Marian Regional Medical Center

Community Benefit 2018 Report and 2019 Plan
A message from

Sue Andersen, President and CEO of Marian Regional Medical Center, and Kevin G. Walthers, PhD, Chair of the Dignity Health Marian Regional Medical Center Community Board of Directors.

Dignity Health’s approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Marian Regional Medical Center shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2018 (FY18), Marian Regional Medical Center provided $30,505,409 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $44,236,977 in unreimbursed costs of caring for patients covered by Medicare.

Marian Regional Medical Center’s Community Board reviewed, approved, and adopted the Community Benefit 2018 Report and 2019 Plan at its meeting duly held on November 14, 2018.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 805-739-3593.

Sue Andersen
President & CEO
Marian Regional Medical Center

Kevin G. Walthers, PhD
Chair, Hospital Community Board of Directors
Marian Regional Medical Center
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## At-a-Glance Summary

| Community Served | Marian Regional Medical Center’s Santa Maria (MRMC-SM) campus serves communities within the Santa Maria Valley, and has a defined primary service area which includes the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434) and Nipomo (93444). MRMC-SM has a secondary service area extending into Buellton (93427), Lompoc (93436 & 93437), Los Alamos (93440), Los Olivos (93441), and Santa Ynez (93460). Marian Regional Medical Center’s Arroyo Grande (MRMC-AG) campus primary service area extends from the northern most boundary of the Santa Maria service area and includes Arroyo Grande (93420), Grover Beach (93433), Nipomo (93444), Oceano (93445), and Pismo Beach (93449). |
| Economic Value of Community Benefit | $30,505,409 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $44,236,977 in unreimbursed costs of caring for patients covered by Medicare |
| Significant Community Health Needs Being Addressed | The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital’s most recent Community Health Needs Assessment (CHNA). Those needs are: Education, Access to Mental Health, Homelessness/Housing, Cardiovascular Disease and Stroke, Cancer Screenings |
| FY18 Actions to Address Needs | In FY18, Marian Regional Medical Center’s Santa Maria and Arroyo Grande campuses took numerous actions to help address identified needs. These included: Cancer Prevention and Screening; Care Transitions for discharged patients with heart disease, pneumonia, and chronic obstructive pulmonary disease; Cardiovascular Disease and Stroke lectures and screenings; Diabetes Prevention and Self-Management; chronic disease self-management workshops; osteoporosis screening; balance and fall prevention; access to Pacific Central Coast Health Centers; planning a continuum of care of perinatal mood and anxiety disorders; and Dignity Health Community Grants which provided $176,000 in funding to Accountable Care Communities that addressed Education, Homelessness/Housing and Mental Health. |
| Planned Actions for FY19 | For FY19, the hospital plans to increase the number of chronic disease and diabetes self-management workshops offered; pilot the Healthy Eating Living Program (HELP) and evidence based childhood obesity program; and will continue with enhanced strategies to achieve the measurements and goals of the programs. |
This document is publicly available at https://www.dignityhealth.org/central-coast/locations/marianregional/about-us/community-benefits. This document is shared with the Foundation and Hospital Community Board and used as a reference in grant applications. Community partners refer to the document when applying for community grants.

Written comments on this report can be submitted to the Marian Regional Medical Center’s Community Health/Benefit Department at 1400 East Church St., Santa Maria, CA 93454 or by email to CHNA-CCSAN@dignityhealth.org.
MISSION, VISION AND VALUES

Marian Regional Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

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.
OUR HOSPITAL AND THE COMMUNITY SERVED

About Marian Regional Medical Center

Marian Regional Medical Center’s (MRMC) two campuses, one in Santa Maria (MRMC-SM) and the other in Arroyo Grande (MRMC-AG), serve the northern portion of Santa Barbara County and the southern-most section of San Luis Obispo County. The Santa Maria campus is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. The combination of a growing patient population, technology advancements and the desire to provide the highest level of care led MRMC-SM to open the doors to a new state-of-the-art, 191-bed facility in the May of 2012.

The facility houses a 21-bed NICU, the largest and most comprehensive perinatology/neonatology service on the Central Coast. MRMC-SM also has a 99-bed Extended Care Center, Homecare/Hospice and Infusion Service, and over 35 outpatient health centers. Marian’s Emergency Department sees the highest number of trauma cases throughout Santa Barbara and San Luis Obispo Counties. As a Level III Trauma Center, Marian has become a Receiving Center, serving more than 6,000 patients monthly with access to medical experts specializing in emergency resuscitation, surgery, and intensive care. MRMC-AG is located in Arroyo Grande approximately 15 miles north of the Santa Maria campus and has been serving the health care needs of the Five Cities area since it became a member of Dignity Health in 2004. MRMC-AG has a 67-bed acute care facility with a 20-bed Acute Rehabilitation unit that serves patients who suffer functional loss from illnesses such as stroke, neurological and brain injury, spinal cord injury or other impairments requiring rehabilitation.

Description of the Community Served

Marian Regional Medical Center serves communities within the Santa Maria Valley, and has a defined primary service area which includes the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434) and Nipomo (93444). MRMC-SM has a secondary service area extending into Buellton (93427), Lompoc (93436 & 93437), Los Alamos (93440), Los Olivos (93441), and Santa Ynez (93460). Marian Regional Medical Center’s Arroyo Grande (MRMC-AG) campus primary service area extends from the northern most boundary of the Santa Maria service area and includes Arroyo Grande (93420), Grover Beach (93433), Nipomo (93444), Oceano (93445), and Pismo Beach (93449). A summary description of the community is below, and additional details can be found in the CHNA report online.

Santa Maria Campus

According to the CHNA report of June 2016 MRMC-SM primary service area is home to over 140,000 people, of which 61.2% consider themselves Latino (a) or Hispanic, ranging from a high of 86.1% in Guadalupe and 70.4% in the City of Santa Maria to a low of 23.8% in Orcutt. Poverty rates vary as well, with the City of Santa Maria and Guadalupe having approximately 20% of the population residing in poverty to a low of 6.6% in Orcutt. In addition, just over half of the residents of the City of Santa Maria and Guadalupe reported they attained a high school degree or equivalent. The City of Santa Maria has a youth population (under age 18) that accounts for 30.8% of its’ total population, of which 30.7% of youth reside in poverty according to 2014 estimates. Also, in the City of Santa Maria, it is estimated that only 42.8% of households speak only English at home.

MRMC-SM secondary service area to the west, south, and east, has a smaller population of approximately 71,000 individuals; however, the demographics differ from most parts of MRMC-SM.
primary service area. Buellton, Santa Ynez, Lompoc, Los Alamos and Los Olivos are home to a diverse community as well, with almost half of the population being Caucasian (non-Hispanic white), and Hispanic and Latino(a)s accounting for 40.1% of the population. The high school graduation rate is reported as 81.8%, ranging from a high of 94.9% in Lompoc (93437) to a low of 79.0% in Lompoc (93436).

In addition to the residents captured by the U.S. Census discussed above, the Santa Maria Valley attracts a transient farm-worker population drawn to work in the fields. According to published reports, it is estimated that Santa Maria is home to a population of 15,000 to 25,000 indigenous Indians from the state Oaxaca and neighboring Guerrero many of whom are monolingual in one of the many native Mixteco, Zapotec languages (County of Santa Barbara Community Profile, 2015-2016). Lastly, the 2016 homeless preliminary count for Santa Maria is an estimated 283 sheltered individuals (County of Santa Barbara, 2016).

Demographic information for the MRMC primary service area taken from ©2018 IBM Watson Health provides data on the following:

- Total Population: 176,499
- Hispanic or Latino: 61.6%
- Race: White 30.3.7%, Black/African American 1.2 %, Asian, Pacific Islander 4.8%, Other 2.4%
- Median Income: $66,018
- Uninsured: 5.4%
- Unemployment: 4.3%
- No HS Diploma: 29.8%
- CNI Score: 4.0
- Medicaid Population*: 23.7%
- Other Area Hospitals: 0
- Medically Underserved Areas or Populations: Yes

* Does not include individuals’ dually-eligible for Medicaid and Medicare.

Arroyo Grande Campus
The MRMC-AG campus has a primary service area that serves the neighboring cities of Arroyo Grande, Oceano, Grover Beach, and Pismo Beach as well as the area southward through Nipomo to the border of Santa Barbara County. According to the CHNA report of June 2016 the MRMC-AG campus serves a different demographic than the MRMC-SM campus. The MRMC-AG service area has a population of approximately 76,000 individuals, with two-thirds considering themselves white, not Hispanic or Latino (a). The Hispanic and Latino (a) population of the MRMC-AG service area is approximately one-quarter of the total population. The MRMC-AG service area has about a 90% high school graduation rate, and also serves a mature population with those over the age of 65 accounting for 16.7% of the service area.
Demographic information for the MRMC-AGCH campus service area taken from ©2018 IBM Watson Health provides data on the following:

- Total Population: 72,455
- Hispanic or Latino: 29.4%
- Race: White 62.7%, Black/African American .6 %, Asian, Pacific Islander 3.8%, Other 3.4%
- Median Income: $73,042
- Uninsured: 6.1%
- Unemployment: 3.3%
- No HS Diploma: 11.2%
- CNI Score: 3.2
- Medicaid Population*: 17.2%
- Other Area Hospitals: 0
- Medically Underserved Areas or Populations: Yes

* Does not include individuals’ dually-eligible for Medicaid and Medicare.
One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. 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.
COMMUNITY ASSESSMENT AND PLANNING PROCESS

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

Community Health Needs Assessment

The significant needs that form the basis of the hospital’s community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in June 2016.

The hospital conducts a CHNA at least every three years to inform its community health strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

- **Educational attainment level** is the one independent variable that closely correlates with an increase in health and wellness. Numerous findings on residents’ health indices and health disparities based on educational attainment were found with almost 30% reported having a sixth grade education or less.
- **Lack of access to mental health** services has been substantiated through community stakeholder interviews, key stakeholder nominal group process and MRMC-SM Emergency Department data.
- **Homelessness and overcrowding in rentals** was identified in community stakeholder interviews and key stakeholder groups confirming the lack of affordable housing in both service areas. There is only one homeless shelter in Santa Maria, none in Arroyo Grande.
- **Cardiovascular disease and stroke** is the number one cause of death in MRMC-SM & MRMC-AG service area. It is also important to note that over half of the population is either overweight or obese.
- **Cancer** is the second leading cause of death in MRMC-SM and MRMC-AG service area. Depending on type of cancer screening, 30 to 40% of those eligible for the screening have not completed the process.

Education, homelessness/housing and access to mental health are each a significant health need the hospital has chosen not to address alone. The hospital is limited in resources to address education and
homelessness/housing independent of our community partners. Considerable investigation revealed
education and homelessness/housing are being addressed but there is still work to be done.

Alan Hancock College has created a college-going culture among 5th – 8th grade students and their
families. The program introduces families to Alan Hancock College and the programs and services
available through early outreach events.

Care coordinators from both the SM and AG campus have partnered with 5 Cities Homeless Coalition
and Good Samaritan to provide case management and respite services for medically fragile homeless
patients. Home For Good /United Way builds community relationships with other non-profits then
identifies, assesses and provides services to chronically homeless individuals while case managing them
to provide a link to primary care, behavioral health services and income or employment support.

By collaborating with community-based organizations we hope to facilitate a seamless continuum of
care and develop relationships that can be addressed through the Dignity Health Community Grants
Program. MRMC-SM is in continued dialogue with the County of Santa Barbara to develop plans to
open an inpatient behavioral health unit in our area to help address the critical mental health needs of the
community.

Additional detail about the needs assessment process and findings can be found in the CHNA report,
which is publicly available at:
https://www.dignityhealth.org/-/media/cm/media/documents/CHNA/CHNA-Marian.ashx?la=en or upon
request at the hospital’s Community Health office.

Creating the Community Benefit Plan

Rooted in Dignity Health’s mission, vision and values, Marian Regional Medical Center is dedicated to
improving community health and delivering community benefit with the engagement of its management
team, Community Board and the Community Benefit Committee. The board and committee are
composed of community members who provide stewardship and direction for the hospital as a
community resource (see Appendix A). These parties review community benefit plans and program
updates prepared by the hospital’s community health director and other staff.

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
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

Program planning for the next year included input from members of the Community Benefit Committee,
senior leadership, clinical experts and program owners. Existing activities were reviewed for
effectiveness, the need for continuation, or the need for enhancement. Programs were enhanced
(existing programs) by utilizing current literature, expert advice or evidence based protocols
(e.g., Healthy People 2020). When enhancing current programs, specific attention was given to the
program’s ability to address the identified needs from the most recent CHNA, incorporate the five core
principles noted above and serve the vulnerable population. Collaboration with community partners
also led to improved program design, best practices and effective interventions. Program development includes a plan for monitoring for performance and quality to find areas of improvement to facilitate their success. The Community Benefit Committee, senior leadership, Community Board and the system office (Dignity Health) receive regular program updates.

MRMC will continue to partner with community-based organizations, community health clinics and other community partners providing services and activities such as health fairs, free health screening events, and health education programs to promote, educate, and help bridge the gap between services and the underserved. Recruiting, training and mentoring Promotores from the Santa Barbara County Promotores Coalition will support both MRMC campuses to increase awareness and attendance among the Latino community for nutrition, chronic disease management, health screenings, diabetes, cardiovascular disease, stroke and cancer awareness.
2018 Report and 2019 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs’ goals, measurable objectives, expenses and other information.

This report 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.

Report and Plan Summary

<table>
<thead>
<tr>
<th>Health Need: Education</th>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
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<tbody>
<tr>
<td></td>
<td>Medical Literacy</td>
<td>Explore utilization of medical literacy tool to help providers assess the appropriate level to teach their patients about health related matters (discharge instructions, prevention, etc.)</td>
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<td></td>
<td>Front Porch Project</td>
<td>Partnering with Community Action Commission’s Front Porch Project to work with underage young girls who may have been rape or human trafficked victims. Teaching healthy snack options, utilizing a self-esteem program from Dove Soap to build self-worth and importance of “me”.</td>
<td>☒</td>
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<td></td>
<td>DOVE Self Esteem and Confident me workshops</td>
<td>Partnering with local school districts and community based organizations who will refer high risk youth to our programs to build their self-worth and encourage higher education,</td>
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Anticipated Impact: Improve self-esteem and encourage higher education through a variety of venues. Medical Literacy can improve outcomes of those inpatients by speaking to them on a level they understand and can relate (visual, reading, hearing).
**Health Need:** Access to Mental Health

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<th>Active FY18</th>
<th>Planned FY19</th>
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<tbody>
<tr>
<td>Perinatal Mood and Anxiety Disorder Program Pilot for Education</td>
<td>Provide education and support groups to Mixteco and Spanish speaking women; pregnant to include those with children up to one year old.</td>
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<tr>
<td>Support Groups</td>
<td>Individuals with Cancer, Diabetes, Stroke, Grief and Perinatal Mood and Anxiety Disorders are offered support groups at a variety of locations throughout the service area.</td>
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<td>Mommy and Me; Sibling Class; Baby Safe CPR</td>
<td>These classes offer mommy and new baby and opportunity to bond with other mommy’s in the Mommy and Me class. The sibling class offered to pregnant parents younger children information about them becoming a new big sister or brother and Baby Safe Cardiopulmonary Resuscitation is provided to moms and dads for “just in case” situations.</td>
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<tr>
<td>Care Transition Coordinators</td>
<td>Provide discharged patients a smooth transition from hospital to home</td>
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**Anticipated Impact:** Increase mental wellness in a transitional phase of a person life by providing the necessary resources to do so.

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**Health Need:** Homelessness and Housing

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<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
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<tbody>
<tr>
<td>Fund Accountable Care Communities (ACC) whose goal is address homelessness/housing</td>
<td>Community Grant to 5 Cities Homeless Coalition which provides both shelter, medical care, and case managing with the goal of meeting all the basic needs, medical care and mental health the individual needs; and to Home For Good /United Way who provides services to chronically homeless individuals with a housing first approach.</td>
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<tr>
<td>Provide respite care to homeless discharged patients</td>
<td>Good Samaritan Homeless Respite Care program is collaboration between MRMC and the Good Samaritan Shelter and 5 Cities Homeless Coalition in which beds are reserved for MRMC homeless discharged patients that need respite care.</td>
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<tr>
<td>Provide in-kind amenity bags containing personal hygiene</td>
<td>MRMC donates amenity bags containing personal hygiene products to Good Samaritan Shelter and 5 Cities Warming Centers.</td>
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**Anticipated Impact:** Provide a warm handoffs for discharged patients who are both medically fragile and homeless to increase healthy outcomes and provide possible housing opportunities.
## Health Need: Cardiovascular Disease and Stroke

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<th>Active FY18</th>
<th>Planned FY19</th>
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| Offer bilingual and bicultural cardiovascular disease and stroke awareness information and risk assessments at community health events and community lectures | - Community Health educators provide cardiovascular disease and stroke awareness information and risk assessments at community health events and community lectures.  
- FAST Fridays-Stroke assessments in the community. Heart Aware program- online risk assessment tool. | ☒           | ☒           |
| Offer disease self-management workshops                   | - Healthier Living, Take Care of Your Life  
- Healthy for Life Wellness Program  
- Diabetes Empowerment Education Program (DEEP)            | ☒           | ☒           |
| Offer telephonic support to discharged heart failure patients | Telephonic nursing support through Care Transitions Program.                         | ☒           | ☒           |

**Anticipated Impact:** Increase cardiovascular disease and stroke awareness, prevention, and management to the most vulnerable populations in northern Santa Barbara county to increase early detection.

## Health Need: Cancer Prevention and Screening

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<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
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<tbody>
<tr>
<td>Cancer prevention education, screenings</td>
<td>Increase the awareness of cancer prevention and available screenings through focused outreach and education activities among community stakeholders in our target population. Coordinate colon, prostate, skin, lung and breast screenings services for clients in both the underserved and broader community.</td>
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<tr>
<td>Hereditary Cancer Risk Assessment and Genetic Counseling</td>
<td>Provide hereditary risk assessments and genetic counseling referrals for people identifying with a family history of cancer.</td>
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<tr>
<td>Cancer Rehabilitation Program</td>
<td>Cancer exercise specialist designs group, individual and aquatic exercise programs that promote recovery in patients, alleviates cancer symptoms and reduces reoccurrence rates.</td>
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<td>Cancer Support Groups and Psychosocial Care</td>
<td>Support groups and psychosocial counseling provide cancer patients, survivors and caregivers with critical care needs outside of treatment protocols to ensure a comprehensive approach to quality care and promote spiritual and emotional healing.</td>
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Cancer Nutrition Counseling Services

Program dietician offers nutrition classes and one-on-one counseling services to mitigate treatment symptoms and promote recovery among cancer patients. The program also delivers monthly culturally competent Spanish nutrition classes for cancer patients, survivors and families in the Latino community, educating participants on healthy food behaviors that assist in cancer prevention and decrease the incidence of chronic illness.

**Anticipated Impact:** To reduce cancer-related disparities in a medically underserved population through the increase of cancer awareness and prevention activities, screenings, genetic counseling, rehabilitation and psychosocial support.

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<th>Community Grants Program</th>
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One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY18, the hospital awarded five grants totaling $229,145. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

<table>
<thead>
<tr>
<th>Grant Recipient</th>
<th>Project Name</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Home for Good /United Way of Northern Santa Barbara County</td>
<td>20 Now Santa Maria</td>
<td>$61,771</td>
</tr>
<tr>
<td>Community Action Partnership of SLO County</td>
<td>Recuperative Care Program</td>
<td>$31,295</td>
</tr>
<tr>
<td>Foodbank of Santa Barbara County</td>
<td>Diabetes Impact Group Program</td>
<td>$30,000</td>
</tr>
<tr>
<td>Good Samaritan Shelter</td>
<td>Warm Hand Off Project</td>
<td>$76,200</td>
</tr>
<tr>
<td>SLO Noor Foundation</td>
<td>Expanding Access to Cancer Screening and Primary Care in North County San Luis Obispo</td>
<td>$29,879</td>
</tr>
</tbody>
</table>

**Anticipated Impact**

The anticipated impacts of the hospital’s activities on significant health needs are summarized above, and for select program initiatives 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 needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

**Planned Collaboration**
The following is a list of the community-based organizations with which the hospital will collaborate to deliver programs specifically related to Education, Access to Mental Health and Homelessness and Housing.

**Education**
- Alan Hancock College and Foundation
- Boy’s and Girl’s Club, Santa Maria and Oceano
- City of Santa Maria, Recreation and Parks Department
- Cuesta College and Foundation
- Discovery Museum
- Five Cities Homeless Coalition
- Good Samaritan Shelter
- Little House by the Park (Guadalupe Family Resource Center)
- United Way
- Catholic Churches: St. Mary’s of Assumption, St. Patrick’s, and St. Joseph’s

**Access to Mental Health**
- Caregiver Workshops and Support Groups
- Home For Good/United Way
- Child Abuse Listening Mediation (CALM)
- City of Santa Maria’s Mayor Task Force for Youth
- Community Counseling Center
- Family Resource Agency’s Santa Maria Valley Youth and Family
- Santa Barbara County Department of Behavioral Wellness- Planning the inpatient behavioral health unit in north Santa Barbara County
- Santa Barbara County Promotores Coalition
- Transitions Mental Health Association

**Homelessness / Housing**
- 5 Cities Homeless Coalition
- Catholic Charities
- Home for Good/United Way
- Good Samaritan Shelter
- People Self-Help Housing
- Salvation Army

**Financial Assistance for Medically Necessary Care**

Marian Regional Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the 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 amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.
The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital’s web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Actions taken to inform the community about the hospital’s Financial Assistance Policy are as follows:

- **Community Benefit Report**: Included the policy’s plain language summary and a statement about the availability of financial assistance in the report posted online.
- **Community Health/Community Benefit Committee**: Shared the policy or plain language summary with the committee, which includes community representatives.
- **Community Partner Agencies or Networks**: Shared the policy or plain language summary with public and/or private community partner agencies or networks that serve the health and social needs of poor and vulnerable populations. Agencies/networks are as follows: Santa Maria Bonita School District; Lucia Mar Unified School District; Guadalupe Family Resource Center; Santa Maria Family Resource Center; Catholic Charities; Home for Good/United Way; and 5 Cities Homeless Coalition

**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.
### Significant Health Needs Addressed
- Education
- Access to Mental Health
- Homelessness or Housing
- Cardiovascular Disease and Stroke
- Cancer Screenings

### Core Principles Addressed
- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

### Program Description
Marian Cancer Care Program at both Arroyo Grande and Santa Maria campuses addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurse, social worker, certified cancer exercise trainer and registered dietician.

### Community Benefit Category
A1a, d, e – Community Health Improvement Services; A1e-Health Care Support Services; A2d Community Based Clinical Services; E3d-Financial and In-Kind Donations

### FY 2018 Report

#### Program Goal / Anticipated Impact
The goal of the Marian Cancer Program at both Arroyo Grande and Santa Maria campuses is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase of cancer awareness and prevention activities, screenings, genetic counseling, rehabilitation and psychosocial support.

#### Measurable Objective(s) with Indicator(s)
1. Increase the number of target population patients (under/uninsured, medically underserved Latino and seniors) by 5% (381) who are utilizing the cancer education program (EMMI Solutions) to improve patient knowledge of disease, procedures, treatment and drive cancer screenings.
2. Increase number of target population patients (under/uninsured, medically underserved Latino and seniors) receiving screening services by disease site: Colonoscopy-10% (32); Prostate-25% (17); Skin-10% (93); Lung - 10% (454).
3. Increase by 10% (32) the number of target population patients (under/uninsured, medically underserved Latino and seniors) referred to cessation support services for currently smoking lung patients.
4. Increase by 20% (123) the number of target population cancer patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track number of patients needing financial assistance to participate.
5. Track the number of medically underserved patients transported and financially assisted for transportation needs.
6. Increase by 20% (47) monthly nutrition counseling participation among the target Latino population. Ensure at least 20% of participants can identify at least one healthy behavior from nutrition counseling they have adopted into their lifestyle over the past month. With the Marian community health needs assessment demonstrating the community is comprised of more than 60% Latino, it is imperative that programs and measurements target this population.
<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>Planned Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Ensure at least 50 women identified as having missed an annual breast cancer screening in 2016, return for a mammogram service.</td>
<td>Community Health Centers of the Central Coast, SLO Noor Free Clinic, Community Action Partnership of San Luis Obispo County, City of Santa Maria, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, SBCEO Health Linkages, Wisdom Center, Santa Barbara County Promotores Coalition, Community Partners in Caring, local Latino</td>
</tr>
<tr>
<td>8. Increase the number of new patients from target population (under/uninsured, medically underserved Latino and seniors) enrolled in the Cancer Rehabilitation Program by 10% (150). Ensure a minimum of 65 rehabilitation patients will continue to exercise 4 weeks after program completion</td>
<td></td>
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<tr>
<td>9. Follow up 24 patients who participated in psychosocial support program to assess needs, determine effectiveness of counseling services provided and link (if necessary) to additional support services offered.</td>
<td></td>
</tr>
<tr>
<td><strong>Intervention Actions for Achieving Goal</strong></td>
<td>Community Health Centers of the Central Coast, SLO Noor Free Clinic, Community Action Partnership of San Luis Obispo County, City of Santa Maria, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, SBCEO Health Linkages, Wisdom Center, Santa Barbara County Promotores Coalition, Community Partners in Caring, local Latino</td>
</tr>
<tr>
<td>1. Utilize both lay and nurse navigators to assess patient needs and appropriately assign education modules from “EMMI Solutions” to improve patient knowledge and specific patient concerns about cancer care.</td>
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<tr>
<td>2. Increase the awareness of cancer prevention, screening activities and genetic counseling referrals through intervention actions that include: attending target population outreach events (both Latino and elderly), one-on-one medical literacy education to community stakeholders frequented by target Latino population; revision of outreach materials to ensure demographic and culturally applicability; electronic dissemination of information through community partners; and the utilization of nurse navigators and translation services to ensure follow up, coordination of cancer care services and necessary referrals.</td>
<td></td>
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<tr>
<td>3. Provide the necessary transport or financial support to patients in need of transportation assistance.</td>
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<tr>
<td>4. Develop and implement a culturally competent Spanish nutrition and healthy behavior program for cancer patients, survivors and families in the Latino community. Utilize the support of Spanish promotores and registered dietitian to educate participants on healthy food behaviors that can assist in cancer prevention, mitigating cancer symptoms and decrease the incidence of chronic illness. Collaborate across Marian departments to ensure comprehensive care and refer participants as necessary to other Marian culturally appropriate education and disease management programs.</td>
<td></td>
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<tr>
<td>5. Identify barriers that inhibit women from engaging in breast cancer screening services. Develop a breast cancer outreach strategy that removes identified barriers and provides access for women who have not returned for annual mammograms.</td>
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<tr>
<td>6. Identify medically eligible patients to enroll in the Cancer Rehabilitation Program; conduct a 4 week post program, telephonic follow-up to track how many patients continue to utilize the exercise activities and knowledge gained, thereby lowering the risk of recurrence.</td>
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<tr>
<td>7. Implement a follow up mental health assessment support plan that utilizes the distress screening tool to re-evaluate the psychosocial needs of past program patients, 3 months after completing allocated support services, and refer them to additional support services as needed in their continuum of care.</td>
<td></td>
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</table>
Program Performance / Outcome

1. 404 (6% increase from FY17) of our target population patients (under/uninsured, medically underserved Latino and seniors) have utilized the cancer patient education program (EMMI Solutions®), to improve patient knowledge of disease, procedures, treatment and drive cancer screenings. Target was to increase annually by 5%.

2. 683 of our target population patients (under/uninsured, medically underserved Latinos and seniors) were assisted with screening services this fiscal year: 55 colorectal screenings (68% increase from FY17); 55 prostate screenings (204% increase from FY17); 31 skin screenings (66% decrease from FY17); and 542 lung screenings (25% increase from FY17).

3. 14 (56% decrease from FY17) of our target population lung cancer patients (under/uninsured, medically underserved Latinos and seniors) has been referred and enrolled in smoking cessation support services. Annual target was to increase by 10%.

4. 42 of target population patients (under/uninsured, medically underserved Latinos and seniors) received counseling support services in the genetic counseling program this quarter (25% increase from FY17), while 32 of the patients received critical financial assistance to participate in the program ($8,000). Target was to have an annual increase of 20%.

5. 842 medically underserved patients were transported this quarter, while 77 patients were supported with financial assistance for transportation needs, totaling $3,850.

6. 136 medically underserved Latino patients have been supported through the nutrition counseling program this quarter (194% increase from FY17). Annual target was to increase by 20%. Additionally 81% of returning group participants were able to identify at least one healthy behavior they have adopted into their lifestyle since participating in the program. Annual goal was to ensure 20% of participants adopted one healthy behavior change.

7. The Cancer Outreach Program contacted 187 uninsured women who were identified as non-compliant for their annual mammogram screening in 2017. 111 of them were linked to the PHC for their ‘Well Woman’ check but only 15 have returned for their subsequent mammogram screening service. The annual goal was to ensure 50 uninsured women return for a mammogram service.

8. 176 (17% increase from FY17) new patients from target population (under/uninsured, medically underserved Latino and seniors) enrolled and participated in the Cancer Rehabilitation Program this quarter. 74 (89%) of patients who have completed the cancer rehabilitation program reported the use of continued exercise four weeks after program completion. The annual program goal was 65.

9. 45 patients who participated in the psychosocial support program have been followed up post program completion. All patients demonstrated improved emotional stability in their follow up assessments. The annual program target was to follow up 24.
<table>
<thead>
<tr>
<th>Hospital’s Contribution / Program Expense</th>
<th>Program Expense $1,908,318.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2019 Plan</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Program Goal / Anticipated Impact</strong></td>
<td>The goal of the Marian Cancer program at both Arroyo Grande and Santa Maria campuses is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase in participation of rehabilitation and psychosocial support services as well as cancer awareness and prevention activities, including screenings and genetic counseling.</td>
</tr>
</tbody>
</table>
| **Measurable Objective(s) with Indicator(s)** | 1. Track the number and monitor the results of target population patients (under/uninsured, medically underserved Latinos and seniors) counseling and social support referrals to ensure improved patient outcomes.  
2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving screening services: Colonoscopy-10% (55); Prostate-10% (55); Skin-20% (31); Lung-10% (542); Genetic Counseling-10% (196)  
3. Track and describe the under/uninsured population requesting financial assistance for cancer care needs. Track the number of medically underserved patients transported for cancer care.  
4. Increase by 20% (136) monthly nutrition counseling and education participation among target population patients (under/uninsured, medically underserved Latinos and seniors). Ensure at least 20% of returning education participants identify at least one healthy behavior from nutrition classes they have adopted into their lifestyle over the past month.  
5. Ensure at least 50 under/uninsured women identified as having missed an annual breast screening, return for a mammogram service.  
6. Increase the number of new patients from target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 10% (176). Ensure at least 80% of patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion. |
| **Intervention Actions for Achieving Goal** | 1. Utilize both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to psychosocial support services and follow up to ensure improved patient outcomes and behavioral needs are met.  
2. Increase awareness of cancer prevention, screening activities and genetic counseling referrals through intervention actions that include: attending target population outreach events, one-on-one medical literacy education to community stakeholders frequented by target Latino population; the dissemination of information and events via social media, radio and print material; and the utilization of nurse navigators for the coordination of cancer screening services and necessary referrals.  
3. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance.  
4. Develop and implement a hybrid nutrition and healthy behavior program for cancer patients, survivors and families in both English and Spanish for the medically underserved communities. Utilize the support of the lay patient navigator and dietician to educate participants on healthy behaviors that can assist in cancer prevention, mitigating cancer symptoms and decrease the incidence of chronic illness. Encourage target population patients to seek further support through one-on-one nutrition counseling. |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Develop a breast cancer outreach strategy that removes identified barriers and provides access for under/uninsured women who have not returned for annual mammogram screenings.</td>
</tr>
<tr>
<td>6.</td>
<td>Identify medically eligible patients to enroll in the Cancer Rehabilitation Program; conduct a 4 week post program, telephonic follow-up to track how many patients continue to utilize the exercise activities and knowledge gained, thereby lowering the risk of recurrence.</td>
</tr>
</tbody>
</table>

**Planned Collaboration**

Community Health Centers of the Central Coast, SLO Noor Free Clinic, Community Action Partnership of San Luis Obispo County, City of Santa Maria, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, SBCEO Health Linkages, Wisdom Center, Santa Barbara County Promotores Coalition, Community Partners in Caring, local Latino barber shops and beauty parlors, local Latino markets and laundry mats, Employment Development Department (EDD) Santa Maria, *El Show de La Revista OKEY* Magazine, *La Buena* Radio, local ranches/ wineries, California Farm Labor Contractors, People Self-Help Housing, St John’s Newman, St Joseph’s, St Mary’s, Chumash Tribal Council and clinics, Sunny Country Radio, Every Woman Counts (EWC) program, Jack Helping Hand, Alan Hancock Community College and Lucia Mar Unified School District.
# Cardiovascular Disease and Stroke

## Significant Health Needs Addressed
- Education
- Access to Mental Health
- Homelessness or Housing
- Cardiovascular Disease and Stroke
- Cancer Screenings

## Core Principles Addressed
- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

## Program Description
Cardiovascular disease/stroke is one of the leading causes of death in the north Santa Barbara and San Luis Obispo County. Assessment of cardiovascular risk status will be implemented to identify those medical or lifestyle conditions that may lead to development of the disease. This program can enable community members to take control of their health and encourage follow-up and treatment of risk factors by their health care provider.

## Community Benefit Category
A1a – Community Health Education-Lectures; A2d- Community Based Clinical Services; A1d – Community Health Education-Support Group

## FY 2018 Report

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke.</th>
</tr>
</thead>
</table>
| **Measurable Objective(s) with Indicator(s)** | 1. Increase cardio/stroke screening by 10% (689) at 6 target population health fair events.  
2. Increase by 10% (111) the number of people provided cardiac/stroke education as part of the Healthy for Life Wellness Program.  
3. Educate 50 screened at-risk individuals regarding healthy lifestyle (through Health for Life Wellness Program) to reduce cardiovascular risk in the target population.  
4. Provide 4 FAST Friday events for target populations (Spanish and elderly)  
5. Present Explaining Stroke 101 class in Spanish twice and to an elderly population two times.  
6. 70% of participants enrolled in CDSMP program will complete the workshop.  
7. Nurse will maintain outreach at broader and poor locations for FAST Friday stroke education. |
| **Intervention Actions for Achieving Goal** | 1. Program Champions agreed that any blood pressure identified as more than 140/90 and/or blood glucose >200 will be tagged for a 30 day telephone follow up call.  
2. RN will train promotores on risk factors for conducting 3 month telephonic support for participants to self-report  
3. Identify qualified interpreter to assist in FAST Friday and Explaining Stroke 101 Spanish classes.  
4. Conduct 30 day follow up calls for each of the cardiac stroke screening events linking them with a PCP if required (3 days post intervention) and follow up questions. |
| **Planned Collaboration** | Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education. Local partner invitations for health fair events. |

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Marian Regional Medical Center  
Community Benefit FY 2018 Report and FY 2019 Plan  
24
| Program Performance / Outcome | 1. A total of 639 people were screened for cardio/stroke risk a 1% decrease from last FY2017. |
|                              | 2. A total of 86 were provided cardio/stroke prevention education a 3% decrease from FY 2017. |
|                              | 3. Ninety at risk individual for cardio/stroke were educated on healthy lifestyle to reduce their risk a 5% increase from last FY2017. |
|                              | 4. A total of 28 FAST Fridays were done with a total of a total of 674 individual were screened. |
|                              | 5. One Spanish Stroke 101 presentation was conducted with 47 participants and 2 stroke 101 presentation were conducted to 126 seniors. |
|                              | 6. 67% of the participants enrolled in the CDSMP program completed the workshop. |
|                              | 7. Nurse maintain outreach at broader and poor location for FAST Friday’s stroke education. |

| Hospital’s Contribution / Program Expense | Program expense: $23,444 |

| FY 2019 Plan |

| Program Goal / Anticipated Impact | Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke. |

| Measurable Objective(s) with Indicator(s) | 1. Increase cardio/stroke screening by 5% (639) at 6 target population health fair events. |
|                                          | 2. Increase by 5% (861) the number of people provided cardiac/stroke education as part of the Healthy for Life Wellness Program. |
|                                          | 3. Educate 100 screened at-risk individuals regarding healthy lifestyle (through Health for Life Wellness Program) to reduce cardiovascular risk in the target population. |
|                                          | 4. 20% of the participants identified with no primary care provider, and aware for the first time they have elevated glucose, BP and cholesterol will self-report at 3 months self-report lifestyle modifications. |
|                                          | 5. Provide 4 FAST Friday events for target populations (Spanish and elderly). |
|                                          | 6. Present Explaining Stroke 101 class in Spanish twice and to an elderly population two times. |
|                                          | 7. 70% of participants enrolled in CDSMP program will complete the workshop. |

| Intervention Actions for Achieving Goal | 1. Establish baseline for target population’s use of Cardiac Risk Assessment Tool. |
|                                         | 2. Provide “Explaining Stroke 101” and “Cardiovascular Disease” lectures for target population in English and Spanish. |
|                                         | 3. All screened participants will be referred to all Dignity Health Wellness Programs. |
|                                         | 4. At-risk individuals will be provided appropriate education, referrals, and follow-up and will be placed on a 3 month follow up call list. |
|                                         | 5. At –risk individuals will self-report lifestyle modification at their 3 month follow up call. |

| Planned Collaboration | Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, American Heart Association, |
### Significant Health Needs Addressed
- Education
- Access to Mental Health
- Homelessness or Housing
- Cardiovascular Disease and Stroke
- Cancer Screenings

### Core Principles Addressed
- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

### Program Description
The Care Transitions program provides consistent telephonic patient follow-up and education thereby decreasing the number of participant admissions to the hospital focusing on COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure.

### Community Benefit Category
A3-e Health Care Support Services

### FY 2018 Report

#### Program Goal / Anticipated Impact
Decrease hospital readmissions and decrease unnecessary emergency department use for all participants with Chronic Obstructive Pulmonary Disease (COPD), diabetes, pneumonia, cardiac event, sepsis and heart failure enrolled in the program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage.

#### Measurable Objective(s) with Indicator(s)
1. 90% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis.
2. 90% of participants enrolled in the program will self-report that they keep follow-up appointments with their physician(s) on an ongoing basis.
3. Readmission rate for CHF and COPD patients enrolled in Care Transitions (CT) will be at 6% or less on a quarterly basis.
4. Emergency Room use of patients on CT will be tracked quarterly to identify the % of patients using ER on a monthly basis, reported quarterly.
5. Reinstall a Patient Satisfaction Survey Tool that is sent out when a patient is discharged and achieve a score 90% Excellent on the overall care provided, starting in the 2nd Quarter. Reported quarterly.
6. Utilizing available communication tools (Dashboard, Octavia, e-mail) send at least 75% of patients not taken for care (NTFC) and 100% of appropriate mobile patients enrolled in Care Transition to Community Benefit Education Department for enrollment in CDSMP workshop.
7. Those NTFC and Care Transitions patients registered for CDSMP, 65% will complete the workshop.

#### Intervention Actions for Achieving Goal
1. Patients referred to Care Transitions (CT) from hospital discharge will be called within 48-72 hours to enroll into the program, nurse will identify any problems or symptoms they may have and intervene with education and medication reconciliation.
2. CT will utilize Medical Social Worker support by phone or home visit to assist with patient barriers to success with their plan of care.
3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their meds.
4. Identify patients who are having difficulty with physician follow up and assist in locating MD and getting appointments.
5. Provide information to patients and their caregivers on home safety, Family Caregiver Program, medication and disease information specific to their needs and identify those needing support.

6. A quarterly statistical summary will be conducted to identify Emergency Room (ER) use for patients with COPD, CHF and all cause readmissions to tract ER use/readmission rate.

7. Patient Satisfaction Survey will be sent out beginning 2nd quarter, to all Care Transition patients who are discharged with a “graduate” (3 months) designation within 2-3 weeks of post intervention, with a return envelope, and scores will be tracked to identified issues.

| Planned Collaboration | CenCal and the community resources that provide care transition interventions – post acute care services. Home Health Care Services; Hospice services; Dignity Health Hospitals and the Care Coordinators; Family Caregiver Program at MRMC with the MSW Navigator. |

| Program Performance / Outcome | MRMC -
A total of 493 patients were admitted to Care Transition program and a total of 588 patients were served in the year.
2. There were a total of 7370 attempted contacts made, and 4209 actual contacts made.
3. Medication compliance for the year and follow up physician appointments for the year were both at 96%.
4. The readmission rate for CHF was 6.5% and for COPD the rate was 4.1%.

AGCH campus -
1. A total of 236 patients were admitted to Care Transition Program and a total of 279 patients were served during the year.
2. There were a total of 3293 total contacts attempted and a total of 1776 contacts actually made.
3. Medication compliance for the year was at 97% and for follow up with physician, the compliance was 99%.
4. The readmission rate for CHF was 1.6% and for COPD was 2.5% for the year.

Both MRMC & AGCH -
1. For all Care Transition programs – in late April, Octavia was initiated, which facilitates referrals for Care Transition and coordination of care for all post-acute hospital care providers.
2. Those NTFC and Care Transitions patients registered for CDSMP, on two out of four completed the workshop which indicated a 50% completion rate. |

| Hospital’s Contribution / Program Expense | Program Expense: $556,519 |

| FY 2019 Plan | Decrease hospital readmissions and decrease unnecessary emergency department use for all participants with all high risk and complex patients discharged from the hospital – to include diagnosis of COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure enrolled in the program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage |

| Measurable Objective(s) with Indicator(s) | 1. 95% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis. |
2. 95% of participants enrolled in the program will self-report that they keep follow-up appointments with their physician(s) on an ongoing basis.
3. Readmission rate for CHF and COPD patients enrolled in Care Transitions (CT) will be at 6% or less on a quarterly basis.
4. Emergency Room use of patients on CT will be tracked quarterly to identify the % of patients using ER on a monthly basis, reported quarterly.
5. Patient Satisfaction Survey Tool that is sent out when a patient is discharged/graduated will achieve a score 90% Excellent on the overall care provided, reported quarterly.
6. Utilizing available communication tools (Octavia) send at least 75% of patients not taken for care (NTFC) and 100% of appropriate mobile patients enrolled in Care Transition to Community Benefit Education Department for enrollment in CDSMP workshop.
7. Those NTFC and Care Transitions patients registered for CDSMP, 65% will complete the workshop

| Intervention Actions for Achieving Goal | 1. Patients referred to Care Transitions (CT) from hospital discharge, and who are identified as appropriate for Care Transition, will be called to enroll into the program, nurse will identify any problems or symptoms they may have and intervene with education and medication reconciliation.  
2. CT will utilize Medical Social Worker support by phone or home visit to assist with patient barriers to success with their plan of care.  
3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their meds.  
4. Identify patients who are having difficulty with physician follow up and assist in locating MD and getting appointments.  
5. Provide information to patients and their caregivers on home safety, Family Caregiver Program, medication and disease information specific to their needs and identify those needing support.  
6. A quarterly statistical summary will be conducted to identify Emergency Room (ER) use for patients with COPD, CHF and all cause readmissions to track ER use/readmission rate.  
7. Patient satisfaction Survey will be sent out to patients who are discharged due to “graduation” designation within 2-3 weeks from the last call and will be given a return envelope and scores will be tracked. |
| Planned Collaboration | Care Coordinators at the Dignity Health Hospitals; Home Health, Hospice, Cardiac Rehab; Family Caregiver Program; Octavia program; CCN dept; QI dept; ER, hospitalists, MSW staff and the Readmission Committees. |
# Diabetes Prevention and Self-Management

| Significant Health Needs Addressed | ❑ Education  
|                                   | ❑ Access to Mental Health  
|                                   | ❑ Homelessness or Housing  
|                                   | ❑ Cardiovascular Disease and Stroke  
|                                   | ❑ Cancer Screenings |

| Core Principles Addressed | ❑ Focus on Disproportionate Unmet Health-Related Needs  
|                          | ❑ Emphasize Prevention  
|                          | ❑ Contribute to a Seamless Continuum of Care  
|                          | ❑ Build Community Capacity  
|                          | ❑ Demonstrate Collaboration |

| Program Description | Provide a comprehensive evidence-based diabetes management program for the ADA recognized program providing education with registered dietitian and nurse specializing in diabetes management. The program will improve behavior and self-management practices of diabetic patients; enhance and improve the access and delivery of effective preventive health care services |

| Community Benefit Category | A1-c Community Health Improvement Services |

## FY 2018 Report

| Program Goal / Anticipated Impact | Increase diabetes self-management skills in the target population for pre diabetic and diabetics. |

### Measurable Objective(s) with Indicator(s)

1. **90% of participants enrolled in the ADA recognized Diabetes Self-Management Education Program will maintain program goal by decreasing their A1c 0.5% or maintain 7% or below, at 3-6 month intervention.**
2. **10% of patients referred to the Diabetes Education Center, will participate in the Diabetes Support Group.**
3. **100% of patients referred to the Diabetes Education (ADA accredited) Program that are under and uninsured will receive at least one of the following:**
   - Registered Dietician diabetes education
   - Registered Nurse diabetes education
   - Diabetes Empowerment Education Program (DEEP)

      Increase Spanish ADA accredited series and hold at least one series in FY 2018

### Intervention Actions for Achieving Goal

1. Explore option to provide individual/group education at the MRMC-AG Campus for the population served.
2. Explore how to standardize Diabetic Education and Support throughout the central coast service area.
3. Request 3 month follow up A1C order upon patient enrollment in DSMT
4. Identify and train Community Education staff to conduct Spanish ADA accredited series (4 per series)
5. All Diabetes Education patient face sheets will be screened and forwarded to CDSMP/DEEP Coordinator (30 days post intervention) for enrollment in DEEP and support groups.

### Planned Collaboration

Physician offices; MRMC; Community Benefit Department; Dignity Health Clinics; Dignity Home Health; Care Transition program; Alliance for Pharmaceutical Access; SLO Noor Clinic; Food Bank; CenCal; CHCCC
| Program Performance / Outcome | 1. For 2017-18 FY, 34 individuals completed (voluntary) DSME -4 series, group classes. Seventeen of the 34, were eligible to have the post A1c lab completed and, results were available. All 17, met program goal by 100%, to decrease A1c by 0.5% or, maintain 7% or, below at 3-6 mo. intervention. Measureable objective was 90%.  
2. Twenty- two percent, 132 individuals of 609 referrals, attended Diabetes Support group sessions, English and Spanish. Measurable objective was 10%.  
3. For the first half of the 2017-18 FY (1st and, 2nd quarters), only a referral to the “DEEP Program” was approved by administration. One hundred and forty-eight individuals (not all under/uninsured) were referred to “DEEP Program.” Eleven individuals, 7 % (11/148) completed DEEP workshops for the first half of the FY. For the second half of the FY (3rd and 4th quarters), 17 individuals were identified as under/ uninsured. Nine saw RD for individualized visit, 3 saw RN for an individualized visit, one individual was a “no show,” and, one was referred to Cancer Center RD. Additionally, 84 (not all under/ uninsured) individuals were referred to “DEEP Program.” Ten percent (8/84) were reported as attending workshops. Therefore, measureable objective met by 100%.  
4. A Spanish ADA accredited (4 series group class) was not implemented. |
| Hospital’s Contribution / Program Expense | Program expense: $ 210,840 |
| FY 2019 Plan |
| Program Goal / Anticipated Impact | Increase diabetes awareness and self-management skills in target population for prevention and management of individuals with pre-diabetes and, diabetes. |
| Measurable Objective(s) with Indicator(s) | 1. Improve community awareness of Diabetes Education available.  
2. Increase pre-diabetes education visits offered thru Diabetes Empowerment Education Program classes, diabetes support groups and, physician referrals of 9 (2018 Fiscal Year) by 5% in 2019 Fiscal Year.  
3. Increase Diabetes Support group attendance by 5%.  
4. Increase diabetes education visits offered thru diabetes support groups and, physician referrals and, recent hospitalizations of 34 (2018 Fiscal Year) by 5% in 2019 Fiscal Year.  
5. Individuals with uncontrolled diabetes that are at high risk of complications will be contacted via telephonic services. |
| Intervention Actions for Achieving Goal | 1. Participate in 4 Community Health events for seniors/underserved populations. Providing diabetes education, prevention information and programs available through center.  
2. Identify pre-diabetes population in need of individual education and counseling as well as classes available on management of diabetes available from Diabetes Empowerment Education Program classes, community outreach, diabetes support groups and, physician referrals and, recent hospitalizations.  
3. Invite and educate community about English and Spanish Diabetes Support groups available at community events, physician offices / clinics, and lab clinics.  
4. Identify diabetes individuals in need of individual nutritional and/or diabetes nursing education from Diabetes Empowerment Education Program classes, community outreach, diabetes support groups, physician referrals and, recent hospitalizations. |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Assess progress of individuals at high risk for complications by follow-up phone calls that are identified via recent hospitalizations or, recent participation in Diabetes Empowerment Education Program, diabetes support groups and, diabetes clinic visits.</td>
</tr>
<tr>
<td><strong>Planned Collaboration</strong></td>
<td>MRMC /AG CTP teams, Dignity Health Comm. Benefit team, Pharmacy, Alliance of Pharmaceutical Access, Cencal, Medicare, Dignity Health Medical Group, Dignity Health Nutrition Services, Dignity Health Business Services, Dignity Health Marketing, Physician offices (all Central Coast), Dignity Health clinics, CHCCC, underserved / uninsured / underinsured / seniors in the community at high risk for chronic disease.</td>
</tr>
</tbody>
</table>
## Dignity Health Community Grants Program

| Significant Health Needs Addressed | ☑  Education  
|------------------------------------|-----------------------------------  
|                                    | ☑  Access to Mental Health  
|                                    | ☑  Homelessness or Housing  
|                                    | ☑  Cardiovascular Disease and Stroke  
|                                    | ☑  Cancer Screenings  
| Core Principles Addressed          | ☑  Focus on Disproportionate Unmet Health-Related Needs  
|                                    | ☑  Emphasize Prevention  
|                                    | ☑  Contribute to a Seamless Continuum of Care  
|                                    | ☑  Build Community Capacity  
|                                    | ☑  Demonstrate Collaboration  
| Program Description                 | This program provides 501(3) c “accountable care communities” the opportunity to apply for funds designed to meet the hospitals health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.  
| Community Benefit Category          | E2a - Financial and In-Kind Donations  

### FY 2018 Report

| Program Goal / Anticipated Impact | Grant funds will be awarded to organizations in hospital service area to “Accountable Care Community” which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address such as Education, Homelessness/Housing and Access to Mental Health.  
|-----------------------------------|----  
| Measurable Objective(s) with Indicator(s) | 1.  Provide grant writing workshops in the Spring of each calendar year.  
|                                    | 2.  Build richer ACC that are focused on multiple significant health needs.  
|                                    | 3.  100% of funded ACC will update local community benefit committees on their project.  
|                                    | 4.  100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained.  
| Intervention Actions for Achieving Goal | Community Education Coordinators will work closely with agencies to form a more succinct “Accountable Care Community” for services the hospital is unable to address itself.  
| Planned Collaboration | Those community partners who submit a Letter of Intent  
| Program Performance / Outcome | 1.  A grant writing workshop was held in May 2018 at the Arroyo Grande campus with 27 participants representing the Central Coast.  
|                                    | 2.  Community Education Coordinators worked closely with local community agencies in forming Accountable Care Communities that would meet the needs of the hospitals prioritized health needs.  
|                                    | 3.  All 3 ACC was scheduled to present in at the quarterly Community Benefit meetings to give updates on their projects.  
|                                    | 4.  Community Education Coordinator continues to work with ACC to provide concise descriptive quarterly outcomes for committees review.  
|                                    | 5.  100% of funded ACC have scheduled quarterly and sometimes meeting more often to ensure outcomes are accomplished and they continue their work with the local hospital.  
| Hospital’s Contribution / Program Expense | Provided $229,145 in grant money awarded to the community for the purpose of improving the quality of life of the residents of Northern Santa Barbra County.  

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Marian Regional Medical Center  
Community Benefit FY 2018 Report and FY 2019 Plan
<table>
<thead>
<tr>
<th>FY 2019 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Goal / Anticipated Impact</strong></td>
</tr>
<tr>
<td>Grant funds will be awarded to organizations in hospital service area to “Accountable Care Community” which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address Access to Behavioral Health and Homelessness/Housing.</td>
</tr>
<tr>
<td><strong>Measurable Objective(s) with Indicator(s)</strong></td>
</tr>
<tr>
<td>1. Provide grant writing workshops in the Spring of each calendar year.</td>
</tr>
<tr>
<td>2. Build richer ACC that are focused on multiple significant health needs.</td>
</tr>
<tr>
<td>3. 100% of funded ACC will update local community benefit committees on their project.</td>
</tr>
<tr>
<td>4. 100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained</td>
</tr>
<tr>
<td><strong>Intervention Actions for Achieving Goal</strong></td>
</tr>
<tr>
<td>1. Community Education Coordinator will work closely with agencies to form a more succinct “Accountable Care Community” (ACC) for services the hospital is unable to address itself.</td>
</tr>
<tr>
<td>2. Coach ACC to provide more concise, comprehensive quarterly measurable outcomes.</td>
</tr>
<tr>
<td>3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee.</td>
</tr>
<tr>
<td>4. Funded ACC will present at Community Benefit Committee meetings.</td>
</tr>
<tr>
<td><strong>Planned Collaboration</strong></td>
</tr>
<tr>
<td>Those community partners who submit a Letter of Intent.</td>
</tr>
</tbody>
</table>
### Medical Literacy

| Significant Health Needs Addressed | ☑ Education  
|-----------------------------------|-----------------  
|                                    | ☑ Access to Mental Health  
|                                    | ☑ Homelessness or Housing  
|                                    | ☑ Cardiovascular Disease and Stroke  
|                                    | ☑ Cancer Screenings  
| Core Principles Addressed | ☑ Focus on Disproportionate Unmet Health-Related Needs  
|                                    | ☑ Emphasize Prevention  
|                                    | ☑ Contribute to a Seamless Continuum of Care  
|                                    | ☑ Build Community Capacity  
|                                    | Demonstrate Collaboration  
| Program Description | Provide a better hospital experience by identifying patient’s medical literacy, learning preferences and preferred language.  
| Community Benefit Category | A need as reflected in the Community Health Needs Assessment 2015.  

| FY 2018 Report |  
|----------------|-----------------  
| Program Goal / Anticipated Impact | Better determine patient’s medical literacy, learning preferences and preferred language and thereby deliver them better education and experience  
| Measurable Objective(s) with Indicator(s) | Reduce current baseline of 50% error rate (with 30% of the time it severely wrong) to 20% error rate for type of Learning preference and Literacy required of patient in Mother Baby.  
| Intervention Actions for Achieving Goal | 1. Use REALM-R (Rapid Estimate of Adult Learning in Medicine-Revised) and the Learning Style Preference tool (available in English and Spanish) to assess the appropriate method of each patient to teach them about health related manners. (3 minutes a bed for both tools).  
2. Provide in-service for literacy tools during huddles.  
3. Identify gaps in education services.  
4. Identify 3 medical students to provide spot surveys of Literacy and Learning attributes for patient’s ability regarding medical literacy as part of daily rounding.  
5. Work with PACT volunteers.  
6. Investigate possibility of working with medical students to compare initial detection of Literacy and Learning attributes for patients as documented in Cerner to discharge learning.  
7. Improve existing methods for detection of literacy rate and learning style  
8. Improve all staff awareness of literacy in general and each patients needs in specific.  
Investigate where to post literacy and learning preference for patient  
| Planned Collaboration | Nurses, volunteers, medical students  
| Program Performance / Outcome | 1. Identified Med/Surg unit as pilot for program. The outcomes to report on quarterly is to reduce current baseline of 50% error rate (with 30% of the time it severely wrong) to 20% error rate for type of Learning preference and Literacy required of patient.  
2. A PowerPoint for My Journey has been developed and sent to Administration for approval using the Rapid Estimate of Adult Learning in Medicine-Revised (REALM-R) and the Learning Style Preference tool (available in English and Spanish) so nursing staff can assess the appropriate method of each patient to teach them about health related manners.  

Marian Regional Medical Center  
Community Benefit FY 2018 Report and FY 2019 Plan  
34
3. Team has gotten approval to commence project as a pilot with a selected staff team to develop work flow, evaluation, and pilot implementation on a unit as well as for the launch of the PowerPoint in My Journey.

<table>
<thead>
<tr>
<th>Hospital’s Contribution / Program Expense</th>
<th>Program expense: $8,000</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>FY 2019 Plan</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Goal / Anticipated Impact</strong></td>
<td>Better determine patient’s medical literacy, learning preferences and preferred language and thereby deliver them better education and experience</td>
</tr>
<tr>
<td><strong>Measurable Objective(s) with Indicator(s)</strong></td>
<td>1. Reduce current baseline of 81% error rate (with 31% of the time it severely wrong) to 20% error rate for type of Learning preference and Literacy required of patient in Cerner.</td>
</tr>
</tbody>
</table>
| **Intervention Actions for Achieving Goal** | 1. Develop next steps to determine work flow, evaluation of work flow, and implementation of using the Rapid Estimate of Adult Learning in Medicine-Revised (REALM-R) and the Learning Style Preference tool (available in English and Spanish) with selected staff team.  
| **Planned Collaboration** | Hospital Leadership, nursing staff, and physicians. |
**Pacific Central Coast Health Centers**

| Significant Health Needs Addressed | ☑ Education  
|-----------------------------------|----------------|
|                                    | ☑ Access to Mental Health  
|                                    | ☑ Homelessness or Housing  
|                                    | ☑ Cardiovascular Disease and Stroke  
|                                    | ☑ Cancer Screenings  

| Core Principles Addressed | ☑ Focus on Disproportionate Unmet Health-Related Needs  
|                         | ☑ Emphasize Prevention  
|                         | ☑ Contribute to a Seamless Continuum of Care  
|                         | ☑ Build Community Capacity  
|                         | Demonstrate Collaboration  

| Program Description | The Santa Maria, Family Medicine and Higuera Clinics assure access to quality primary health care for the residents of North West Santa Maria and San Luis Obispo, focusing on the underserved, uninsured/underinsured. These Community Clinics address health disparities, with a focus on patients who are homeless.  

| Community Benefit Category | C3-Hospital Outpatient Services  

| FY 2018 Report |  

| Program Goal / Anticipated Impact | The Pacific Central Coast Health Center locations of Bunny Street, Family Medicine and Higuera Street provide top quality comprehensive accessible, affordable healthcare with customer friendly service and easy access to services in our community. PCCHC promotes wellness and necessary care for illnesses while achieving a high level of quality and compassion which we want for our own families.  

| Measurable Objective(s) with Indicator(s) | 1. Enroll a total of 50 uncontrolled diabetic patients in CDSMP Self-Management Program and/or DEEP (Diabetes Empowerment Education Program.  
|                                           | 2. Enroll 100 assigned CenCal or uninsured children in Reach out and Read program during the well child visit.  
|                                           | 3. Enroll 50 patients with a BMI of 28 or greater in Healthy for Life Wellness Program (HFL).  
|                                           | 4. Participate in a minimum of 10 outreach events throughout the year where health education and screenings can be performed.  
|                                           | 5. Provide local schools with a total of 50 free or low cost physicals, health screenings and the newly requested concussion clinic.  
|                                           | 6. Implement and provide concussion screenings for all sports physicals. Establish a baseline number of how many patients were referred to concussion clinic.  
|                                           | 7. Provide and participate in 2 “no charge flu clinics” at Marian Community Clinic for 150 patients during FY18 flu season.  

| Intervention Actions for Achieving Goal | 1. Utilize data from Electronic Health Care System to identify poorly controlled diabetic patients to ensure proper referral is made. This information will allow us to partner with Marian Regional Medical Center and other outside non-profits to provide education.  
|                                         | 2. Implement Read Out and Reach program at the MCC-SM Clinic and Family Medicine Center.  
|                                         | 3. Utilize data from Electronic Health Care System to create a workflow to identify patients with a >BMI of 28 and ensure proper referrals are provided.  

Marian Regional Medical Center  
Community Benefit FY 2018 Report and FY 2019 Plan  
36
4. Expand all 3 clinics to after-hours medical care (MCC-SM, FMC, and Higuera) to 1 Saturday a month, at minimum.
5. Continue partnership with outside non-profit organizations to provide diabetic education workshop.
6. Identified the need for a concussion clinic for youth athletes during sports physical visits.
7. Partner with local community organizations to identify flu vaccine outreach opportunities

<table>
<thead>
<tr>
<th>Planned Collaboration</th>
<th>Santa Barbara County Food Bank, Community Education Dept., YMCA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Performance / Outcome</strong></td>
<td></td>
</tr>
<tr>
<td>1. Referred a total of 109 patients to CDSMP and DEEP Programs; total of 3 enrolled.</td>
<td></td>
</tr>
<tr>
<td>2. No referrals to Reach out and Read as our program application was not complete.</td>
<td></td>
</tr>
<tr>
<td>3. Referred a total of 91 patients with BMI greater than 28 to health education department; total of 10 enrolled.</td>
<td></td>
</tr>
<tr>
<td>4. Participated in the following outreach programs:</td>
<td></td>
</tr>
<tr>
<td>- Family Medicine – Vision Exams (27 pre-school)</td>
<td></td>
</tr>
<tr>
<td>- Family Medicine – Allan Hancock – BP Checks (25)</td>
<td></td>
</tr>
<tr>
<td>- Marian Community Clinic - Day of the Farm Worker – 12/3/2017 Clinic Consultations 250</td>
<td></td>
</tr>
<tr>
<td>- Family Medicine – Pismo Open – (197) Random Glucose and BP</td>
<td></td>
</tr>
<tr>
<td>- Food Bank – 5 Health screenings A1c with a total of 54 patients served. Locations were Guadalupe, Santa Maria and Lompoc. Marian Community Clinic and Lompoc Health Center</td>
<td></td>
</tr>
<tr>
<td>5. Family Medicine – SMHS (3) Referred and treated for Concussion Clinic</td>
<td></td>
</tr>
<tr>
<td>6. Provided 99 free physicals and health screenings</td>
<td></td>
</tr>
<tr>
<td>7. No baseline established as concussion screenings are not performed. Concussion exams provided upon request from athletic directors or team doctors.</td>
<td></td>
</tr>
<tr>
<td>8. 257 flu shots given at 2 no charge flu shot events.</td>
<td></td>
</tr>
</tbody>
</table>

| Hospital’s Contribution / Program Expense |
| No expenses were documented due to the ongoing discussion among the system office: Community Health and Finance departments determining the recommended percentage of expense to be claimed as a community benefit expense. |

| **FY 2019 Plan** |
| Increase healthcare access by providing free health screenings and appropriate health care community referrals. |

| Measurable Objective(s) with Indicator(s) | |
| 1. PHC will refer a total of 60 patients per month that present with a diagnosis of Diabetes or Obesity with a BMI great than 28 to the following programs; |
|   - CDSMP Self-Management Program |
|   - DEEP (Diabetes Empowerment Education Program) |
|   - Healthy for Life Wellness Program (HLW) |
| 2. Increase Blood Pressure Screenings and random glucose testing by 5% (baseline 25 blood pressure checks, 197 random glucose) |
| 3. Participate in 10 Community Outreach Events. |
| 4. Increase flu shots by 5% for FY19 flu season. (baseline 257) |
| 5. Increase free sports physicals and health screenings by 5% in local schools which will include concussion education and awareness. (Baseline 99) |
| **Intervention Actions for Achieving Goal** | 1. Utilize data from Electronic Health Care System to identify poorly controlled diabetic patients to ensure proper referral is made. This information will allow us to partner with Marian Regional Medical Center and other outside non-profits to provide education.  
2. Utilize data from Electronic Health Care System to create a workflow to identify patients with a >BMI of 28 and ensure proper referrals are provided.  
3. Continue partnership with outside non-profit organizations to provide diabetic education workshop.  
4. Partner with local community organizations to identify flu vaccine outreach opportunities  
5. Identified the need sports physicals and concussion awareness in local high schools. |
| **Planned Collaboration** | Dignity Health Community Education Center, Dignity Health Diabetic Center, Santa Maria Joint High School District |
### Perinatal Mood and Anxiety Disorder

| Significant Health Needs Addressed | ☐ Education  
| ☒ Access to Mental Health  
| ☐ Homelessness or Housing  
| ☐ Cardiovascular Disease and Stroke  
| ☐ Cancer Screenings |

| Core Principles Addressed | ☒ Focus on Disproportionate Unmet Health-Related Needs  
| ☒ Emphasize Prevention  
| ☒ Contribute to a Seamless Continuum of Care  
| ☒ Build Community Capacity  
| ☒ Demonstrate Collaboration |

| Program Description | Improve screening and treatment for Perinatal Mood and Anxiety Disorder (PMAD) by engaging pediatricians, obstetricians, mother’s primary care providers, and other key stakeholders in health care to address the link between maternal and child health |

| Community Benefit Category | A1-a Community Health; A2-d Community-Based Clinical Services |

### FY 2018 Report

| Program Goal / Anticipated Impact | Reframe postpartum depression as a common part of postpartum recovery to help lessen the stigma associated with getting help. |

| Measurable Objective(s) with Indicator(s) | 1. Provide 500 pregnant and delivered Spanish and Mixteco moms with postpartum depression education and support groups to reduce the stigma of mental health.  
2. Refer 500 mothers to pediatrician or primary care provider for PMAD screening |

| Intervention Actions for Achieving Goal | 1. Create an algorithm for promotores to provide mental health referrals for uninsured, underinsured and co-pay mommies.  
2. Share Edinburg scale with mommies so they become familiar with questions.  
3. Provide education to Spanish moms on the use of 211.  
Provide promotores on-going education for postpartum depression. |

| Planned Collaboration | Santa Barbara County Public Health Dept.; SBC Promotores Coalition; CALM; Behavioral Wellness |

| Program Performance / Outcome | 1. Using the Dashboard and since July 277 Spanish and Mixteco newly delivered moms have been contacted and invited to participate in Cambio de Vida con un Bebé; our culturally sensitive program name to be more discerning of the stigma attached to depression.  
2. A total of 97 moms and dads received postpartum depression education and were offered to attend a monthly support groups to reduce the stigma of mental health.  
3. While it was the promotoras intent to refer 500 mothers to pediatrician or primary care provider for Perinatal Mood and Anxiety Disorder (PMAD) screening we do not have a mechanism to document its success. RN's are offering the Edinburg tool to expectant moms in Labor and Delivery.  
4. The results of 10 and above on the Edinburg scale from Spanish and Mixteco moms were used as the criteria to refer them to the Spanish Cambiode Vide con un Bebe support group meetings, 79 mom’s fit this criteria. |
<table>
<thead>
<tr>
<th>Hospital’s Contribution / Program Expense</th>
<th>Program expense: $42,961</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2019 Plan</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Program Goal / Anticipated Impact</strong></td>
<td>Reframe postpartum depression as a common part of postpartum recovery to help lessen the stigma associated with getting help.</td>
</tr>
</tbody>
</table>
| **Measurable Objective(s) with Indicator(s)** | 1. Provide 150 pregnant and delivered Spanish and Mixteco moms with postpartum depression education to reduce the stigma of mental health.  
2. Increase attendance by 5% in monthly Spanish support groups.  
3. Refer 40 mothers to the appropriate community resources. |
| **Intervention Actions for Achieving Goal** | 1. Using Octavia Spanish and Mixteco newly delivered moms will be contacted and invited to participate in Cambio de Vida con un Bebé; our culturally sensitive program name to be more discerning of the stigma attached to depression.  
2. Those mothers that have attended Cambio de Vida con un Bebé will be invited to participate in monthly support groups.  
3. Provide education to Spanish moms on the use of 211. |
| **Planned Collaboration**                | Santa Barbara County Public Health Dept.; SBC Promotores Coalition; CALM; Behavioral Wellness, PMAD Stakeholders network |
# Economic Value of Community Benefit

Marian Regional Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2017 through 6/30/2018

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Persons Served</th>
<th>Net Benefit</th>
<th>% of Org. Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits for Poor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>4,127</td>
<td>4,116,456</td>
<td>0.8</td>
</tr>
<tr>
<td>Medicaid *</td>
<td>100,221</td>
<td>15,417,929</td>
<td>2.8</td>
</tr>
<tr>
<td>Other Means-Tested Programs</td>
<td>4</td>
<td>9,514</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Community Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Community Health Improvement Services</td>
<td>48,605</td>
<td>2,825,552</td>
<td>0.5</td>
</tr>
<tr>
<td>C - Subsidized Health Services</td>
<td>754</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>E - Cash and In-Kind Contributions</td>
<td>113</td>
<td>1,619,682</td>
<td>0.3</td>
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<tr>
<td>F - Community Building Activities</td>
<td>11</td>
<td>3,076</td>
<td>0.0</td>
</tr>
<tr>
<td>G - Community Benefit Operations</td>
<td>15</td>
<td>237,831</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Totals for Community Services</strong></td>
<td>49,498</td>
<td>4,686,141</td>
<td>0.9</td>
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<tr>
<td><strong>Totals for Poor</strong></td>
<td>153,850</td>
<td>24,230,040</td>
<td>4.5</td>
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<tr>
<td><strong>Benefits for Broader Community</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Community Health Improvement Services</td>
<td>4,544</td>
<td>769,441</td>
<td>0.1</td>
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<tr>
<td>B - Health Professions Education</td>
<td>746</td>
<td>5,482,793</td>
<td>1.0</td>
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<tr>
<td>G - Community Benefit Operations</td>
<td>10</td>
<td>23,135</td>
<td>0.0</td>
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<tr>
<td><strong>Totals for Community Services</strong></td>
<td>5,300</td>
<td>6,275,369</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Totals for Broader Community</strong></td>
<td>5,300</td>
<td>6,275,369</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Totals - Community Benefit</strong></td>
<td>159,150</td>
<td>30,505,409</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>100,723</td>
<td>44,236,977</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Totals with Medicare</strong></td>
<td>259,873</td>
<td>74,742,386</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $34,259,039.
APPENDIX A: HOSPITAL COMMUNITY BOARD FISCAL YEAR 2018

Rebecca Alarcio (Chair)
Community Educator/Administrator, Ret.

Carolyn Baldiviez, D.D.S.
Dentist

Debbie Blow, Ph.D.
Superintendent, Orcutt Union School District

Julie Coleman
Philanthropist / Chair, Arroyo Grande
Community Hospital Foundation Board

Michael Bouquet
Businessman
Business Manager, Toyota of Santa Maria

Sister Pius Fahlstrom, OSF
Finance / Religious Sponsor
Sisters of St. Francis

Kevin Ferguson, M.D.
Physician / Pathologist

Terry Fibich
Retired Fire Chief

Steve Flood, D.D.S.
Dentist

Jacqueline Frederick, Esq.
Attorney / Community Leader
Frederick Law Firm

Angelica Gutierrez (Immediate Past Chair)
Finance / Banking Institution Executive
Rabobank America

Tom Martinez
Architect
Martinez & Associates

Juan Reynoso, M.D.
Physician / Emergency Medicine

Sister Carol Snyder, OSF
Religious Sponsor
Sisters of St. Francis

Kevin G. Walthers, Ph.D. (Vice Chair)
College Superintendent / Educator
Allan Hancock College

James Wesner
Agriculture Business Owner

Joseph Will (Secretary)
Businessman / Construction Executive
CalPortland

Elaine Yin, M.D.
Physician/OB-Gyn

Hospital Representatives
Sue Andersen
Vice President / Service Area CFO

Charles J. Cova
Senior Vice President, Operations
Dignity Health

Kenneth R. Dalebout
Administrator, Marian Arroyo Grande Campus

Alex Harrison, M.D.
Cardiology
President of the Medical Staff

Villa Infanto, MBA RN
Vice President, Patient Care Services

Eugene Keller, M.D.
Vice President, Quality, Service Area

David Ketelaar, M.D.
Emergency Medicine
Chief of Staff

Kerin A. Mase
APPENDIX A: COMMUNITY BENEFIT COMMITTEE FY 2018

David Duke, M.D.
Physician Advisor
Case Management & Utilization Review

Sister Pius Fahlstrom, OSF
Ret. Financial Analyst / Religious Sponsor

Terry Fibich
Hospital Community Board Member

Bill Finley
VP / Chief Financial Officer

Katherine Guthrie
Senior Regional Director, Cancer Services

Dr. Melvin Lopez
Pacific Central Coast Health Centers

Chelsea Leitcher
Chaplain, Marian Regional Medical Center

Flora Washburn
Manager, Chaplaincy Services & Pastoral Care

Dora Robles
Manager of Clinical Operations
Pacific Central Coast Health Centers

Tina McEvoy, RN
Care Transitions, Service Area Coordinator

Anne Rigali
Foundation Board Member

Heidi Summers, MN, RN
Senior Director, Education and Mission Integration

Kathleen Sullivan, Ph.D., RN
Vice President, Post-Acute Care Services

Elizabeth Snyder, MHA
Vice President, Pacific Central Coast Health Centers

Sandy Underwood
Senior Community Education Coordinator

Marian Regional Medical Center
Community Benefit FY 2018 Report and FY 2019 Plan

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**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.

**Medically Fragile Respite Care** – Patients discharged from MRMC-SM or MRMC-AG campus that are homeless need a secure place to stay while recovering from their hospital stay. Good Samaritan Shelter in Santa Maria provides respite beds for these homeless medically fragile patients. At the end of their stay MRMC-SM are billed a day rate. The shelter has an in-house clinic that facilitates the patient’s limited medical care. The same is true for those patients needing this service from the MRMC-AG campus which is about 18 miles north of Santa Maria. Lucia Mar Unified School District (LMUSD) and the 5 Cities Homeless Coalition identified more than 1400 “homeless” children in the LMUSD and provided services and education. Home for Good/United Way works to identify chronically homeless people with comorbidities and providing housing first, case management for supportive services and referrals for mental health service.

The **Marian Family Medicine Residency Program** is an Accreditation Council of Graduate Medical Education (ACGME) approved three-year post-graduate primary care training program for Family Medicine physicians. The Marian Family Medicine program, now in its 5th Academic year, has achieved great success in its mission of training and recruiting new primary care physicians to care for the patients on the Central Coast. This year the Marian Hospital Community Board and Organized Medical Staff at MRMC committed to the mission of the creation of a new ACGME approved program in Obstetrics and Gynecology (OB/GYN). This 4 year program has now started the 2018-19 academic year with 3 new resident physicians in its first inaugural class. The program will ultimately have 12 total residents when it reaches its final full complement in July of 2021. Marian Regional Medical Center chose to add an OB/GYN program as a way to address the critical need of projected shortages of OB/GYN physicians in our region and throughout the nation. All of our new residents benefit from the privilege of providing care for patients in our communities and the access to training and from the focused attention of our outstanding medical staff at MRMC. The Marian Family Medicine and OB/GYN Residency programs will provide the educational opportunities and patient experiences necessary to produce outstanding future physicians for the benefit of our Central Coast region and our Nation for many years to come.

**Human Trafficking** – This initiative was launched in FY 2015 with an emergency response team established and a roll out of the first phase of education and training for hospital clinical staff to increase awareness of this System initiative. Subsequent trainings were held for non-clinical staff. An algorithm was developed that engages community resources to partner with several non-profit organizations, law enforcement and the Santa Maria Court System. Plans are underway to model this response team at the MRMC-AG campus. In partnership with Community Action Commission’s Front Porch Program MRMC-SM campus is working with the programs coordinator for the making of hard referrals for those girls who have been trafficked or are rape victims. Six girls between 12 and 15 have built a secure nurturing relationship with the coordinator of our Confident Me Program. We are offering nutrition education, self-esteem building, and bi-monthly support groups. The teens have grown into more confident young women with goals of continuing their education and becoming more confident in their personhood.
Janet’s Closet/Pediatric Closet – The Pediatric Closet was established in October, 2016. The purpose of the infant and children’s recycle and donation program is to serve the inpatient population in need. The Pediatric Closet serves the entire hospital and is frequently used by the Emergency Department. Marian Regional Medical Center Staff has 24 hour access to the closet. MRMC partners with the Children’s Resource Network of the Central Coast in offering this program to over 2500 children. Over 510 articles of children’s clothing was donated to the Thomas Fire and Montecito Flood Victims. This summer a second TEEN Closet was open to serve our adults and teens.

Health Profession Education – Both the Santa Maria and Arroyo Grande Campus regularly sponsor training for medical students, nurses, and other students in the health care field. Hundreds of hours each year are committed to providing a clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapist, social workers, pharmacists, and other health professionals from universities and colleges. Both campuses also provide hospital experience based training opportunities for nursing students needing to conduct their clinical rounding. For over a year both campuses have partnered with local community colleges by donating money so the college could disperse funding as needed for purposes of addressing community wide workforce issues such as school-based programs on health care careers.

Hospital staff serves on many community committees and boards in the service area such as: Santa Maria Boys and Girls Club, Area Agency on Aging, Community Partners in Care, 1st Five Advisory Board, Live Well Santa Barbara County, Active Aging Committee, CALM, Santa Barbara County Education Office’s Promotores Coalition, Guadalupe Family Resource Center and the Women’s Commission of Santa Barbara County.

The MRMC-AG campus serves 100 box lunches a month through the local Catholic Church; provides the Salvation Army four weekly milk deliveries for those homeless using their facility and serves monthly meals to homeless adults in a local park. Additionally in the AG campus service area there is a strong connection to the Lucia Mar Unified School District and through the Boys and Girls Club of Oceano providing nutrition education (Healthalicious) and self-esteem workshops to local elementary and junior high schools as well as summer programs. The Lucia Mar Unified School District is committed to providing an Independent Study Classroom for teen pregnant moms; the MRMC-AG campus supported these efforts through a donation to the program.

The Santa Barbara County Education Office’s Health Linkages program is the fiscal agent for the Santa Barbara County Promotores Coalition. The lead promotora (Community Health Worker) is an essential part of the success of this program. Marian provides financial support for this position. Promotores are an integral part of outreach provided at both campuses.

The Marian Osteoporosis Center offers a range of comprehensive services focusing on the evaluation and management of patients with osteoporosis as well as a number of free community service and education program including a consultative clinical resources for those at risk of diagnosed with osteoporosis; diagnostic bone mineral density testing, post-fracture osteoporosis management, support groups, and fall prevention risk assessments screenings available at health fairs or our local clinic.

High Risk Infant Follow-up is for children who require special care as neonates; this is an integral part of the continuum of their care. The follow-up program provides developmental testing by a pediatric
nurse. This program supplements the role of the local physician who provides primary health care for the child. Its goal is to provide developmental testing for certain categories of high-risk infants.

Concussion Education for Students
Sports-related concussion, a type of traumatic brain injury caused by a blow or bump to the head that can change the way a brain works, is one of the most serious public health concerns among the nation’s 8 million high school athletes. There is only one program – Barrow Brainbook - offered through the Dignity Health Concussion Network that mandates rigorous athlete-specific, athlete-directed concussion education. The Dignity Health Concussion Network was developed by Dr. Javier Cardenas, a nationally recognized neurologist. It is comprised of four primary services: concussion education, cognitive measurement, professional education and consultation, and concussion research. In MRMC’s service area a total of 99 free sports physicals were provided to high school athletes at the following schools: Santa Maria, Pioneer Valley, and Ernest Righetti. For FY 2019 every free sports physical offer will include concussion education and awareness.
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.
Arroyo Grande Community Hospital; 345 South Halcyon Road, Arroyo Grande, CA 93420; Financial Counseling, 805-489-4261, ext 4411; Patient Financial Services, 888-488-7667;  
www.dignityhealth.org/arroyo-grande/paymenthelp

Marian Regional Medical Center; 400 East Church St, Santa Maria, CA 93454; Financial Counseling, 805-739-3541; Patient Financial Services, 888-488-7667;  
www.dignityhealth.org/marianregional/paymenthelp