the radio (n= 65; 9.2%). Some mentioned their doctor, their children's school, church, and their workplace.

Prioritized Description of Significant Community Health Needs

As a result of a comprehensive community needs review, St. John's Hospitals' Community Wellness Team, in collaboration with the Dignity Health Ventura County Community Board's Healthy Communities Committee, has established a tiered approach to prioritize identified community health needs as follows:

Tier I community needs are those that are:

- the <u>most urgent</u> and
- <u>not being addressed due to a lack of community resources</u> to address the need.

Tier II community needs are

- <u>less urgent</u> but that are
- <u>not being fully addressed</u> by existing community resources.

Tier III community needs are

- <u>entrenched or somewhat permanent</u> challenges to good health and
- <u>somewhat adequately addressed</u>/met by existing community resources.

Tier IV community needs

- <u>being adequately addressed</u> by existing community resources.

The identified Community Health Needs are prioritized in this tier approach as follows:

Figure 18. *Prioritized Description of Significant Health Needs*

TIER I
Obesity & Overweight (especially re. a lack of health lifestyle education)
68.4% of participants are either overweight or obese   32.1% of participants report no physical inactivity   - Precursor to chronic conditions   - Recommended fruit and vegetable intake not met
Access to Healthcare (especially education re. available resources like insurance)
- Nearly a quarter (24.0%) of participants do not have health insurance   - Hispanics and middle age are without health insurance   22.5% of participants could not see a doctor because of the cost   - In contrast to doctor visits, dental visits are reported less frequently   8.2% of participants have never been to the dentist
Homeless Health Issues
- As of 2015, there were 1,417 adults and children who were homeless   - The cities of Oxnard and Ventura account for two thirds (66.1%) of the homeless population
Lack of Mental Health Resources (especially Spanish language)
- Identified by key stakeholder gatherings   - Known lack of providers in Ventura County   - Known lack of resources in the community
TIER II
Diabetes & Prediabetes
18.0% of participants have diabetes and 5.3% have prediabetes
Cardiovascular Health
32.8% have high blood pressure- percent is higher than the CDC's BRFSS CA rate   32.6% have high blood cholesterol
Cancers
- More than quarter (28.4%) of females have not received the age appropriate cervical cancer screening   - Almost half (40.5%) of survey respondents over the age 50 have not received colonoscopies   - Nearly half (45.3%) of males over the age 40 have not been screened for prostate cancer
TIER III
Social determinants of poor health (poverty, environment, etc.)
20.9% of El Rio residents are living below poverty level   - Lower levels of Education among Hispanic population
TIER IV (none identified)

Resources Potentially Available to Address Needs

While resources are available to address the needs of the community, the needs are too significant for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and institutions. Ventura County is home to a wealth of organizations, businesses, and nonprofits including our own St. John's Regional Medical Center, and the following:

Boy and Girls Club of Greater Oxnard and Port Hueneme

Cal Fresh

Cal Works

Catholic Charities

Clinicas Del Camino Real

El Concilio Family Learning Centers

El Consulado Mexicano

FoodShare, Inc.

Gold Coast Health Plan

Homeless Prevention and Rapid ReHousing Program (HPRP)

Interface Children and Family Services – 211 Ventura County Helpline

Oxnard Senior Centers (various locations)

Ventura County Behavioral Health

Ventura County Public Health

SJRMC will continue to build community capacity by strengthening partnerships among various, local community-based organizations.

Impact of Actions Taken Since the Preceding CHNA

Primary care for the poor and marginalized is a leading focus of Dignity Health. Dignity Health shares a commitment to improve the health of our community and delivers programs and services to achieve those goals. Since the preceding 2013 CHNA several improvements in health behaviors, health outcomes, resources and services have been made.

In efforts to address lack of financial resources and chronic conditions of the Oxnard community, Dignity Health St. John's Regional Medical Center, increased collaboration, mobile health fairs and immunizations and health education.

Health Ministries

Through increased collaboration and generosity of local businesses, the activities in the Health Ministries program provide basic needs support to over 7,000 individuals a year. The food pantry who serves clientele with incomes no higher than 138% of federal poverty guidelines, distributes food and hot meals during the entire year to help meet basic needs of those with low income. Clothing donations, gifts through the Adopt a Family and community referrals to local agencies, bus passes, and financial assistance were also provided to county residents.

Community Building

To further create and promote collaboration, Dignity Health SJRMC and SJPVH, convenes a monthly "Ventura County Networking Meeting." Members of the Ventura County Networking share county wide efforts to address the needs of the vulnerable. Presentations on the health needs of residents are highly encouraged and welcomed. During the year a number of presentations where held on Senior Concerns, Food Share, Ventura County Behavioral Health, Dignity Health Community Grants, Ventura County Child Support Division and Alzheimer's Association, and others.

Health Fairs and Immunizations

Our mobile health fairs reach the Latino population and the working poor with no health insurance. Through the mobile health fairs we are able to provide free healthcare services; such as screenings in blood sugar, blood pressure, anemia, waist circumference as well as offer preventative health education to low income and underinsured children and adults.

To improve school readiness for children, through prevention, vaccinations, and early interventions, proposed to improve the immunization rates for children, and in addition to adults.

Health Education Programs

In conjunction with health screenings, preventative and self-management education is offered. Community members are invited to participate in programs like the Adult Diabetes and Education and Support Group, Chronic Disease Self- Management Program, Hello Health: Living Well with Diabetes, and free A1C screenings. Almost all programs, with the exception of the diabetes support group, are offered both in Spanish and English and free of charge.

Heart Failure (CHAMP) Program

As part of our commitment to give persons with heart failure and their family members 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, we offer a heart failure program. The comprehensive program offers consistent telephone follow-up and education and when applicable or necessary home health follow-up, cardiac rehab.

Senior Wellness

Our senior wellness program aims to provide seniors with tools to improve their health and wellness. The Energizer's Walking program, and senior wellness screenings at various senior center locations, are programs that benefit our senior population. The services offered are bilingual and free to the community.

Appendix A: US Census Data

	City of Oxnard (93030, 93033, 93035)	El Rio, CDP (93036)	City of Port Hueneme (93041)
Population			
Total Population Estimate, 2014	205,437	7,198	22,139
Population under 5 years, 2010	8.9%	8.7%	8.6%
Population under 18 years, 2010	29.8%	30.0%	26.6%
Population 65 and over, 2010	8.3%	9.2%	11.0%
Race and Ethnicity			
Hispanic or Latino alone, 2010	73.5%	86.0%	52.3%
White alone, not Hispanic or Latino, 2010	14.9%	11.3%	33.6%
Asian alone, 2010	7.4%	1.0%	6.0%
Black or African American, alone, 2010	2.9%	0.8%	5.1%
American Indian or Alaska Native alone, 2010	1.5%	2.8%	1.4%
Native Hawaiian and Other Pacific Islander, 2010	0.3%	0.3%	0.5%
Education			
High School Graduate, 2010-2014	64.7%	57.3%	76.8%
Poverty			
Below Poverty Level	16.0%	20.9%	18.3%
Without Health Insurance	25.8%	34.0%	22.8%

* All estimates are sourced from the U.S. Census Bureau's American Community Survey unless otherwise indicated.

Appendix B: Community Health Survey & Results (N=806)

Please circle or place a "√" with your answer for each question.

1. **My age is _____ years.** *Average age: 49 years (n=806)*

Age Groups

18-25	(n=78; 9.7%)	46-55	(n=105; 13.0%)
26-35	(n=156; 19.4%)	56-65	(n=126; 15.6%)
36-45	(n=141; 17.5%)	66 and above	(n=200; 24.8%)

2. **What is your zip code?** *(n=796; did not answer=10)*

Oxnard: *(n=275; 34.5%)* **93030** *(n=243; 30.5%)* **93033** *(n=42; 5.3%)* **93035** *(n= 137; 17.2%)* **93036** *(n=37; 4.6%)* **93041** *(n=62; 7.8%)* **Other**

3. **I am:** *(n=257; 34.4%)* **Male** *(n=491; 65.6%)* **Female** *(n=748; did not answer=58)*

4. **What is the highest grade or year of school you completed?** *(n=796; did not answer=10)*

(n=41; 5.2%) No formal education (n=116; 14.6%) Some College
(n=191; 24.0%)Elementary School (n=52; 6.5%) Associate of Arts Degree (AA, AS)
(n=116; 14.6%) Junior High/Middle School (n=32; 4.0%) Trade School (i.e. mechanic, etc.)
(n=54; 6.8%) Some High School (n=76; 9.5%) Bachelor's Degree (BA, BS)
(n=93; 11.7%) High School Diploma (n=24; 3.0%) Master's Degree (Graduate School)
(n=1; .1%) Doctorate Degree (PhD)

5. **How many children under the age of 18 live in your house?** *(n=781; did not answer=21)*

Of those answering at least one child, the average is 4. (n=434)

(347 participants responded 0 children under age 18 living in household).

6. **And how many adults live in your house?** (n=796; did not answer=10)

Average 5

7. **What do you consider as your race or origin?** *(Please mark with a "√".)*

(n=50; 6.2%) Indigenous Indian (Oaxaca or Guerrero)
(n=550; 68.7%) Hispanic or Latino(a)
(n=104; 13.0%) Asian (n=68; 8.5%) White

(n=29; 3.6%)   *Other (American Indian or Alaska Native, Native Hawaiian or Other Pacific Island, Black or African American, Other)*

Wellness

1. **In general how would you rate your health?** *(n=798; did not answer=8)*

   (n=38; 4.8%)   Poor   *(n=113; 14.2%)*   Very Good

   (n= 205; 25.7%) Fair   *(n=45; 5.6%)*   Excellent

   (n=397; 49.7%) Good

2. **Do you currently suffer from any chronic diseases listed below.**

   (n=154; 19.1%) Arthritis   *(n=10; 1.2%)* Chronic Lung Disease
   (n=41; 5.1%)   Heart Disease   *(n=47; 5.8%)* Chronic Pain
   (n=0; 0.0%)   Parkinson's Disease   *(n=134; 16.6%)* Other

Other condition reported: Asthma, anxiety, back pains, glaucoma, migraines, osteoporosis, kidney problems, anemia, depression, fibromyalgia, and others.

3. **Do you currently participate in any physical activities or exercises at least three times a week? For example, walking, running, or any other physical fitness activity.** *(n=785; did not answer=21)*

(n=518; 66.0%) **Yes**   *(n=252; 32.1%)* **No**   *(n=15; 1.9%)* **Don't know/Not sure**

4. **How many servings of fruit do you eat each day? _____ servings**
   (n=782; did not answer=24)

                  Average 2

   40 participants responded eating 0 vegetables per day.

5. **How many servings of vegetables do you eat each day? _____ servings**
   (n=774; did not answer=32)
                  Average 2

48 participants responded eating 0 vegetables per day.

6. **How many cans of soda or other sugary drinks do you drink per week? _____**
   (n=725; did not respond=81)

Of those responding at least one drink, the average amount of soda or other sugary drinks per week is 9 (n=685)

(40 participants responded drinking 0 cans of soda or sugary drinks per week).

Health Care Access

7. **Do you have any kind of health insurance?** *(n=788; did not respond=18)*

   (n=508; 64.5%)   *Yes (Private, Medical, Medicare)*
   (n=48; 6.1%)   *Yes, Affordable Care Act (Obama Care)*
   (n=43; 5.5%)   *Yes, but only emergency, restricted, or pregnancy restricted Medi-Cal.*

(n=189; 24.0%) No

8. **How long has it been since you last visited a doctor for a routine checkup?**
(n=790; did not answer=16)

(n=602; 76.2%) Within the past year   *(n=43; 5.4%)* 5 or more years ago
(n=116; 14.7%)   Within the past 2-4 years   *(n=29; 3.7%)* Never

9. **In the last 12 months, how many times did you go to an emergency room to get care for yourself?** _____ *(n=729; did not answer=77)*

Of those responding at least one time, the average number of emergency room visits is 5 (n=145).

(584 participants responded 0 visits to the emergency room in the past 12 months.)

10. **How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to a dental specialist, such as an orthodontist.** *(n=796; did not answer=10)*

(n=481; 60.4%) Within the past year   *(n=87; 10.9%)* 5 or more years ago
(n=163; 20.5%) Within the past 2-4 years   *(n=65; 8.2%)*   Never

11. **Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?** *(n=788; did not answer=18)*

(n=572; 72.6%)   **No**   *(n=22; 2.8%)* **Deductible was too high**

(n=177; 22.5%)   **Yes**   *(n=17; 2.2%)* **Don't know/Not sure**

12. **Besides cost, were there other reasons you could not see a doctor during the past 12 months?** *(n=527; did not answer=279)*

(n=99; 18.8%)   You had to wait too long for an appointment
(n=54; 10.2%)   You had to work
(n=31; 5.9%)   You had no way to get there
(n=343; 65.1%)   I did not delay getting medical care or did not need medical care

13. **How do you typically find community health resources? (health and wellness programs, support groups, etc.)** *(n=703; did not answer=103)*

(n=503; 71.6%) Friends/Family   *(n=35; 5.0%)*   TV
(n=39; 5.5%)   Newspaper   *(n=61; 8.7%)*   Internet
(n=65; 9.2%)   Radio

Health Conditions

14. Have you ever suffered from a

Stroke   *(n=761; did not answer=45)*

(n=744; 97.8%) **No**   *(n=14; 1.8%)* **Yes**   *(n=3; .4%)* **Don't Know/ Not Sure**

Heart attack *(n=751; did not answer=55)*

(n=724; 96.4%) **No**   *(n=20; 2.7%)* **Yes**   *(n=7; .9%)* **Don't Know/ Not Sure**

15. **Have you ever been told by a doctor or other health professional that you have high blood pressure?** *(n=780; did not answer=26)*

(n=256; 32.8%)   Yes   *(n=37; 4.7%)* Yes, borderline high
(n=21; 2.7%) Yes, only during pregnancy (female)   *(n=466; 59.7%)* No

     a. **If yes, do you currently take medicine to control your high blood pressure?** *(n=323; did not answer=483)*

(n=169; 52.3%) **Yes**   (n=152; 47.1%) **No**   (n=2; 0.6%) **Don't know/Not sure**

16. **Have you ever been told by a doctor that you have diabetes?** *(n=777; did not answer=29)*

(n=140; 18.0%)   Yes   (n=41; 5.3%)   Prediabetes
(n=14; 1.8%) Yes, only during pregnancy (female)   (n=582; 74.9%) No

     b. **If yes, do you take medicine to control your diabetes?** *(n=246, did not answer=560)*

(n=104; 42.3%) **Yes**   (n=140; 56.9%) **No**   (n=2; 0.8%) **Don't know/Not sure**

17. **Have you ever been told by a doctor or other health professional that you have high cholesterol?** *(n=779; did not answer=27)*

(n=254; 32.6%) **Yes**   (n=493; 63.3%) **No**   (n=32; 4.1%) **Don't know/Not sure**

     c. **If yes, do you currently take medicine to control your high cholesterol?** *(n=362; did not answer=444)*

(n=154; 42.5%) **Yes**   (n=203; 56.1%) **No**   (n=5; 1.4%) **Don't know/Not sure**

18. **Have you ever had a cancer diagnosis?** *(n=779; did not answer=27)*

(n=61; 7.8%) **Yes**   (n=715; 91.8%) **No**   (n=3; .4%) **Don't know/Not sure**

     d. ***If yes, what type (breast, skin, lung, etc.)?*** _____
        Cancer Types: Breast (20), skin (11), prostate (5), uterus (4), colon (2), cervical (1), lung (1), and others.

19. **How many different medications do you take on a daily basis? (including vitamins, over the counter medicines, and prescription medications)** *(n=628; did not answer=178)*

Of those responding at least one medication, vitamin, or over the counter drug, average number of medication is 9.

208 participants responded taking 0 medications, vitamin, or over the counter drugs.

 (n=34; 4.3%) _____ **Check "√" here if you don't know or are not sure.** *(n=806)*

20. **Have you ever told your loved ones what they should do, if you were not able to make your own medical decisions?** *(n=772; did not answer=34)*

(n=299; 38.7%) **Yes**   *(n=466; 60.4%)* **No**   *(n=7; .9%)*   **Don't know/Not sure**

21. **A colonoscopy is when a tube is inserted in the rectum to view the bowel for signs of cancer and other health problems. Have you ever had this exam?**

    Participants > 50 year. *(n=373)*

(n=222; 59.5%) **Yes**   *(n=147; 39.4%)* **No**   *(n=4; 1.1%)* **Don't Know/ Not Sure**

Women's Health

22. **For women, a Pap test is a test for cancer of the cervix. Have you had a Pap test during the past three years?**

    Women over the age of 21 who have had a pap test *(n=465)*

(n=333; 71.6%) **Yes**   *(n=125, 26.8%)* **No**   *(n=7, 1.5%)* **Don't Know/Not Sure**

23. **A mammogram is an x-ray of each breast to look for breast cancer. Have you had a mammogram?**

    Women over the age of 40 who have had a mammogram *(n=300)*

(n=269; 89.7%) **Yes**   *(n=29; 9.7%)* **No**   *(n=2; 0.6%)* **Don't Know/ Not Sure**

      e. **If yes, when was your last mammogram?** _____ **yr(s) ago.** *(n=215)*

(n=177; 82.3%) 1-2 years   (n=13; 6.0%)   5-10 years

(n=23; 10.7%)   3-4 years   (n=2; .9%)   11 or more years

Men's Health

24. **For men, a prostate cancer screening can be done through a blood test (called PSA test) or a digital rectal exam. Have you ever been screened for prostate cancer?**

    Men over the age of 40 who have had a PSA test   *(n=161)*

(n=88; 54.7%) **Yes**   *(n=66; 41.0%)* **No**   *(n=7; 4.3%)* **Don't Know/ Not Sure**

Other Topics

25. ***Are you currently….?***   *(n=756; did not answer=50)*

(n=312; 41.3%) Employed   *(n=166; 22.0%)* Retired

(n=49; 6.5%) Full Time Student   *(n=45; 6.0%)* Unemployed

(n=4; .5%) Active Military   *(n=15; 2.0%)* Unable to work

(n=136; 18.0%) Homemaker   *(n=29; 3.8%)* Disabled

There were 19 respondents who were employed whilst being a student.

Employment Type *(n=213; did not answer=593)*

*(n=60; 28.2%)*Agriculture   *(n=57; 26.8%)* Customer Service

(n=3; 1.4%)   Management   *(n=42; 19.7%)* Professional

(n=16; 7.5%) Education   *(n=3; 1.4%)* Self-Employed

(n=26; 12.2%) Health Care   *(n=6; 2.8%)* Volunteer

26. **Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the last 30 days was your mental health <u>not good</u>?** _____ **days** *(n=502; did not answer=304)*

Of those responding at least one day, average number of days when mental health was not good is 12 days (n=188)

314 respondents said they had had 0 days were there mental health was not good.

   (n=100; 12.4%) **_____ Check "√" here if you don't know or are not sure.** (n=806)

27. **Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?** *(n=745; did not answer=61)*

(n=55; 7.4%) **Yes**   *(n=681; 91.4%)* **No**   *(n=9; 1.2%)* **Don't know/Not sure**

28. **Are you the caretaker of any adult other than yourself?** *(n=757; did not answer=49)*

(n=89; 11.8%) **Yes**   *(n=667; 88.1%)* **No**   *(n=1; .1%)* **Don't know/Not sure**

29. My **height** is _____   My **weight** is _____ lbs.
(n=649; did not answer=157)

(n=11; 1.7%)   **Underweight**   *(n=248; 38.2%)*   **Overweight**

(n=194; 29.9%)   **Normal**   *(n=196; 30.2%)*   **Obese**

30. **In the past 30 days, did you ever consume more than 5 alcoholic drinks for a man or 4 drinks for a woman at one time?** *(n=772; did not answer=34)*

(n=90; 11.7%) **Yes**   *(n=676; 87.6%)* **No**   *(n=6; .8%)* **Don't know/Not sure**

31. **Does anyone in your household smoke? (i.e. tobacco products, e-cigarettes, etc.)** *(n=774; did not answer=32)*

(n=84; 10.9%) **Yes**   *(n=685; 88.5%)* **No**   *(n=5; 0.6%)* **Don't know/Not sure**

32. **How safe do you feel in your current living situation?** *(n=756; did not answer=50)*

(n=12; 1.6%) **Never Safe**   *(n=26; 3.4%)* **Rarely Safe**   *(n=101; 13.4%)* **Sometimes Safe**

         (n=145; 19.2%) **Often Safe**   *(n=472; 62.4%)* **Always Safe**

THANK YOU FOR COMPLETING THE SURVEY!

Dignity Health Employee or Volunteer

Interviewer _____   Location _____

Sub ID _____   Data Input Y N   By _____

Appendix C: Community Health Survey Collection Locations

Casa Merced

Center for Employment and Training

Downtown Oxnard Plaza Park

Faith Community Nurse Network

Francis Huggins Community Health Clinic

Mary Star of the Sea Parish

Our Lady of Guadalupe Parish

Oxnard College Community Market

Oxnard Housing Authority

Palm Vista Senior Center

RCIA Group OLG Parish

Rio Mesa High School

Rio Plaza Elementary School

Santa Clara Chapel

South Oxnard Senior Center

St. John's Regional Medical Center Food Pantry

St. Mary Magdalen

Tri Counties Regional Center – Foster Grandparent Program

Villa Madera

Walking Program - Boy and Girls Club of Greater Oxnard and Port Hueneme

Wilson Senior Center

Appendix D: Summary of Community Leader Interviews

The following provides a summary of community leader discussion regarding their perspective of the community they represent and its strengths and weaknesses/needs.

Ventura County Public Health Department Director, Rigoberto Vargas
May 18, 2016

Ventura County Public Health (VCPH) Director, Rigoberto Vargas, identified not two but three top health needs the county is faced with. Cancer, being number one, is still among the top two leading causes of death with a number of them being preventable. Diabetes in Ventura County ranks among the top ten leading causes of death and many times is underreported. Although obesity may be tapering off, it is still very high. It's not a cause of death but it is a risk factor for diabetes and heart disease. Vargas states that healthy foods are not affordable to all. Oxnard has lower income and higher poverty rates that make it difficult for families to meet basic needs.

There are still a number of uninsured individuals. Those who are insured are not utilizing all the services offered because they may not be aware of their insurance plan coverage. VCPH's Director, recommends we continue to work with individuals to navigate and educate them through their health insurance plans as well prevention services and mental health.

In order to overcome some of these challenges, Vargas states we continue to collaborate, form partnerships and be proactive in addressing the core root causes of health and that we promote educational attainment resources, economic development housing and poverty, because they all affect health.

Oxnard Police Department, Chief Jeri Williams
May 2, 2016

Chief Williams, of the Oxnard Police Department, feels that as a society we are not doing the best to address mental health and substance abuse. Kids are running to something, they're looking for acceptance and a need to belong. Marijuana, either medicinal or recreational, impacts the brain development of the youth. She states that the community needs to be educated on the effects of marijuana and the high levels of THC levels in comparison to years before.

Chief Williams also points out high blood pressure, diabetes, and obesity. Lack of access and affordability to healthy foods and farmer's market forces our youth and parents to by unhealthy foods; causing a wide range of illnesses. She encourages healthy foods to be made affordable and accessible but also fun for the youth. Using animated characters and public service announcements on the radio can help reach

children. Public outreach is far better than it used to be, however, she would like to see that we honor time spent outdoors.

Williams further says that we cannot do everything on our own, it's nice when entities come together to offer community events in which we promote wellness.

Port Hueneme City Councilman, Jim Hensley
April 26, 2016

Jim Hensley feels one of the greatest concerns facing the community is water supply. Water drives agriculture and people are not being educated on how to save our water supply. He expresses that the Oxnard community would benefit from a swimming pool to teach children and seniors swimming lessons and this in turn would help keep the youth active. He further expresses the need to improve the built environment and the need to repair Oxnard's pathways and alleys. Lastly, Hensley states, collaboration with El Concilio, Oxnard City Parks and Recreation, and Dignity Health can bring education to children and adults and increase community awareness.

Appendix E: Stakeholder Forum Organization Attendees

Stakeholder Forum

May 3, 2016

Representation from:

Alzheimer's Association

Boys and Girls Club of Greater Oxnard and Port Hueneme

California Lutheran University

California Rural Legal Assistance

Camarillo Health Care District

Child Health and Disability Prevention (CHDP)

Community Action of Ventura County

Consulado de México- Ventanilla De Salud

El Centrito Family Learning Centers

FOOD Share, Inc.

Gold Coast Health Plan

Human Services Agency

Human Services Agency- HSA

Livingston Memorial Visiting Nurse Association and Hospice

Oasis Catholic Charities

Project Access

Turning Point Foundation

Ventura County Medical Resource Foundation

Ventura County Public Health

Ventura Health Care Agency

Appendix F: Community Stakeholder Focus Group Summary

May 3, 2016

What are our communities' strengths or what is working well today?

- Education on diabetes in the community
- Gold Coast and other organizations have done a good job in enrolling individuals to educational and preventative services
- Ventura County Public Health has great collaboration with other organizations to decrease STD's and HIV rates

What are our challenges and weaknesses?

- Access to care- *s*ome people cannot afford care.
- Poor families cannot afford ACA health insurance plan or the deductibles.
- Availability to affordable healthy foods; when people cannot afford healthy foods they purchase fast foods.
- There are a huge number of baby boomers coming into ages of chronic illnesses like dementia and other cognitive losses.
- Training is needed in ER for patients with dementia and their caregiver
- Transportation to health appointments in Ventura County - people may have to take 2-3 buses, long waits to see a doctor, doctors sometimes send patients to ER or urgent care.
- Lack of physician appointments especially for urgent care
- Difficulty in getting an urgent appointment during the weekend
- Quality bilingual care, especially for Mestizo community
- Need for safe parks
- There is a lack of mental health providers - Mental health problems are increasing in the community. Some mental health policies prevent people from getting mental health services for free.
- Caregiver burnout - anxiety, loss of sleep, getting ill themselves

How do we overcome these challenges?

- Funding to address issues that are surfacing
- Collaboration
- Communication
- Cooperation
- Competition can destroys this
- Need for healthy communities and coalitions and self-sustainable programs
- Support for families with members with disabilities like Autism, etc.

Appendix G: Stakeholder Survey and Summary

1. In general, how would you rate the overall quality of the healthcare delivered to your communities?

	Poor	Fair	Good	Very Good	Excellent	Don't Know
Ambulance Care						
Child Care						
Chiropractor						
Dentists						
Emergency Room						
Eye Doctor/ Optometrists						
Family Planning Services						
Home Health						
Hospice						
Inpatient Services						
Mental Health Services						
Nursing Home/ SNF						
Outpatient Services						
Pharmacy						
Primary Care						
Specialist Physician Care						
Clinic Urgent/ Care						
Public Health Departments						
School Nurse						

2. In your opinion, what are the top health needs in Ventura County?

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
Access to Care					
Affordable Health Insurance					
Cancer					
Diabetes					
Drugs/Alcohol					
HIV/AIDS					
Heart Disease					
Mental Disorders					
Obesity					
Respiratory Disease					
Sexually Transmitted Diseases					
Stroke					
Suicide					

Stakeholder Survey Summary

Each participant offered their top three needs from the survey above, although all had different views on the top three health needs facing the community, needs that emerged most frequently related to affordability and access to health insurance, diabetes and prediabetes along with obesity, mental health in reference to the lack of mental health providers, dental care, and drugs and alcohol.

Other needs that surfaced were eye care and prescription for glasses, decreasing long wait times for a scheduled appointment, access to available substance abuse detox and inpatient programs and resources for the homeless.

Table 19. *Ratings of services in Ventura County*
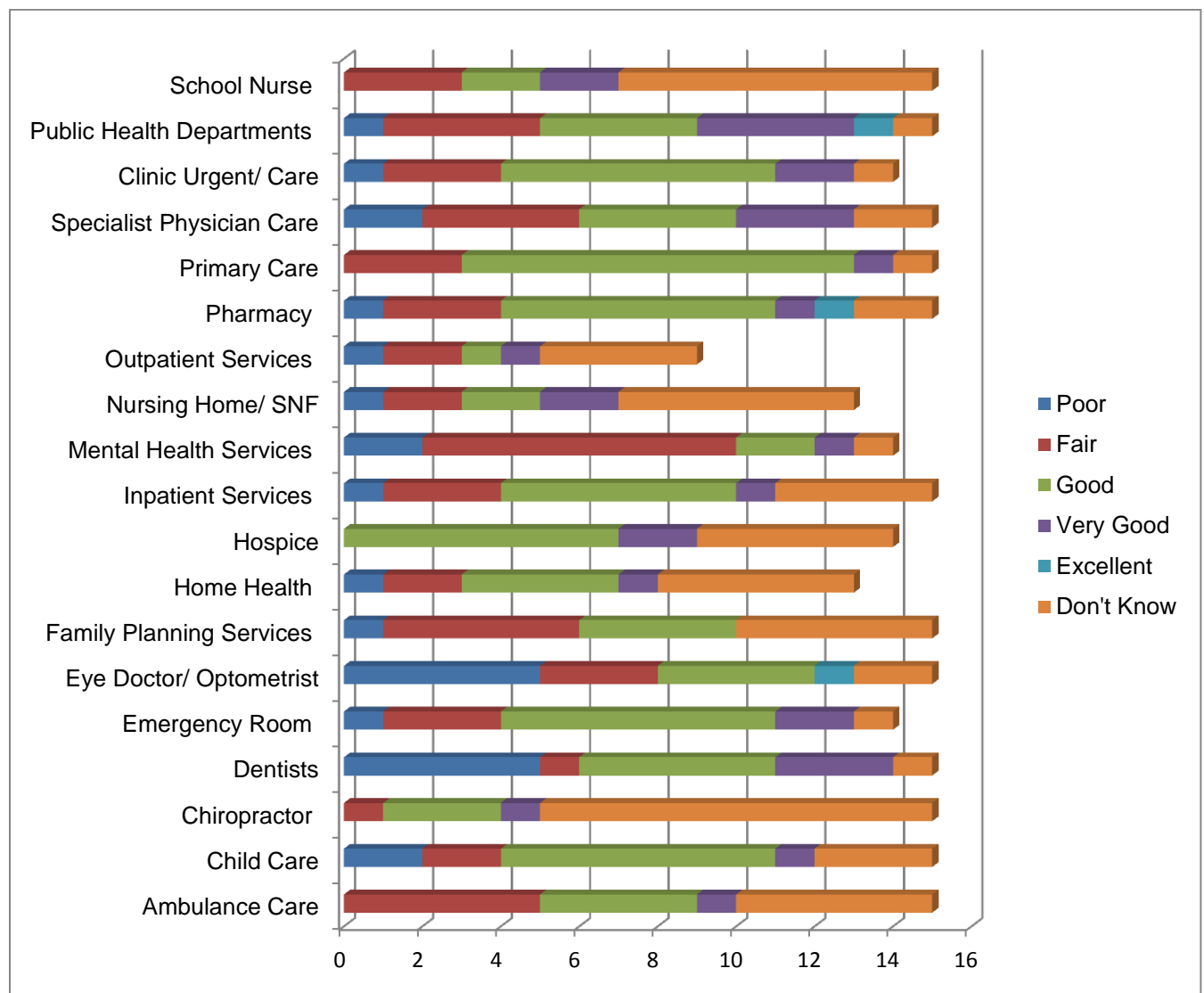
Appendix H: Healthy People 2020 Comparison

Healthy People (HP) 2020 Objective	Met (✓) Unmet (✗)	HP 2020 Target	HP 2020 Baseline	SJRMC (n=806)	CDC BRFSS, 2014	
					CA Rate	US Rate
Access to Health Care						
AHS-1.1 Increase the proportion of people with medical insurance	✗	100%	83.2%	76.0%	85.2%	87.6%
AHS-6.2 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care	✗	4.2%	4.7%	22.5%	13.5%	13.1%
OH-7 Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year	✓	49.0%	44.5%	60.4%	65.1%	65.3%
Cancer Screening						
C-17 Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines	✓	81.1%	73.7%	82.3%	77.3%	73.0%
C-15 Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines	✗	84.5%	93.0%	71.6%	75.2%	75.2%
C-16 Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines	✗	70.5%	52.1%	59.5%	66.6%	69.3%
Cardiovascular Health						
HDS-5.1 Reduce the proportion of adults with hypertension	✗	26.9%	29.9%	32.8%	28.7%	31.4%
HDS-7 Reduce the proportion of adults with high blood cholesterol levels	✗	13.5%	13.5%	32.5%	37.7%	38.4%
Diabetes						
D-1 Reduce the annual number of new cases of diagnosed diabetes in the population	✗	7.2%	8.0%	18.0%	10.3%	10.0%
Weight Status						
NWS-8 Increase the proportion of adults who are at a healthy weight	✗	33.9%	30.8%	29.9%	37.7%	33.4%
NWS-9 Reduce the proportion of adults who are obese	✓	30.5%	33.9%	30.2%	24.7%	29.6%
General Health Status (above or below state or national level compared to CDC BRFSS, 2014)						
Experience Fair or Poor Overall Health	> ✗	----	----	30.5%	18.1%	16.4%
Health Indicators						
Heart Attack	< ✓	----	----	2.7%	3.5%	4.4%
Stroke	< ✓	----	----	1.8%	2.7%	3.0%
Prediabetes	> ✗	----	----	5.3%	2.6%	1.3%
Overweight	> ✗	----	----	38.2%	35.0%	25.4%
Arthritis	< ✓	----	----	19.1%	20.4%	26.0%

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