Marian Regional Medical Center

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021

Marian Regional Medical Center

Arroyo Grande Community Hospital

Dignity Health
Marian Regional Medical Center

A message from…

Sue Andersen, President and CEO of Marian Regional Medical Center, which includes Arroyo Grande Community Hospital, and Mike Bouquet, Chair of the Dignity Health Marian Regional Medical Center Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessment. This assessment is conducted with community input, including from the local public health department. Our initiatives to deliver benefits to the community include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital with community partners, and investing in efforts that address social determinants of health.

Marian Regional Medical Center has a commitment to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2021 Report and 2022 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. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report these to our community.

In fiscal year 2021 (FY21), Marian Regional Medical Center provided $42,708,130 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $54,605,054 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its October 13, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any input that you may have by reaching out to Patty Herrera at 805-739-3593.

Sue Andersen
President/CEO

Mike Bouquet
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Marian Regional Medical Center which includes Arroyo Grande Community Hospital serves the communities of the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434), Nipomo (93444), Arroyo Grande (93420), Grover Beach (93433), Oceano (93445), and Pismo Beach (93449).
Economic Value of Community Benefit	$42,708,130 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $54,605,054 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). Needs being addressed by strategies and programs are: • Educational attainment for adults in the community; • Access to primary health care, including behavioral health; • Aging, more mature population; and, • Chronic disease prevention and management
FY21 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: Cancer Prevention and Screenings; Cardiovascular Disease and Stroke lectures and screenings; Chronic Disease Self-Management workshops; Diabetes Prevention and Management and Diabetes Education Empowerment Program (DEEP). The Street Medicine Program was expanded to two outings a month to address the health concerns of the unsheltered. The Faith Community Nursing/Health Ministry program was launched to focus on identifying and serving the needs of the more mature population in our community. The Perinatal Mood and Anxiety Disorder (PMAD) program provided mental health support for families in the Santa Maria Valley. A total of $270,358 was awarded in the Dignity Health Community Grants program to Accountable Care Communities that address educational attainment and basic needs for the aging and more mature population
FY22 Planned Programs and Services	For FY22, the hospital plans to continue to offer the chronic disease and diabetes self-management workshops via the ZOOM platform due to the uncertainty of COVID infection. Increase cancer awareness on the importance of early detection for colon, breast, and cervical cancer. Continue offering our mental health support to families impacted by PMAD. Our Faith Community Nursing/Health Ministry will continue to access the needs of the more mature population. Continue with our Street Medicine rounds among the unsheltered.

This document is publicly available online at https://www.dignityhealth.org/central-coast/locations/marianregional/about-us/community-benefits

Written comments on this report can be submitted to the MRMC's Mission Integration Office at 1400 E. Church Street, Santa Maria, CA 93454 or by email to CHNA-CCSAN@DignityHealth.org.

Our Hospital and the Community Served

About Marian Regional Medical Center

Marian Regional Medical Center which includes Arroyo Grande Community Hospital is a member of Dignity Health, which is a part of CommonSpirit Health.

Marian Regional Medical Center (MRMC) is located at 1400 East Church Street in Santa Maria, California, and is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Between 1940 and present day, MRMC has transformed into a state-of-the-art, 191-bed facility that is well positioned to serve a continuously growing patient population. MRMC is designated a STEMI Receiving Center in Santa Barbara County, and is designated a Level III Trauma Center by Santa Barbara County's Emergency Medical Services Agency. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. Our cancer care program is accredited as a Comprehensive Community Cancer Center by the American College of Surgeons' Commission on Cancer. The campus houses a comprehensive perinatology/ neonatology program, providing specialized care to the tiniest of patients. This year MRMC Center was pleased to announce the grand opening of a new Pediatric Emergency Department to enhance care for youth in the community. The new addition of the nearly 2,000 square foot unit includes: seven dedicated pediatric beds including three triage rooms, a separate pediatric entrance, a dedicated pediatric nurse's station, and a newly designed lobby. The increase in overall beds brings the total Emergency Department beds to 42, including private adult rooms. The hospital license also includes a 95 bed skilled nursing facility, homecare, hospice and home infusion programs, along with outpatient labs and radiology centers throughout the community.

Arroyo Grande Community Hospital (AGCH) is located at 345 South Halcyon Road in Arroyo Grande, California and is approximately 15 miles north of Santa Maria. The AGCH has been serving the health care needs of the Five Cities area since it became a member of Dignity Health in 2004. AGCH is rated a top Joint Replacement Center by Blue Shield and among the top in the Nation for Joint Replacement, offering the latest in robotic and other technologically advanced orthopedic procedures. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. This year AGCH completed the construction of their new Emergency Department to better meet the needs of the growing community. The new building, which altered the façade of the hospital, features 20 private treatment rooms compared to the 11 bed ward and semi-private rooms that previously existed. Specialized rooms are designated for infectious disease isolation, gynecology, gastroenterology, trauma, bariatric patients, and orthopedic emergencies, as well as fast-track beds for patients with less urgent conditions. It also features a specialized exam room for patients experiencing behavioral health related issues. The hospital also has a 20 bed acute rehab center.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

Marian Regional Medical Center which includes Arroyo Grande Community Hospital is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements.

The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's website.

Description of the Community Served

The community served by Marian Regional Medical Center and Arroyo Grande Community Hospital has a population of just over 235,000 individuals. Marian Regional Medical Center in Santa Maria serves the City of Santa Maria, Guadalupe, Nipomo, and Orcutt. Arroyo Grande Community Hospital serves the community extending from the northernmost boundary of the MRMC service area and includes the communities of Arroyo Grande, Grover Beach, Nipomo, Oceano, and Pismo Beach. Nipomo demographic information will be included in the MRMC-discussion to prevent duplication. A summary description for each community is below. Additional details can be found in the CHNA report online

Marian Regional Medical Center
MRMC serves a community that is home to nearly 150,000 residents, where the majority resides within Santa Maria City. The community served by MRMC-SM is culturally diverse with the majority of residents (64.8%) considering themselves of Latino (a) or Hispanic origin, 25% are Spanish speaking only. With respect to educational attainment, over 40% of Santa Maria and Guadalupe residents aged 25 and over did not complete high school. Specifically, within Santa Maria City zip code 93458, 53.9% of all adults over age 25 and over did not complete high school and 21.7% of the population resides in poverty. The community MRMC serves is host to a reported 720 homeless individuals.

In addition to the residents captured by the formalized data sources 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.

Arroyo Grande Community Hospital
The AGCH serves the community of the "Five Cities" area which includes the neighboring cities of Arroyo Grande, Grover Beach, Nipomo, Oceano, and Pismo Beach. Demographics of the AGCH service area indicate 66% of the residents are non-Hispanic white and an estimated 26% are Hispanic or Latino (a). The AGCH service area has a high school graduation rate of 89.3% for those aged 25 and older.

Approximately, one in five residents (21.1%) are 65 years and older. The community MRMC-AG serves is host to a reported 359 homeless individuals.

Two medically underserved communities have been designated within the MRMC primary service area by the Health Resources and Services Administration (HRSA), including Guadalupe (MUA/P ID: 00301) and Arroyo Grande (MUA/P: 00395).

Demographic information for the MRMC which includes AGCH was taken from Claritas Pop-Facts 2020; SG2 Market Demographic Module provides data on the following:

Marian Regional Medical Center

- **Total Population:** 154,675
- **Race:**
  - 25.0% White
  - 1.3% Black/African American,
  - 66.4% Hispanic or Latino
  - 5.0% Asian/Pacific Islander
  - 2.3% All Others
- **% Below Poverty** 9.4 %
- **Unemployment:** 5.7 %
- **No HS Diploma:** 31.9%
- **Medicaid (household):** 8.6 %
- **Uninsured (household):** 5.5 %

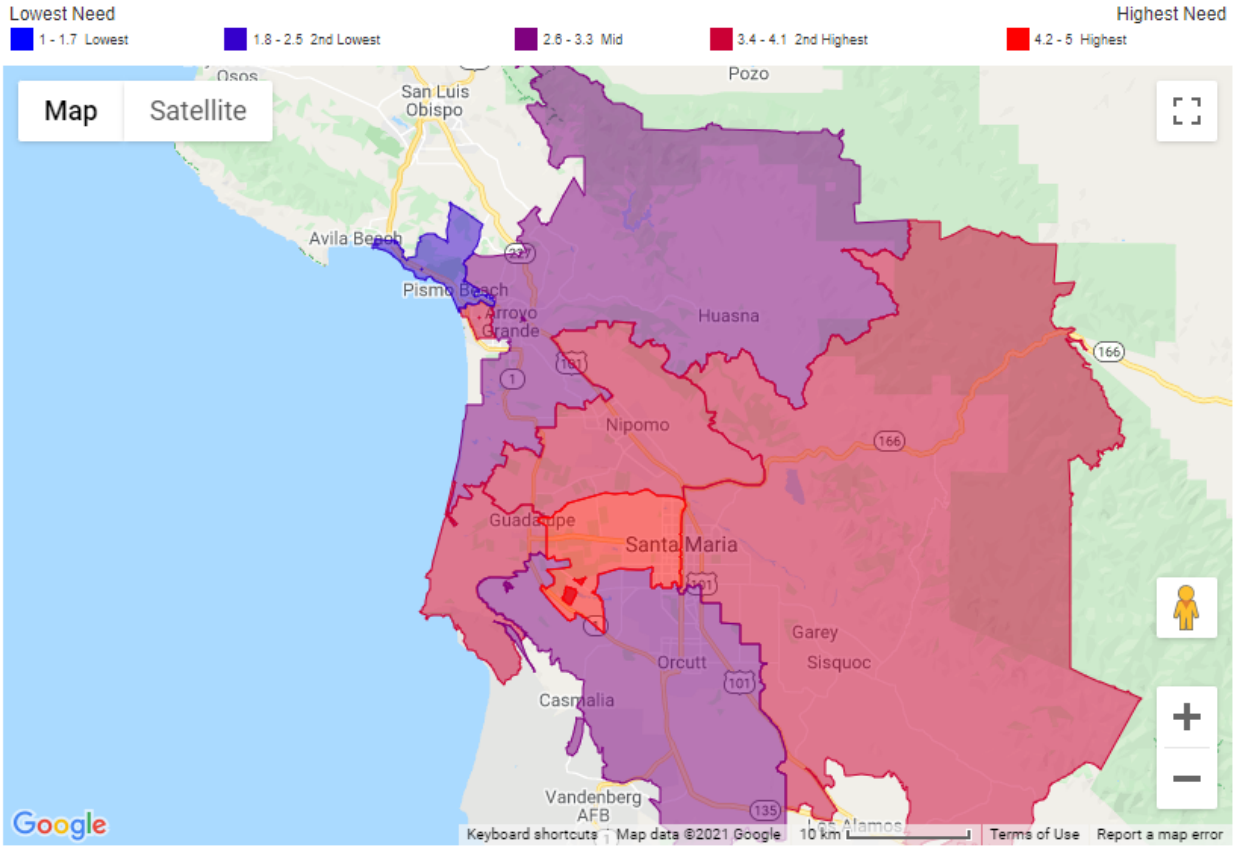
Arroyo Grande Community Hospital

- **Total Population:** 117,893
- **Race:**
  - 60.3% White
  - 1.2% Black/African American,
  - 30.5% Hispanic or Latino
  - 4.5% Asian/Pacific Islander
  - 3.5% All Others
- **% Below Poverty** 4.8%
- **Unemployment:** 5.0%
- **No HS Diploma:** 8.6 %
- **Medicaid (household):** 4.8 %
- **Uninsured (household):** 3.2 %

Community Need Index

One tool used to assess health needs 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 healthcare 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.



Mean(zipcode): 3.5 / Mean(person): 3.6 CNI Score Median: 3.7 CNI Score Mode: 4

Zip Code	CNI Score	Population	City	County	State
93420	2.8	29901	Arroyo Grande	San Luis Obispo	California
93433	3.8	13202	Grover Beach	San Luis Obispo	California
93434	4	7699	Guadalupe	Santa Barbara	California
93444	3.6	21779	Nipomo	San Luis Obispo	California
93449	2.4	7965	Pismo Beach	San Luis Obispo	California
93454	4	40126	Santa Maria	Santa Barbara	California
93455	3	45046	Santa Maria	Santa Barbara	California
93458	4.2	61804	Santa Maria	Santa Barbara	California

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its 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, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in June 2019.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

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/central-coast/locations/marianregional/about-us/community-benefits or upon request at the hospital's Community Health office.

Significant Health Needs

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

- Low adult educational attainment.
- Improve access to primary health care, including behavioral health
- The underserved needs of the aging, more mature population
- Chronic disease prevention and management.

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2021 Report and 2022 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 FY21 and planned activities for FY22, 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.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. 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 works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

Marian Regional Medical Center which includes Arroyo Grande Community Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Rooted in Dignity Health's mission, vision and values, Marian Regional Medical Center the Community Board and the Community Benefit Committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see page 45). 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. 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 dependent by the current COVID-19 situation 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. Continue collaborating with the Santa Barbara County Promotores Coalition and Herencia Indígena will support both MRMC and AGCH to increase awareness and attendance among the Latino/Hispanic and Mixteco community for nutrition, chronic disease management, health screenings, diabetes, cardiovascular disease, and stroke and cancer awareness.

Impact of the Coronavirus Pandemic

As the stay home orders and COVID-19 restriction began to be lifted, Marian Regional Medical Center remained vigilant and proactive in collaborating with Santa Barbara County Public Health, and accessing the needs of our community partners. Due the resurgence of COVID-19 and the Delta Variant, the bilingual COVID-19 Information line was reactivated and staffed by the Community Health Department with the focus of assisting those callers needing help obtaining a vaccine appointment. Bilingual vaccine public service announcements were developed and aired on the local radio stations and television stations. Ongoing collaboration efforts between Santa Barbara County Public Health, Community Health Centers of the Central Coast, and MRMC Community Education focused on developing COVID-19 vaccine education outreach to the Latino population which resulted in the establishing mobile vaccine clinics in strategic neighborhoods in San Luis Obispo County.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Educational Attainment

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is encourage higher education, adult literacy and medical literacy.	☒	☒
Bilingual Support Groups	• Free cancer, diabetes, and grief support groups offered.	☒	☒
Spanish & Mixteco Interpreters	• Providing bilingual bicultural interpreter services to hospital departments for non-English speaking patients.	☒	☒

Impact: Improve community health efficacy by providing programs based on an individuals' spoken language and literacy level.

Collaboration: Planned collaboration with Santa Maria Bonita and Orcutt School Districts, Herencia Indígena, MRMC Care Coordination, Social Work, ED, and Labor and Delivery departments.

Health Need: Access to Primary Health Care including Behavioral Health

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, medical prescriptions, and behavioral health care.	☒	☒
Financial assistance programs	• Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.	☒	☒
Street Medicine Program	• Offering very basic health and needs assessments to unsheltered individuals	☒	☒
Perinatal Mood Anxiety Disorder	• Provide mental health support to families impacted by perinatal mood and anxiety disorder.	☒	☒

Impact: Increase access to free and low cost medical care and resources to provide early detection, prevention, and management of illness.

Collaboration: Planned collaboration with Marian Family Medicine Residency Program SLO Noor free medical and dental clinics, MRMC/AGCH care coordination and social work departments, Alliance for Pharmaceutical Assess (APA Inc.), Mission Hope Cancer Center, Pacific Central Coast Health Centers and MRMC Community Health Department

Health Need: Aging, more Mature Population

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, dental care, medical prescriptions, and behavioral health care.	☒	☒
Dignity Health Wellness programs	• Free evidence based self-management disease workshops.	☒	☒
Financial assistance programs	• Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.	☒	☒
Faith Community Nursing/Health Ministry program digest	• Free program which approaches care as a "whole person" address the spiritual, physical, mental and social health of the person in their faith community	☒	☒

Impact: Increase support for the development of an Adult Based Health Care Program which: approaches the needs of the mature adult in a whole person approach which should include the following: a lunch/nutrition program, caregiver program, behavioral wellness component, and end of life discussion component

Collaboration: Planned collaboration with Dignity Heath's Home Health, Care Coordination, Transitions Care Center, Social Work, Family Service Agencies, Meals on Wheels, SB Foodbank, APA Inc. Pacific Central Coast Health Centers, and Area on Aging Agency

Health Need: Chronic Disease and Management

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Dignity Health Wellness programs	• Free evidence based self-management disease workshops.	☒	☒
Free Screening Mammogram clinics	• Cancer Care program offers free screening mammograms to women who are uninsured or underinsured.	☒	☒
Faith Community Nursing/Health Ministry program digest	• Free program which approaches care as a "whole person" to address the spiritual, physical, mental and social health of the person in their faith community.	☒	☒
Support Groups	• Free cancer, diabetes, stroke, and grief support groups offered.	☒	☒

Impact: Increase cancer cardiovascular disease, diabetes, and stroke awareness, prevention, and management to the most vulnerable populations in SLO county and to increase early detection and management

Collaboration: : Planned Collaboration Community Clinics of the Central Coast, Pacific Central Coast Health Centers, and Santa Barbara Public Health Department, Mission Hope Cancer Center

Community Grants Program

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. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY21, the hospital awarded the grants below totaling $ 270,358. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Family Service Agency of Santa Barbara County	Senior and Caregiver Support	$ 65,990.75
Future Leaders of America (FLA)	A-G For All!	$ 65,900.75
Los Osos Cares, Inc.	Basic Needs and Resources for Vulnerable & Seniors	$ 30,522.75
SLO Noor Foundation	Dental Care Access and Service Expansion for Uninsured and Underinsured	$ 30,522.75
Alliance for Pharmaceutical Access (APA)	Coronavirus Pandemic Community Support Grant	$ 10,000.00
Catholic Charites	Coronavirus Pandemic Community Support Grant	$ 20,000.00
Community Partners in Caring	Coronavirus Pandemic Community Support Grant	$ 5,484.20
Estero Bay Kindness Coalition	Coronavirus Pandemic Community Support Grant	$ 5,484.20
Hospice of San Luis Obispo County	Coronavirus Pandemic Community Support Grant	$ 5,484.20
Pregnancy & Parenting Support of San Luis Obispo County	Coronavirus Pandemic Community Support Grant	$ 5,484.20
SLO Bangers Syringe Exchange and Overdose Prevention Program (NASEN)	Coronavirus Pandemic Community Support Grant	$ 5,484.20
Unitarian Society of Santa Barbara	Coronavirus Pandemic Community Support Grant	$20,000.00

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. 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.

Cancer Prevention and Screening Program	
Significant Health Needs Addressed	❑ Education Attainment ❑ Access to Primary Health Care including Behavioral Health ✔ Aging, More Mature Population ✔ Chronic Disease Prevention and Management, including Cancer
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 2021 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 in participation of rehabilitation and psychosocial support services as well as cancer awareness, prevention activities, screenings and genetic counseling.
Measurable Objective(s) with Indicator(s)	1. Increase the number by 5% of target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services. 2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving cancer prevention and screening services: Colonoscopy-5% (100); Prostate-5% (64); Skin-5% (119); Lung-5% (1,144); Smoking Cessation-5% (150); Survivorship Care Plans-5% (95); Emmi services-5% (350); 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track number of patients needing financial assistance to participate: Genetic Counseling-5% (83) 4. 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. 5. Increase by 5% (1,328) monthly nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). Ensure at least 35% of returning education participants identify at least one healthy behavior from nutrition classes they have adopted into their lifestyle over the past month. 6. Increase the number of new patients from target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 5% (87). Ensure at least 50% of

	patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion.
Intervention Actions for Achieving Goal	1. Maximize the use of both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to available psychosocial support services. 2. Provide cancer prevention and screening information through counseling and support services, outreach events, social media platforms, radio and print material. 3. Provide the necessary financial support for genetic counseling to medically underserved patients in need of assistance. 4. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance. 5. Continue to utilize the support of the lay patient navigator and dietitian to educate participants in medically underserved communities 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. 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.
Collaboration	Community Health Centers of the Central Coast, SLO Noor Free Clinic, Community Action Partnership of San Luis Obispo County, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, Wisdom Center, 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, St John's Newman Church, St Joseph's Church, St Mary's Church, Sunny Country Radio, Every Woman Counts (EWC) program, Jack Helping Hand, Alan Hancock Community College, Lucia Mar Unified School District, Bonipak Produce and New Tech High School.
Performance / Impact	1. 1,710 medically underserved patients have been screened and referred to social support services this fiscal year (39% increase from FY20): 65 received free counseling services with follow up assessments and 1,302 were connected to other psychosocial supportive services, including financial support, exercise rehab, nutritional counseling, nurse navigator support and spiritual guidance. 2. Patients assisted with screening services this fiscal year: 109 (SM:94/FC:15) colorectal screenings (10% increase from FY20, 7 new cancer cases have been identified); 0 prostate and skin screenings (due to COVID-19, screenings have been postponed); 1,002 (SM:686/FC:316) lung screenings (6% increase from FY20, 12 new cancer cases have been identified); 213 smoking cessations (37% increase from FY20); 118 survivorship care plans 100% increase from FY20) and 617 Emmi participants (75% increase from FY20).

	3. 107 (SM: 86/FC: 21) under/uninsured patients were served by the genetic counseling program (29% increase from FY20) 72 were assisted financially, totaling $21,096(SM: $14,321; FC: $6,775). 4. 341 under/uninsured patients have been provided financial assistance for cancer care needs: (60%) female; (67%) Hispanic; (60%) unemployed; (34%) laborers; (70%) under 60 years of age; and (28%) supporting 2 or more children. Additionally, 3,591 medically underserved patients have been transported for cancer care and another 342 (SM: 367/FC: 75) patients were supported with financial assistance for transportation needs, totaling $17,100 (SM: $13,338; FC: $3,762). 5. 1,452 (SM: 1,376/FC: 76) medically underserved patients were supported through the nutrition counseling program this fiscal year (31% increase from FY20), while 83% of nutrition participants demonstrated at least one healthy behavior change they have adopted into their lifestyle. 6. 156 new patients enrolled in the Cancer Rehabilitation Program this fiscal year (50% increase from FY20). 78% of patients contacted four weeks following their cancer rehabilitation program completion reported the use of continued exercise.
Hospital's Contribution / Program Expense	Program Expense: $ 1,475,713
FY 2022 Plan	
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 in participation of rehabilitation and psychosocial support services as well as cancer awareness, prevention activities, screenings and genetic counseling.
Measurable Objective(s) with Indicator(s)	1. Track target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services. 2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving cancer prevention and screening services: Colonoscopy-5% (109); Prostate-5% (64); Skin-5% (119); Lung-5% (1,002); Smoking Cessation-5% (213); Survivorship Care Plans-5% (95); Emmi services-5% (617). 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track number of patients needing financial assistance to participate: Genetic Counseling-5% (107). 4. 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. 5. Increase by 5% (1,328) monthly nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). Ensure at least 50% of patients nutritionally counseled identify at least one healthy behavior in follow-up visit, which they have adopted into their lifestyle. 6. Increase the number of new patients from target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 5% (87). Ensure at least 50% of

	patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion.
Intervention Actions for Achieving Goal	1. Maximize the use of both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to available psychosocial support services. 2. Provide cancer prevention and screening information through counseling and support services, outreach events, social media platforms, radio and print material. 3. Provide the necessary financial support for genetic counseling to medically underserved patients in need of assistance. 4. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance. 5. Continue to utilize the support of the lay patient navigator and dietitian to educate participants in medically underserved communities 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. 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.
Planned Collaboration	Community Health Centers of the Central Coast, SLO Noor Free Clinic, Planned Parenthood (Santa Barbara, Ventura San Luis Obispo County), Community Action Partnership of San Luis Obispo County, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, Wisdom Center, 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, St John's Newman Church, St Joseph's Church, St Mary's Church, Sunny Country Radio, Every Woman Counts (EWC) program, Jack Helping Hand, Alan Hancock Community College, Lucia Mar Unified School District, Bonipak Produce and New Tech High School.

Cardiovascular Disease and Stroke Program	
Significant Health Needs Addressed	❑ Education Attainment ✔ Access to Primary Health Care including Behavioral Health ✔ Aging, More Mature Population ✔ Chronic Disease Prevention and Management, including Cancer
Program Description	Cardiovascular disease/stroke is one of the leading causes of death in the north Santa Barbara and San Luis Obispo County. As the leading cardiac hospital in SLO County FHMC strongly emphasizes early dictation and prevention. Through a risk assessments and education program of cardiovascular and stroke it 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; A2d- Community Based Clinical Services; A1d – Community Health Education: Support Group
FY 2021 Report	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention education, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase attendance in our Healthy for Life (HFL) Nutrition Class and Diabetes Education Empowerment Program (DEEP) by 5%. 2. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 risk factors for cardiovascular disease and stroke. 3. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 ways to reduce their risk of cardiovascular disease and stroke. 4. Forty percent of the participants attending our DEEP workshops will self-report taking their blood pressure during the course of the 6 week workshop.
Intervention Actions for Achieving Goal	1. Promote our ZOOM HFL and DEEP workshops on social media, hospital website, and other printed media outlets. 2. Recruit participants using Octavia. 3. Ask participants the 4 post workshop questions on cardiovascular disease and stroke at the 3rd session for HFL and at the post survey phone call for DEEP participants. 4. Track responses of the post workshop questions on cardiovascular disease and stroke on spreadsheet after each workshop. 5. Ask DEEP participants to take their blood pressure and weight on the 1st, 3rd, and 6th session and record in their body measurement form in their manual. 6. Instructors will track the blood pressure reading and weights on a spreadsheet of each participant that self-reports to them.
Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, Community Partners, and Pacific Health Centers of the Central Coast.
Performance / Impact	1. At total of 127 participants attended the ZOOM Healthy for Life workshops indicating a 13% increase from last year. A total of 63

	participants attended the ZOOM DEEP workshops which indicated a 5% increase from last year. Demographics of the participants were 115 Latino, 12 white, 112 females, and 15 males. 2. 100 % of the of the participants attending either our HFL or DEEP workshop were able to identify 2 risk factors for cardiovascular disease and stroke post completion of the workshop. (Baseline 80%) 3. 92 % of the participants attending either our HFL or DEEP workshop were able to identify 2 ways to reduce their risk for cardiovascular disease and stroke post completion of the workshop. (baseline 80%) 4. 53 % of the of the participants attending our DEEP workshops will self-report taking their blood pressure during the course of the 6 week workshop (baseline 100%)
Hospital's Contribution / Program Expense	Program Expense: $ 73,104
FY 2022 Plan	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention education, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 risk factors for cardiovascular disease and stroke. 2. Eighty percent of the participants in DEEP workshop are able to answer correctly on their posttest survey that carbohydrates break down to glucose which can affect their risk for heart disease and stroke. 3. Eighty of the participants attending our DEEP workshops will be able to identify goals to help control their diabetes by answering yes on their posttest survey which can affect their risk of heart disease and stroke.
Intervention Actions for Achieving Goal	1. Promote our ZOOM HFL and DEEP workshops on social media, hospital website, and other printed media outlets. 2. Recruit participants using Octavia. 3. Track responses of the post workshop questions on carbohydrates and diabetes control.
Planned Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, Community Partners, and Pacific Health Centers of the Central Coast.

Diabetes Prevention and Self-Management Program	
Significant Health Needs Addressed	❑ Education Attainment ✔ Access to Primary Health Care including Behavioral Health ✔ Aging, More Mature Population ✔ Chronic Disease Prevention and Management, including Cancer
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 2021 Report	
Program Goal / Anticipated Impact	The program goals include improved self-management practices and lifestyle changes for patients with diabetes. The program also works to enhance and improve access to care and delivery of effective clinical services.
Measurable Objective(s) with Indicator(s)	1. Improve community awareness by participating in one target area each quarter. Provide Diabetes Education currently via phone and/or ZOOM due to COVID. 2. Increase pre-diabetes education visits with telephonic visits, by 3% in quarters 2, 3, and 4. 3. Develop a Diabetes Support Group to be provided by telephone and/or by ZOOM for each quarter. 4. Develop a Diabetes Self-Management Education and Support (DSMES) (4 series) classes and provide these through ZOOM, each quarter. 5. Individuals with uncontrolled diabetes that are at high risk of complications will be contacted via telephone and education services will be offered and provided. Increase the calls by 5 % for each quarter.
Intervention Actions for Achieving Goal	1. Provide diabetes education information through phone or ZOOM to referral sources such as the Transitional Care Center, Dignity Health Clinics, other PCP's, Community Health Centers, Hospital Care Coordinators, and Labs. 2. Identify pre-diabetes population in need of individual education and counseling, via ZOOM. DEEP classes via community outreach, diabetes support groups, pcp referrals, recent hospitalizations per Octavia, Hospital Care Coordinators, TCC care workers, and pharmacy. 3. Invite and educate community about English and Spanish Diabetes Support groups available via hospital staff and identified community locations such as, pcp offices, clinics, and labs. 4. Offer option of ZOOM, DSMES classes to current individualized authorizations and referrals for ADA recognized program for MNT and DSMES. Also, encourage referrals from Diabetes Empowerment Education Program ZOOM classes, community outreach, diabetes support groups, pcp referrals and, recent hospitalizations per Octavia, Hospital Care Coordinators, TCC staff, pharmacy and nutrition services. 5. Access progress of individuals at high risk for complications by follow-up phone calls that are identified via recent hospitalizations or, recent ED visits
Collaboration	MRMC/AG Care Transition teams, discharge call RN, Dignity Health Clinics, Community Benefit team, Pharmacy, Alliance of Pharmaceutical Access, CenCal, Medicare, Nutrition Services, Dignity Health Marketing, Physician offices,

	CHCCC, and CAC. An increased focus with seniors who are underserved, uninsured, underinsured who are at high risk for chronic disease.
Performance / Impact	1. The Referrals to the program steadily increased. 2. The program altered and modernized its staffing and educational materials, Patients were seen timely with PCP collaboration. 3. Patients had a significant A1C reduction and follow-up from COVID hospitalizations was implemented. 4. The program was able to return to face-to-face education and treatment.
Hospital's Contribution / Program Expense	Program Expense: $ 160,768
FY 2022 Plan	
Program Goal / Anticipated Impact	The program goal is to add the diabetes treatment services to a primary care site in order for the patient to experience a total wrap-around approach with multi-disciplinary providers, bi-lingual, and bi-cultural staff under a single location and medical record. It is anticipated that this goal will achieve long term wellness in a culturally appropriate clinical environment.
Measurable Objective(s) with Indicator(s)	1. Reduce patient A1cs by June 30, 2022. 2. Increase access for 10% more diabetic patients.
Intervention Actions for Achieving Goal	1. Move program to clinic at MMC-Bunny by Oct 1, 2021 2. Train RD staff to effectively use Cerner ambulatory and understand practices of the clinic. 3. Link treatment services better with DEEP program 4. Partner with Sansum Diabetes center and Talley Farms for the Farming For Life Program by Nov 1, 2021 5. Set up regular meetings with Sansum and Talley Farms.
Planned Collaboration	MRMC/AG Care Coordination, Transitional Care Center, Dignity Health Clinics, Community Benefit team, Pharmacy, Alliance of Pharmaceutical Access, CenCal, Nutrition Services, Community PCPs CHCCC, and Communify. Community seniors who are underserved, uninsured/ underinsured and who are at high risk for chronic disease.

Dignity Health Community Grants Program	
Significant Health Needs Addressed	✔ Education Attainment ✔ Access to Primary Health Care including Behavioral Health ✔ Aging, More Mature Population ✔ Chronic Disease Prevention and Management, including Cancer
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	E2-Cash and In-Kind Contributions
FY 2021 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 with Access to Behavioral Health and Dental Care. Due to the current COVID-19 Pandemic 25% of the funds will be granted to single non for profit organization whose daily operations has been affected by COVID-19.
Measurable Objective(s) with Indicator(s)	1. 100% of funded Coronavirus Pandemic Impact Grants will address an emerging need due to COVID-19 situation. 2. 100% of the funded ACC will schedule at least quarterly meetings to ensure outcomes are attained.
Intervention Actions for Achieving Goal	1. Send an information letter to community partner announcing the criteria to apply for Coronavirus Pandemic Impact Grants. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Collaboration	Santa Maria and Orcutt School Districts, Transitions Mental Health Association, and other community organizations addressing the community health needs.
Performance / Impact	1. Community Health Manager worked closely with local community agencies in forming Accountable Care Communities that would meet the needs of the hospitals prioritized health needs. 2. All ACC were scheduled to present at the quarterly Community Benefit meetings to give updates on their projects. 3. 100% of funded ACCs have scheduled mid-year meeting to ensure outcomes are accomplished and they continue their work with the local hospital.
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and, $270,358 in grant money awarded to the community for the purpose of improving the quality of life of the residents of northern Santa Barbara County.
FY 2022 Plan	

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 with Access to Behavioral Health and Educational Attainment.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year. 2. Build richer ACCs that are focused on multiple significant health needs. 3. 100% of funded ACCs will update local community benefit committees on their project. 4. 100% of funded ACCs will schedule at least quarterly meetings to ensure outcomes are attained
Intervention Actions for Achieving Goal	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. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Planned Collaboration	Santa Maria and Orcutt School Districts, Transitions Mental Health Association, and other community organizations addressing the community health needs

Faith Community Nursing/Health Ministry Program	
Significant Health Needs Addressed	❑ Educational Attainment ✔ Access to Healthcare, Dental Care including Behavioral Health ✔ Aging, More mature Population ✔ Chronic Disease Prevention and Management, including Cancer
Program Description	The Faith Community Nurse (FCN) program utilizes a Dignity Health employed Faith Community Nurse Coordinator who develops a faith community nursing program throughout the central coast market area. This includes rolling out a health ministry program at her local parish as well as training other nurses to become faith community nurses in their local faith community (church, synagogue, parish, or local community). This is a program that includes collective partnership with nurses who might do this as a volunteer or paid by their faith community and a collaboration with these faith communities to provide a coalition of support through sharing or resources for training and/or support. Faith community nurse programs use the nursing process to address the spiritual, physical, mental, and social health of those part of a local faith community. This is done in relationship with the local faith community and its leadership. With the intentional focus on spiritual health, the Faith Community Nurse primarily uses intervention of education, counseling, prayer, presences, active listening, advocacy, referral, and wide variety of resources available to the faith and healthcare community.
Community Benefit Category	A1-c Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	The approach to care is “whole person” and addresses the spiritual, physical, mental and social health of the members and the greater community.
Measurable Objective(s) with Indicator(s)	There is an intentional focus on spiritual health, the FCN/HM will use active listening, consultation, counseling, decision making support, education, emotional and spiritual support, presence and referral. The individual interactions will be collected and recorded in a secure documentation system. Each FCN will have a Collaborative Agreement with the Faith & Health Partnership and make 20 contacts per quarter.
Intervention Actions for Achieving Goal	1. Promote growth of the FCN/Health Ministry Concept in the community, which will enhance the link between hospital and the community. a. Commission, Hospital Staff/ Chaplains and Spiritual/Church communities 2. Provide Faith Community Nurse (FCN) Course for RNs that are interested in Health Ministry to become FCN in their own congregation/place of worship a. Offer 2 FCN courses per year 3. Establish a team of health ministers/health advocates that have a combined knowledge, experience and willingness to serve to implement programs that respond to the unique needs of the congregation and surrounding community. a. Each FCN will Survey his/her Church community and provided the identified programs/support for that population.

	b. The Program Coordinator will be available to the team and have quarterly Support meetings. 4. Partner with other Community Benefit participants (i.e. Health and Wellness Programs – Health for Nutrition class, Healthier Living - Your life Take Care, DEEP and Fall Prevention) a. Consult with Community Benefit Program Manager Monthly to Coordinate identified programs.
Collaboration	Work with Catholic Health Initiatives on the Mission and Ministry Grant Project. The purpose of the project is to establish quality documentation of the value added by the services provided by Faith Community Nursing and Health Ministers (FCN/HM).
Performance / Impact	Over the last year we had hopes of growing the Central Coast Service Area Faith Community Nurse Program. However, due to COVID-19, with many faith communities not meeting in person it became very difficult to move forward as planned. In 2020 seven local nurses took the Foundations of FCN Course (30 hours of training) which was completed July 2020. In the midst of the pandemic those nurses found creative ways to provide mentoring, consulting, and education as well as offering resources to faith-based programs in our local community. Some of these activities include giving COVID vaccinations as well as COVID education and support (i.e. helping church members register for shots and arranging transportation and addressing reasons for vaccine hesitancy). The nurses have proven to be a trusted individual available to answer questions for people in their community and were able to provide evidence based information. Because we were not unable to start formal parts of our program (i.e., signing collaborative agreements, doing needs assessments in the congregation, etc.) we chose to count the 1,260 contacts from various health ministries conducted by the FCNs throughout the Central Coast market for these last 2 quarters. By Zip code FHMC = 596 MMC/AGCH = 664 93401 – 312 93454 - 378 93402 – 89 93445 - 126 93422 – 195 93455 - 160
Hospital's Contribution / Program Expense	Program Expense: $ 21,018
FY 2022 Plan	
Program Goal / Anticipated Impact	Support growth of the FCN program which will result in enhanced "whole person" (spiritual, physical, mental and social) health to naturally occurring groups of people in the community.
Measurable Objective(s) with Indicator(s)	1. Increase the number of signed Collaborative Agreements throughout the central coast market area: a. 2 agreements in Santa Maria/Orcutt b. 2 agreements in San Luis Obispo c. 1 agreement in Arroyo Grande 2. Increase the number of trained Faith Community Nurses by 6 3. Each FCN will conduct a needs assessment for their faith community.
Intervention Actions for Achieving Goal	1. Formalize the relationships and expectations-Signed Collaborative Agreements

	a. Coordinator to meet with each FCN to understand the unique needs and expectations of each community. b. Coordinator to set up quarterly coalition meetings that can be in person and via zoom. Rotation in person locations so different areas can "host" the meeting. Set an agenda, allow new items to be added from the FCN as needs arise. A special speaker at each meeting to share about "resources" within the community or some other development type of activity. Start with a presentation on advanced care planning. 2. Offer additional training for other nurses interested in FCN. Develop a timeline for next training with location (keep as in person and also zoom). Advertise to local DH nurses, to community board members, to local parishes, etc. Target poor areas (high CNI's) as well as Spanish speaking congregations. 3. Coordinator will work with each FCN and share tools that can be used at the local faith community level to do a needs assessment. After needs assessment Coordinator will meet with the FCN's and review their annual plan based on each unique needs assessment.
Planned Collaboration	Collaborate with local nurses, faith communities and their leaders, non-profit organizations, our community health department of the hospital and the county. Work with Catholic Health Initiatives on the Mission and Ministry Grant Project.

Perinatal Mood and Anxiety Disorder Program	
Significant Health Needs Addressed	❑ Education Attainment ✔ Access to Primary Health Care including Behavioral Health ❑ Aging, More Mature Population ❑ Chronic Disease Prevention and Management, including Cancer
Program Description	This program provides mental health support for families in Santa Barbara county who are impacted by Perinatal Mood and Anxiety Disorder (PMAD) by engaging pediatricians, obstetricians, primary care providers, community-based organizations, and other key stakeholders in maternal health to address the needs of a woman's mental health during and after pregnancy.
Community Benefit Category	A1-a Community Health; A2-d Community-Based Clinical Services
FY 2021 Report	
Program Goal / Anticipated Impact	To support pregnant and postpartum women and their families by facilitating access to social and behavioral health services
Measurable Objective(s) with Indicator(s)	1. Ten workshops will be held for Spanish and Mixteco -speaking women and their families to increase awareness and understanding of perinatal mood and anxiety disorders. 2. Increase attendance by 5% in monthly Spanish support groups. 3. Refer 40 Spanish and Mixteco-speaking women and 100 English-speaking women to the appropriate community resources. 4. Provide system navigation for at least ten women per month, helping connect them to behavioral health support and community resources. 5. Help expand the capacity of two provider offices each month to better screen and refer women for mental health support
Intervention Actions for Achieving Goal	1. Using Octavia Spanish and Mixteco speaking postpartum women 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 women who have attended Cambio de Vida con un Bebé will be invited to participate in monthly support groups. 3. Offer an English-speaking support group at least once a month by January 31, 2021. 4. Provide education to Spanish women on the use of 211 and the PMAD Community Resource Guide. 5. Connect women to psychiatric care, individual counseling and/or support groups and community resources to help strengthen the family system 6. Provide technical assistance to provider offices and community programs via phone, email, and in-person meetings to help enhance coordination of care for their patients.
Collaboration	Santa Barbara County Public Health Department; SBC Promotores Coalition; CALM; Family Service Agency; Community Action Commission of Santa

	Barbara; Santa Barbara County Behavioral Wellness; PMAD Stakeholders Group; private therapists; CHC

Performance / Impact	In FY 21, 250 referrals were received from MRMC, three Dignity Health OB clinics, and various community programs. There were a total of 2,934 deliveries which means approximately 8.5 percent of patients were referred for additional PMAD support.
	● Total number of referrals:
	  o Marian: 86 (34%)
	  o PHC Santa Maria (clinics): 134 (54%)
	  o Other: 30 (12%)
	● 105 (42%) patients connected to a therapist
	● 185 (74%) English; 60 (24%) Spanish; 5 (2%) Mixteco
	● Insurance: 64% Medi-Cal; 35% private
	
	Additional referrals were provided to support groups, public health nursing, psychiatrists, community agencies, breastfeeding and parenting support.
	
	An English PMAD group started November 9, 2020, and is offered the 2nd and 4th Tuesdays of each month via Zoom. LCSW leads with IBCLC support.
	
	Office visits were limited due to the pandemic. Instead, technical support was provided via phone and email, focusing on regular screening for high-risk patients.

Hospital's Contribution / Program Expense	Program Expense: Grant funded
FY 2022 Plan	
Program Goal / Anticipated Impact	To support pregnant and postpartum women and their families impacted by PMAD by facilitating access to social and behavioral health services
Measurable Objective(s) with Indicator(s)	1. At least five PMAD workshops will be held for Spanish and Mixteco-speaking women and their families to increase awareness and knowledge of perinatal mood and anxiety disorders. 2. Increase attendance by 5% in monthly Spanish support groups. 3. Refer 40 Spanish and Mixteco-speaking women to the appropriate community resources. 4. At least 125 women will be referred to appropriate community resources. 5. At least 8 women per month will receive individualized navigation support to help connect them specifically to behavioral health services. 6. At least five women will attend the English PMAD support group.
Intervention Actions for Achieving Goal	1. Using Octavia Spanish and Mixteco speaking postpartum women 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. Flyers for the English-speaking PMAD support group will be distributed to the community, at OB clinics, and directly to patients during their hospital stays.

	3. Assist patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs. 4. Connect women to psychiatric care, individual therapy, and/or support groups.
Planned Collaboration	Santa Barbara County Public Health Department; CALM; Family Service Agency; Santa Barbara County Behavioral Wellness; PMAD Stakeholders Group; private therapists; CHC

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services 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 or AGCH- 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. The shelter has an in-house clinic that facilitates the patient's limited medical care.

- Health Professions Education – Both the MRMC and AGCH 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. Both hospitals have partnered with local community colleges by donating money so the college could disperse funding as needed for purposed of addressing community wide workforce issues such as school-based programs on health care careers.

- 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 has achieved great success in its mission of training and recruiting new primary care physicians to care for the patients of the Central Coast. The Marian Hospital Community Board and the Medical Staff at MRMC has also created a new ACGME approved program in Obstetrics and Gynecology (OB/GYN). This 4 year program started during the 2017-18 academic year and currently has 9 new resident physicians in the first, second, and third years of the program. The OB/GYN program will have 12 total residents when it reaches its full complement of residents in July of 2022. The Marian OB/GYN program will address the critical need of projected shortages of OB/GYN physicians both in our region and throughout the nation. Two 4th year senior residents are schedule to graduate in July from OB/GYN program. All of our residents benefit from the privilege of providing care for the patients in our communities, and the supervision, expertise, and teaching from our outstanding medical staff at MRMC. The Marian Family Medicine and OB/GYN programs are proud to be producing the next generation of outstanding physicians for the benefit of our Central Coast communities and our Nation

- The Marian Family Residency and the Community Health Department have launch the Street Medicine Program which has offer very basic health and basic needs assessments to 264 unsheltered individuals in the service area of MRMC. The Street Medicine conducts two monthly outings every month covering several homeless encampments in the community.

- This year Marian Regional Medical Center continues to contract with Herencia Indígena a local agency which helps facilitate communication between health care providers and indigenous communities throughout the central coast. Currently, Herencia Indígena is providing MRMC 8 Mixteco interpreters in their OB and ED departments.

- Human Trafficking(Suspected Abuse Task Force) – 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. Training has been expanded to include annual training, training of all new employees, and training to other hospital departments. Since the launch

the task force has decided to include and address all types of suspected abuse. The task force includes Marian, Arroyo Grande, and French Hospitals. The manager of community health represents the hospital at the county human trafficking task force acting as their community liaison.

- To keep the children of the community safe and injury free, Marian Regional Medical Center distributed multi-sport child safety helmets and convertible car seats to low income families in need of this essential, life-saving equipment. The California Kids Plates Program provided the protective equipment items to Marian Regional Medical Center to distribute at no cost to underserved patients and their families of children up to age 18. In addition to receiving the gear, education is provided for proper usage.

- 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, YMCA of Santa Maria Valley, Community Partners in Care, 1st Five Advisory Board, Live Well Santa Barbara County, Active Aging Committee, CALM, Santa Barbara County Education Office's Promotoras Coalition, Children & Family Resource Services Family Service Agency, SB County Human Trafficking Task Force, and The Salvation Army.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

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Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2020 through 6/30/2021

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**12,514**	**6,688,280**	**0**	**6,688,280**	**1.0%**
Medicaid	**93,351**	**189,495,595**	**167,314,336**	**22,181,259**	**3.5%**
Community Services					
A - Community Health Improvement Services	19,332	4,272,437	0	4,272,437	0.7%
E - Cash and In-Kind Contributions	4,231	856,207	340,334	515,873	0.1%
G - Community Benefit Operations	0	189,132	0	189,132	0.0%
Totals for Community Services	**23,563**	**5,317,776**	**340,334**	**4,977,442**	**0.8%**
Totals for Poor	**129,428**	**201,501,651**	**167,654,670**	**33,846,981**	**5.3%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	2,001	650,719	0	650,719	0.1%
B - Health Professions Education	947	7,525,105	0	7,525,105	1.2%
D - Research	0	656,744	24,303	632,441	0.1%
F - Community Building Activities	0	25,000	0	25,000	0.0%
G - Community Benefit Operations	0	27,884	0	27,884	0.0%
Totals for Community Services	**2,948**	**8,885,452**	**24,303**	**8,861,149**	**1.4%**
Totals for Broader Community	**2,948**	**8,885,452**	**24,303**	**8,861,149**	**1.4%**
Totals - Community Benefit	**132,376**	**210,387,103**	**167,678,973**	**42,708,130**	**6.7%**
Medicare	**122,656**	**205,920,150**	**151,315,096**	**54,605,054**	**8.6%**
Totals with Medicare	**255,032**	**416,307,253**	**318,994,069**	**97,313,184**	**15.3%**

Hospital Board and Committee Roster

HOSPITAL COMMUNITY BOARD FISCAL YEAR 2021

Rebecca Alarcio
Community Educator | Administrator, Ret.

Phil Alvarado
Superintendent, Ret.
Santa Maria Bonita School District

Carolyn Baldiviez, DDS
Dentist

Michael Bouquet (Vice Chair)
Businessman
Business Manager, Toyota of Santa Maria

Lorena Chavez
Agricultural Business Owner
DL Farm Management, Inc.

Jason Diani
Businessman / Construction Executive
Diani Building Corporation

Holly Edds, EdD
Superintendent | Educator
Orcutt Union School District

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

Kevin Ferguson, MD (Secretary)
Physician | Pathologist

Terry Fibich
Retired Fire Chief

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

Michael Galloway, CPA
Accountant
Andrews, Galloway & Associates

Tom Martinez
Architect
Martinez & Associates

Juan Reynoso, MD
Physician | Emergency Medicine

Christina Slimack
Philanthropist
Chair, Marian Foundation Board

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

Kathy Tompkins
Philanthropist | Community Volunteer

Kevin G. Walthers, PhD (Immediate Past Chair)
College Superintendent | Educator
Allan Hancock College

James Wesner
Agriculture Business Owner

Joseph Will (Chair)
Businessman | Construction Executive
CalPortland

Elaine Yin, MD
Physician | OB-Gyn

Jeff Zambo
Business Owner | Diversified Project Services Int'l
Chair, Arroyo Grande Foundation Board

Hospital Representatives

Mark Allen
Vice President | Chief Operating Officer

Sue Andersen
President & CE

Hospital Representatives (Continued)

Charles J. Cova
Division President & CEO
Dignity Health CA Central Coast

Kenneth R. Dalebout
Administrator, Marian Arroyo Grande

Bill Finley
Vice President | Chief Financial Officer

Brett Lebed, MD
President of the Medical Staff
Urologist

Eugene Keller, MD
Division Vice President, Quality
Dignity Health CA Central Coast

Charles Merrill, MD, FACEP
Chief Medical Officer, Santa Maria

Candice Monge, MSN RN
Vice President | Chief Nursing Officer

Matt Richardson
Division VP | Chief Financial Officer
Dignity Health CA Central Coast

J. Trees Ritter, DO
Chief Medical Officer, Marian Arroyo Grande

Kathleen Sullivan, PhD RN
Vice President, Post-Acute Care Services and
Health Services Operations

George West
Division VP | Mission Integration
Dignity Health CA Central Coast

Founding Sisters Representative
Sr. Patricia Rayburn, OSF
Dignity Health

CommonSpirit Health / Dignity Health
Representative
Marvin O'Quinn, SEVP | COO

MARIAN REGIONAL MEDICAL CENTER
COMMUNITY BENEFIT COMMITTEE FY2021

Sue Andersen
CEO and President
Marian Regional Medical Center
Arroyo Grande Community Hospital

David O. Duke, MD
Physician Advisor
Case Management & Utilization Review

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

Terry Fibich
Member, Hospital Community Board

Katherine Guthrie
Senior Regional Director, Cancer Services

Calandra Park, MSW, RN
Program Coordinator, Perinatal Mental Health
Registered Nurse, Obstetrics

Jean Raymond, RN, MSN, GCNS-BC
Program Coordinator,
Faith Community Nursing/Health Ministry
Registered Nurse

Flora Washburn, MPT
BCCI Manager, Chaplaincy Services & Pastoral Care

Anne Rigali
Member, Marian Foundation Board of Directors

Heidi Summers, MN RN
Senior Director, Mission Integration

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

Edward Lowe
Senior Regional Director
Homecare & Hospice Services

Debbie Blow, PhD
Superintendent, Orcutt School District
Member, Hospital Community Board

Patty Herrera, MS
Manager, Community Health
CA Central Coast Division (North)

Elizabeth Snyder
Sr. Director, Administrative Services