Marian Regional Medical Center

Community Benefit 2023 Report and 2024 Plan

Adopted October 2023

Dignity Health
Marian Regional Medical Center

A message from

Sue Andersen, President and CEO, and Holly Edds, EdD Chair of the Dignity Health Marian Regional Medical Center and Arroyo Grande Community Hospital Community Board.

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 initiatives to deliver community benefit 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 and Arroyo Grande Community Hospital share a commitment with others to improve the health of our community, and deliver programs and services to help achieve that goal. The Community Benefit 2023 Report and 2024 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntarily produce these reports and plans, as well. 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 2023 (FY23), Marian Regional Medical Center and Arroyo Grande Community Hospital provided $41,538,116 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospitals also incurred $22,192,730 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2023 Report and 2024 Plan at its October 11, 2023 meeting.

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

Sue Andersen
President

Holly Edds,EdD
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Marian Regional Medical Center and Arroyo Grande Community Hospital serve 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	$41,538,116 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $22,192,730 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 and dental health; • Health Promotion and Prevention
FY23 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 focused 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 $302,873 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
FY24 Planned Programs and Services	For FY24, the hospital plans to continue to offer the chronic disease and diabetes self-management workshops via the ZOOM platform. 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. Develop collaborations with community partners to implement the Matter of Balance Fall Prevention workshop targeting our mature adult community. Continue with our Street Medicine rounds among the unsheltered. Highlight our Physician Mentoring program to address educational attainment.

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 e-mail to CHNA-CCSAN@DignityHealth.org

Our Hospital and the Community Served

About Marian Regional Medical Center

Marian Regional Medical Center 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. Marian Regional Medical Center has been verified as a Level II Trauma Center by the Verification Review Committee (VRC), an ad hoc committee of the Committee on Trauma (COT) of the American College of Surgeons (ACS). This achievement recognizes the trauma center's dedication to providing optimal care for injured patients. MRMC implemented a cutting-edge, 3D Intracardiac Echo (ICE) catheter called NuvisonNAV by Biosense Webster. It's a significant advancement in the diagnosis and treatment of abnormal heart rhythms. Cardiologists are now able to view an entire chamber of the heart, as it's beating, in 3D, in intricate detail and in real-time while performing minimally invasive procedures.

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. It operates under one hospital license with Marian Regional. 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 hospital also has a 20 bed acute rehab center.Arroyo Grande Community Hospital's (AGCH) acclaimed Acute Rehabilitation Center is the only facility on the Central Coast to utilize the Andago®, a robot-assisted therapy device that helps patients with stroke or brain injury regain their ability to walk. The Acute Rehabilitation Center is also home to the Armeo®Spring, an ergonomic and adjustable exoskeleton that guides arm and hand training through tailored arm weight support. The Armeo can help improve the quality of movement, arm function, muscle strength, range of motion, pain and spasticity, activities of daily living, and cognitive function.

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

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance

provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

Marian Regional Medical Center (MRMC) and Arroyo Grande Community Hospital (AGCH) serve an aggregate community that encompasses all residents of northern Santa Barbara County and southern San Luis Obispo County, CA. The aggregate community is home to over 231,000 individuals residing in Santa Maria, Guadalupe, Nipomo, Orcutt, Arroyo Grande, Grover Beach, Oceano, and Pismo Beach, CA. The MRMC and AGCH defined community does not exclude any low-income or underserved populations and includes all members of the community. The communities served by MRMC and AGCH align with the residence location for 75% of all inpatient discharges.

Marian Regional Medical Center is located in the City of Santa Maria in northern Santa Barbara County, CA. The community served by MRMC includes six zip codes representing the following four cities: 93454, 93455, 93458 (Santa Maria);93434 (Guadalupe);93455 (Orcutt); and 93444 (Nipomo). The City of Santa Maria, Guadalupe and Orcutt are located in northern Santa Barbara County and Nipomo is located in southernmost San Luis Obispo County. Nipomo (93444) is unique because it is equidistant between MRMC and AGCH and is considered a community served by both hospitals.

According to the American Community Survey (2016-2020, 5-year average), the MRMC community is home to 150,072 residents, with the majority (73%) residing within Santa Maria City. Santa Maria is the largest city in Santa Barbara County both in land area and population.

The MRMC community is a culturally diverse area with the majority of residents (67.2%) considering themselves Hispanic or Latino(a) origin. In the MRMC community, 26.6% of individuals over the age of five speak English less than "very well." Educational attainment for adults age 25 and older continues to be a challenge for the MRMC community. Overall, 31.1% of the MRMC community residents ages 25 and over did not complete high school. Furthermore, over half (53.2%) of the adults (age 25 and over) residing in zip code 93458 (Santa Maria), and 44.3% of adults residing in 93434 (Guadalupe) have less than a high school education. Conversely, the highest levels of education can be found in the adult population (age 25 and over) residing in zip code 93455 (Santa Maria/Orcutt) where 69.1% reported having at least some college/associates degree or higher.

According to the U.S. Census, 2016-2020 American Community Survey 5-Year Estimates, poverty levels exceed state (12.6%) and national levels (12.8%) in the following MRMC community locations:

- Zip code 93434 (Guadalupe) approximately 1 in 4 people live in poverty (24.0%);
- Zip code 93458 (Santa Maria), 15.0% of the population are below 100% of the poverty level, and another 14.2% have income between 100 to 149% of the poverty level.

In addition to the residents captured by the formalized data sources above, the transient farmworker population drawn to work in the fields of Santa Barbara County and San Luis Obispo County are supported by indigenous migrants from the Mexican states of Oaxaca and Guerrero. These indigenous migrants are often monolingual in their native pre-Hispanic indigenous language of Mixtec or Zapotec. According to the National Center for Farmworker Health in 2017, there were an estimated 32,066 farmworkers in Santa Barbara County and 17,771 farmworkers in San Luis Obispo County.

The number of individuals counted in the Santa Barbara County 2023 Point in Time Count was 1,887. This was a slight decrease in the number of individuals counted in 2022 (1,962). Most notable was the increase in the number of persons living in shelters or transitional housing versus a decrease in the number of persons living outdoors.The 2023 Point in Time Count for Santa Barbara County reported 472 persons experiencing homelessness in Santa Maria and 8 in Guadalupe.

AGCH in Arroyo Grande, California serves the “Five Cities” community of southern San Luis Obispo County. The “Five Cities" area consists of the neighboring cities of Arroyo Grande, Grover Beach, Nipomo, Oceano, and Pismo Beach. The AGCH community extends from the northernmost boundary of the MRMC community, and includes the following San Luis Obispo County communities and zip codes: 93420 (Arroyo Grande);93433 (Grover Beach);93444 (Nipomo);93445 (Oceano); and, 93449 (Pismo Beach).

According to the U.S. Census, the median age in California is 36.7 years, which is lower than the median age of the five AGCH communities. The median age in 93433 (Grover Beach) is closest to the state level, however 93420 (Arroyo Grande) and 93449 (Pismo Beach) are more than 10 points above the state median age. In 93420 (Arroyo Grande) nearly 25% of the population is age 65 or over and in 93449 (Pismo Beach) this number increases to nearly 32%.

The 2022 San Luis Obispo County Point-in-Time Count was a community-wide effort conducted on February 23rd, 2022 revealed a total of 1,448 persons experiencing homelessness. This was a slight decrease in the number of individuals counted in 2019 (1,483).The Point in Time Count revealed 90 in Grover Beach, 50 in Arroyo Grande, and 20 in Pismo Beach.

Demographic information for the MRMC which includes AGCH was taken from Claritas Pop-Facts 2023; SG2 Market Demographic Module provides data on the following:

Marian Regional Medical Center & Arroyo Grande Community Hospital

- **Total Population:** 237,658
- **Race:**
  - 34.9 % White
  - 1.0% Black/African American,
  - 56.1 % Hispanic or Latino
  - 3.7 % Asian/Pacific Islander
  - 4.3 % All Others
- **% Below Poverty** 6.7 %
- **Unemployment:** 4.0 %
- **No HS Diploma:** 22.8%
- **Medicaid (household):**31.9 %
- **Uninsured (household)**: 6.3 %

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 May 2022

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous CHNA report.

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/about-us/community-health/community-health-programs-and-reports/community-health-needs-assessments
or upon request at the hospital's Community Health office.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Educational Attainment	Adults with a lower educational attainment level have an increase in encountering barriers in obtaining quality health care and are more prone to being negatively impacted by other social determinants of health.	yes
Access to Primary Health Care, Behavioral Health, and Dental Health	Adults have barriers in accessing primary health care which also includes behavioral health and dental health.	yes

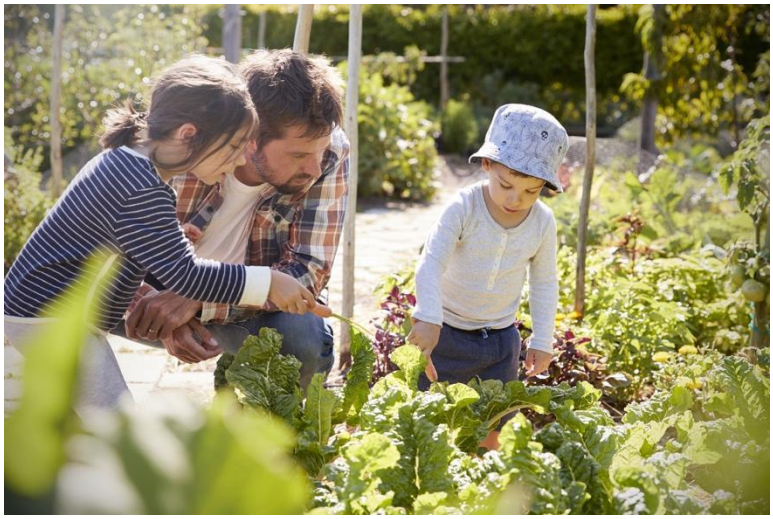
Significant Health Need	Description	Intend to Address?
Health Promotion and Prevention	Adults have barriers accessing preventive health screenings awareness, and education	yes

2023 Report and 2024 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 FY23 and planned activities for FY24, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan



The 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.

Hospital and health system participants included in the contribution in creating this implementation strategy and/or will help in the delivering of programs are the following: Care Coordination, Marian Residency Program, OB department, Nutrition Services, and Mission Hope Cancer Center.

Community input or contributions to this implementation strategy included members from the Community Benefit Committee, senior leadership, clinical experts and program owners met to evaluate the existing programs and develop new programs. Collaboration with community partners also led to improved program design, best practices and effective intervention.

The programs and initiatives described here were selected on the basis of the current 2022 CHNA report, and Healthy People 2030 was utilized when identifying program goals and developing measurable outcomes. These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, senior leadership,

Community Board and the national CommonSpirit Health community health system office (Dignity Health) receive regular program updates.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Advance Community Health Alignment and Integration

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Expand Clinical - Community Partnerships and Linkages

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Build Capacity for More Equitable Communities

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Inspire, Innovate and Scale High Impact Initiatives

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

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	Summary Description	Active FY23	Planned FY24
Community Health Improvement Grant program	• Fund Accountable Care Communities (ACC) whose goal is to encourage higher education, adult literacy and medical literacy.	☒	☒

Physician Mentoring Program	● Provides local high school and college students the opportunity to participate in a rotation which introduces them to the many multidisciplinary facets of medicine.	☒	☒
Spanish & Mixteco Interpreter/Advocacy	● Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. ● Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	☒ ☒	☒ ☒
Health Professions Education	● The hospital provides a clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, and pharmacists. Nursing students conduct their clinical rounding at the hospital. ● The hospital provides the local community colleges financial support to further address community wide workforce issues, such as school-based programs for health care careers.	☒ ☒	☒ ☒
Goal and Impact:Increase awareness of the different careers in health care and to encourage students toward the field of medicine**.**			
Collaborators: Planned collaboration San Luis Coastal School District, San Luis Lucia Mar School District Allan Hancock College, Cuesta College,Future Leaders of America Inc.			

Health Need: Access to Primary Health Care, Behavioral Health, And Dental Care

Strategy or Program	Summary Description	Active FY23	Planned FY24
Community Health Improvement Grant program	● Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, dental care, medical prescriptions, and behavioral health care.	☒	☒
Street Medicine Program	● In collaboration with the Marian Family Residency program, basic health and needs assessments are provided to unsheltered individuals in the MRMC community.	☒	☒
Chronic Disease Prevention and Self-Management Programs	● Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program (DEEP) are offered to community members	☒	☒
Diabetic Prevention and Self-Management Program (English and Spanish) & After-hour clinic	● A new comprehensive, evidence-based, diabetes management program will be offered to the community. The after hour clinic program will include access to a registered dietician and a nurse specialized in diabetes management. These services will be added at a primary	☐	☒

	care site so the patient can experience multi-disciplinary, bi-lingual providers at one location.		
Farming for Life	• A new partnership with Tally Farms has been formalized to launch a program called Farming for Life. Farming for Life will provide free fresh produce for 12 weeks to diabetics enrolled in the program. Participants will undergo four bio/psycho/social evaluations during the twelve weeks.	☒	☐
Behavioral Wellness Support Groups	• Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). • Medically vulnerable population "MVP" for infants born with special medical needs, have a monthly support group. • Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. • Prenatal education programs are offered in Spanish and English to expectant mothers. • A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	☒ ☒ ☒ ☒ ☒	☒ ☒ ☒ ☒ ☒
Behavioral Wellness Center (Crisis Stabilization Unit)	• The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.	☒	☒
MRMC Medical Safe Haven Clinic for Human Trafficking	• Provides a safe space where medical providers can offer a full spectrum of health services for victims and survivors of human trafficking.	☒	☒
Community Health Navigator Program	• The Community Health department will coordinate with the Transition Care Center to develop a "whole person" approach, for example, the MVP Program or DEEP participants, in helping those patients navigate access to medical, behavioral health, and basic needs services.	☐	☒
Faith Community Nurse Program	• Further develop and expand the FCN program throughout the CA Central Coast market. • The FCN program will support the whole person including their spiritual, physical, mental and social well-being.	☒ ☒	☐ ☐
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening. • Provide financial support to medically underserved patients for transportation and genetic counseling. • Work with the school district to educate students and to help students understand cancer screening and prevention and so they can go talk to their parents and grandparents.	☒ ☒ ☒ ☒	☒ ☒ ☒ ☒

	With the goal to reduce cancer-related disparities in a largely rural and medically underserved population through the increase of health education. ● Provide bilingual navigation services through the oncology nurse navigator and oncology social worker to facilitate barriers to cancer awareness, prevention activities, screenings, healthcare,high risk cancer genetic counseling, nutritional counseling, cancer rehabilitation and psychosocial support service .	☒	☒
Spanish & Mixteco Interpreter/Advocacy	● Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. ● Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	☒ ☒	☒ ☒
Substance Use Navigation Program	● Dedicated social workers assist patients presenting with Substance Use Disorder to link with appropriate resources. A naloxone distribution program is also part of the program.	☒	☒
Goal and Impact: Increase access to free medical care and community resources to provide early detection, prevention, and management of illness. Increase smooth transitions for discharged patients by providing access to "medical homes" and pharmaceutical patient assistance programs.			
Collaborators: Planned collaboration with SLO Noor free medical and dental clinics, FHMC care coordination and social work departments, Alliance for Pharmaceutical Assess (APA Inc.), Hearst Cancer Resource Center, Pacific Central Coast Health Centers, and FHMC Community Health Department.			

Health Need: Health Promotion and Prevention

Strategy or Program	Summary Description	Active FY23	Planned FY24
Community Health Improvement programs	● Free evidence based self-management disease workshops.	☒	☒
Cancer Prevention and Screening Program	● Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. ● Conduct community outreach surrounding cancer awareness, nutrition, and screening. ● Provide financial support to medically underserved patients for transportation, genetic counseling. ● Work with the school district to educate students and to help students understand cancer screening and prevention and so they can go talk to their parents and grandparents. With the goal to reduce cancer-related disparities in a largely rural and medically underserved population through the increase of health education. ● Provide bilingual navigation services through the oncology nurse navigator and oncology social	☒ ☒ ☒ ☒ ☒	☒ ☒ ☒ ☒ ☒

	worker to facilitate barriers to cancer awareness, prevention activities, screenings, healthcare,high risk cancer genetic counseling, nutritional counseling, cancer rehabilitation and psychosocial support service .		
Faith Community Nurse Program	● Further develop and expand the FCN program throughout the CA Central Coast market. ● The FCN program will support the whole person including their spiritual, physical, mental and social well-being	☒	☐
Behavioral Wellness Support Groups	● Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). ● Medically vulnerable population "MVP" for infants born with special medical needs, have a monthly support group. ● Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. ● Prenatal education programs are offered in Spanish and English to expectant mothers. ● A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	☒ ☒ ☒ ☒ ☒	☒ ☒ ☒ ☒ ☒
Diabetic Prevention and Self-Management Program (English and Spanish) & After-hour clinic	● A new comprehensive, evidence-based, diabetes management program will be offered to the community. The after hour clinic program will include access to a registered dietician and a nurse specialized in diabetes management. These services will be added at a primary care site so the patient can experience multi-disciplinary, bi-lingual providers at one location.	☐	☒
Farming for Life	● A new partnership with Tally Farms has been formalized to launch a program called Farming for Life. Farming for Life will provide free fresh produce for 12 weeks to diabetics enrolled in the program. Participants will undergo four bio/psycho/social evaluations during the twelve weeks	☒	☐
Mixteco Pregnancy Education	● Culturally appropriate education for Indigenous women to foster healthy pregnancy and maternal outcomes.	☐	☒
Spanish & Mixteco Interpreter/Advocacy	● Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients.	☒ ☒	☒ ☒

	• Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.		
Chronic Disease Prevention and Self-Management Programs	• Promote to the community and provide Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program to community members. Conduct post workshop testing to determine efficacy of the program.	☒	☒
Goal and Impact: Increase cancer cardiovascular disease, diabetes, and stroke awareness, prevention, and management to the most vulnerable populations in Santa Barbara county and to increase early detection and management.			
Collaborators: Planned Collaboration with the Latino Health Coalition. Community Clinics of the Central Coast, Pacific Central Coast Health Centers, SLO Noor free clinics and SLO Public Health Department. FHMC Women's Imaging center, Hearst Cancer Resource Center,			

Community Health Improvement 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 related to CHNA priorities.

In FY23, the hospital awarded the grants below totaling $302,873. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Good Samaritan Shelter	Santa Maria Stabilization Center	$ 100,000
Family Service Agency of Santa Barbara County	Senior and Caregiver Support	$ 68,172
Future Leaders of America (FLA)	Youth Leadership and Education Project	$ 25,000
Community Action Partnership of San Luis Obispo County, Inc	5 Cities Connection for People Experiencing Homelessness	$ 50,000
Los Osos Cares, Inc.	Basic Needs and Resources for Vulnerable & Seniors	$ 40,000
SLO Noor Foundation	Oral Access to Care: Service Expansion for Uninsured and Underinsured	$ 19,701

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Behavioral Wellness Support	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Program provides mental health support through individualized and group support.
Population Served	Underserved population that are seeking mental health support
Program Goal / Anticipated Impact	To support individuals living with a chronic illness and/ or pregnant and postpartum women and their families by facilitating access to needed medical, social and behavioral health services to achieve a healthier self.
FY 2023 Report	
Activities Summary	Outreach and recruitment of participants were done in various ways such as: sending electronic support group flyers to community partners, sending our electronic monthly community health newsletter to our networks,and developing a criteria workshop list in Cerner.
Performance / Impact	1. The Chronic Disease monthly support group had 19 unduplicated individuals attend the support group. 2. The Diabetes support group had a total of 19 unduplicated individuals attend the sessions. 3. A total of 8 PMAD workshops were conducted in Spanish with a total of 190 attending. 4. A total of 47 mommies attended the English PMAD support group and a total of 62 attended the Spanish PMAD support group. Both support groups increase their participation by 5%. 5. A total of 26 individuals received appropriate community resources upon their request.
Hospital's Contribution / Program Expense	MRMC provided in kind space, advertisement, and printing. Program Expense: $86,714
FY 2024 Plan	
Program Goal / Anticipated Impact	1. A total of 20 unduplicated individuals for the fiscal year will participate in the monthly chronic illness support group and the Spanish Diabetic support group. 2. 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. 3. Increase attendance by 5% in both monthly PMAD Spanish and English PMAD support groups. 4. Refer 40 Spanish and Mixteco-speaking women to the appropriate community resources.
Planned Activities	1. Recruit and invite participants that completed the Chronic Disease Self Management program (CDSMP) and/or Diabetes Empowerment Education Program (DEEP) to the monthly support groups. 2. Using Cerner 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. 3. Assist at least 25 patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs.

Cancer Prevention and Screening Program	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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 trainers and registered dietician.
Population Served	Underserved population emphasizing outreach to seniors.
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.
FY 2023 Report	
Activities Summary	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-3% (173); Prostate-3% (68); Lung-3% (1,069); Smoking Cessation-3% (201); Survivorship Care Plans-3% (201); Emmi services-3% (649). 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track the number of patients needing financial assistance to participate: Genetic Counseling-3% (224). 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 3% (2,333) nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). 6. Increase the number of new patients from the target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 3% (147). Ensure at least 50% of patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion.

Performance / Impact	1. 15,248 medically underserved cancer patients have been screened and referred to psychosocial support, nutritional counseling, nurse navigator support, social services support, and support classes this fiscal year (363% increase from FY22). 2. Patients assisted with screening services this fiscal year include: 121 (SM:102/FC:19) colorectal cancer screenings with 6 new cancers being identified (30% decrease from FY22), 20 prostate cancer screening, 1,138 (SM: 608/FC: 530) lung cancer screenings with 19 new cancer cases have been identified (6% increase from FY22); 720 people have been referred for smoking cessations (37% increase from FY22); 108 survivorship care plans completed (46% decrease from FY22) and 735 Emmi participants (13% increase from FY22). 3. 193 (SM: 134/FC: 59) under/uninsured patients were served by the genetic counseling program (14% decrease from FY22) 144 were assisted financially, totaling $45,189 (SM: $31,059/FC: $14,130). 4. 640 under/uninsured patients have been provided financial assistance for cancer care needs: (32%) male; (68%) female; (56%) Hispanic; (47%) unemployed; (22%) laborers; (54%) under 60 years of age; and (18%) supporting 2 or more children. Additionally, 3,198 medically underserved patients have been transported for cancer care and another408 (SM: 364/FC: 44) patients were supported with financial assistance for transportation needs, totaling $20,400 (SM: $18,200/FC: $2,200). 5. 1,367 (SM: 1,177/FC: 190) medically underserved patients were supported through the nutrition counseling program this fiscal year (41% decrease from FY22). 6. 157 new patients enrolled in the Cancer Rehabilitation Program this fiscal year (7% increases from FY22). 54% of patients contacted four weeks following their cancer rehabilitation program completion reported the use of continued exercise.
Hospital's Contribution / Program Expense	MRMC provided in kind space, nutritional services, advertisement, and printing. Program Expense: $1,140,776

FY 2024 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 of health education as well as cancer awareness, prevention activities, screenings and genetic counseling Additionally patient navigation, nutritional counseling, cancer rehabilitation and psychosocial support services.
Planned Activities	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.

Chronic Disease Prevention & Self-Management	
Significant Health Needs Addressed	● Access to Health Care, Behavioral Health, and Dental Health ● Health Promotion and Prevention
Program Description	Dignity Health evidenced based Wellness workshops offer the participant the ability to learn skills that will enhance their capability of managing their chronic disease and help others identify tools that will help them make healthier life choices to prevent/ reduce the acute/long term complications from chronic disease.
Population Served	Underserved populations
Program Goal / Anticipated Impact	Improve the confidence level of the workshop participants in their self-management and/or prevention of their chronic disease.
FY 2023 Report	
Activities Summary	Outreach and recruitment of participants were done in various ways such as: sending electronic workshop and support group flyers to community partners, sending our electronic monthly community health newsletter to our networks,and developing a criteria workshop list in Cerner. Follow up calls were completed 1 month after participants graduated from Chronic Disease Self Management Program (CDSMP), Diabetes Education Empowerment Program (DEEP), and/or Healthy For Life (HFL)
Performance / Impact	1. 100% of the DEEP and CDSMP graduates were able to self-report that they were still practicing 2 of the workshop skills in their daily lives. The most popular skills mentioned were action planning and positive thinking. 2. A total of 51 individuals attended the DEEP workshop which was a 6% increase from FY22. 3. 100% of the HFL graduates were able to identify 2 risk factors for heart and stroke. The 2 most mentioned were being overweight and age.
Hospital's Contribution / Program Expense	MRMC provided in kind space, advertisement, and printing. Program Expense: $ 268,509
FY 2024 Plan	
Program Goal / Anticipated Impact	1. 80% of the Chronic Disease Self Management Program(CDSMP) and Diabetes Education Empowerment Program (DEEP) participants will self-report 1 month after completion of the program 2 self management skills that they have continued to practice. 2. Increase DEEP series class participation by 5 % from FY2023 results. (total for FY 23 was 51)

	3. 80% of the Healthy for Life participants will identify 2 risk factors for heart disease, stroke, and diabetes, 1 month after completion of the program .
Planned Activities	1. Promote the Dignity Health Wellness workshops on community health quarterly newsletter, social media, hospital website, and other media outlets. 2. Contact and ask workshop CDSMP and DEEP participants at 1 month after completion of the workshop to self-report 2 self-management skills that they have continued to practice. 3. Contact and ask workshop HFL participants at 1 month after completion of the workshop to identify 2 risk factors for heart disease, stroke, and diabetes type 1. 4. Track the responses of the HFL, CDSMP, and DEEP on a spreadsheet.

Community Health Improvement Grant Program	
Significant Health Needs Addressed	• Educational Attainment • Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospital's 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.
Population Served	Underserved populations
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the hospital service area to "Accountable Care Community" which align with the hospital's most recent Community Health Needs Assessment report.
FY 2023 Report	
Activities Summary	A press release was sent to the media to inform the central coast of the upcoming Dignity Health Improvement Grant program. A grant criteria informational sheet was posted on the hospital website. The local grant representative facilitated any questions that came from potential applicants. The grantees were invited to present on their project's progress at the quarterly community benefit meetings. Mid-year and final reports were collected from the grantees and sent to the system office by the due date.
Performance / Impact	Six accountable care communities were funded that help address: Education Attainment, Access to primary health care, behavioral health and oral health, and Health Promotion and Prevention.
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and $302,873 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 2024 Plan	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the 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 : Educational Attainment, Access to Health Care, Behavioral Health, and Dental Care, Health Promotion and Prevention.
Planned Activities	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. Funded ACCs will present at Community Benefit Committee meetings.

Faith Community Nursing/Health Ministry Program	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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. 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.
Population Served	Persons from the congregation of the faith nurse belong to emphasizing outreach to seniors.
Program Goal / Anticipated Impact	To support growth of the individual(s) by enhancing the health of the "whole person" (spiritual, physical, mental and social) through the FCN/HM Program.
FY 2023 Report	
Activities Summary	Three accountable care communities were funded that help address: access to primary health care, behavioral health and oral health.
Performance / Impact	The 4 active faith community nurses conducted the following services in their faith communities: blood pressure checks, one on one health education sessions, and when available flu and COVID-19 vaccines. The 4 faith community nurses reached 447 individuals.
Hospital's Contribution / Program Expense	MRMC provided advertisement, and printing. Program Expense: $20,336
FY 2024 Plan	
Program Goal / Anticipated Impact	This has been put on pause due to restructuring.
Planned Activities	

Physician Mentorship Program

Significant Health Needs Addressed	• Educational Attainment
Program Description	Local central coast students shadow physicians and other healthcare professionals from various specialties to give them an opportunity to see the variety and importance of the medical profession.
Population Served	High School students interested in pursuing a career in healthcare.
Program Goal / Anticipated Impact	To encourage local high school and college students to pursue a career in the medical health field.

FY 2023 Report

Activities Summary	An outreach flyer was created to increase exposure of the program throughout the central coast. The flyer was distributed electronically to community partners and hard copies were distributed to local high schools and health events. A recruitment signed letter by the CEO/Presidents of the hospitals were sent out internally and external to health care professionals asking for their participation.
Performance / Impact	1. 80 doctors and medical assistants enrolled to participate in the mentoring program. 2. 40 nurses enrolled to participate in the mentoring program 3. 48 students were accepted to the mentoring program. 4. Instead of Career Day at a middle school Dr. Monica Diaz provided a presentation to both parents and teens during their Famias Unidas monthly meeting sponsored by Future Leaders of America, Inc.
Hospital's Contribution / Program Expense	MRMC provided in kind space, advertisement, and printing. Program Expense: $21,136

FY 2024 Plan

Program Goal / Anticipated Impact	To encourage local high school and college students to pursue a career in the medical health field. 1. Increased enrollment in the program by 5% baseline for FY 2023 was 48. 2. Increased participation among medical providers by 2% baseline for FY 2023 was 120. 3. Extend program rotations to include the nursing profession.
Planned Activities	1. Increase outreach to high school, colleges and alternative schools throughout the Central Coast service area. 2. Contact high school and college counselors asking them for student referrals to the program. 3. Increase recruitment of local physicians and obtain referrals to gain participation. 4. Collaborate with the hospital department managers, directors, and administration to gain participation of the patient care nurses.

	5. Highlight program in the Community Health electronic newsletter which is distributed to community partners including medical facilities throughout the central coast area. 6. Outreach to one middle school to pilot the Career Day: Medical field event . 7. Coordinate with the residency program on the format of the Career Day: Medical field event.

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 healthcare field. Hundreds of hours each year are committed to providing a clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, 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 purposes 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) accredited three-year post-graduate primary care training program for Family Medicine physicians. The 3 year Family Medicine training program has 18 residents. The Marian Family Medicine program has a history of great success in its mission of training and recruiting new primary care physicians to provide for our Central Coast communities. In 2023 five of our seven graduating Family Medicine residents were recruited to stay and practice on the Central Coast.

- The Marian Hospital Community Board, MRMC, and the dedicated Medical Staff at MRMC has created a second ACGME accredited training program in Obstetrics and Gynecology (OB/GYN). The 4 year OB/GYN training program has 12 residents in the program. The graduates of the Marian OB/GYN program will help address the critical need of projected shortages of OB/GYN physicians throughout the nation. The OB/GYN program has already recruited 2 of our graduates to stay and practice locally here in Santa Maria.

- 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 continue with their Street Medicine Program which has offered very basic health and basic needs assessments to 538 unsheltered individuals in the service area of MRMC. The Street Medicine conducts two monthly outings every month covering several homeless encampments in the community.

- The Medical Safe Haven (MSH) program at the Family Medicine Center at Marian Regional Medical Center, an area highly impacted by human trafficking. The MSH program creates a safe space where medical providers can offer ongoing care for victims and survivors of human trafficking, sex and/or labor, through the use of survivor-informed practices that help to minimize further trauma. This integrated-care model offers survivors the full spectrum of health services,

including: primary care, prenatal and obstetrical care, newborn, pediatric and adolescent care, mental health support, vaccinations, STI testing and treatment, PrEP, telehealth, and other essential services. MSH will be serving victims and survivors of human trafficking, sex and/or labor in both Santa Barbara and San Luis Obispo counties. In FY 2023 MSH has already touched the lives of over 34 victims of human trafficking and provided over 84 clinical visits to support their physical and mental health needs.

- Marian Regional Medical Center continues to contract with Herencia Indígena, a local agency which provides culturally appropriate Mixteco interpreters to support medical staff and the Mixteco community. Herencia Indígena has extended their services to the Women's clinic and the Family Medicine Center which are part of the Pacific Health Centers of the Central Coast.

- Human Trafficking(Suspected Abuse Task Force) – This initiative was launched in FY 2015 . Key healthcare personnel within the Dignity system of care partnered to form the Suspected Abuse Task Force with a primary goal of education, process/protocol, and policy implementation. Since its implementation, 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.

- Homeless Health Initiative:In September 2020 Marian and Arroyo Grande launched their Homeless Health Initiative program. Through this system funded pilot position, a full time social worker was hired to specifically address the transitional care needs of patients experiencing homelessness. With dedicated knowledge to specific needs of patients experiencing homelessness, this social worker provides inpatient and ER support and consultation on patients experiencing homelessness, works closely with the multi-disciplinary team on care plans for these patients, follows certain high risk patients to the next level of care including SNFs and respite care, joins community partners in performing street outreach and prevention/early intervention coordination of care, and is the social worker on our street medicine team. This social worker has helped to identify numerous mezzo and macro level factors that impact access to care and provision of care to patients experiencing homelessness, and has joined in community wide efforts to address homeless health needs. Due to the success of this program, this year French Hospital Medical Center replicated this program in a part time capacity. Eventually, the plan for these programs are to work more formally through a population health lens.

- Substance Use Navigation Program: Marian, Arroyo Grande, and French Hospitals started a Substance Use Navigation in 2020. This program focuses on providing increased support through dedicated social workers to patients presenting with Substance Use Disorders. The primary goal of the provider is to provide assessment, intervention, and support while in hospital care, but also to link to appropriate resources with the flexibility to follow patients post-acutely as needed. Identified patients who are seen by providers after hours may also receive a follow up call from social work to coordinate care if/when appropriate. Naloxone Distribution Programs were also launched at all 3 hospital sites through the support of this program. Eventually, the plan for these programs are to work more formally through a population health lens.

- Employees donated to the following drives: Street Medicine Sock Drive, Salvation Army Angel Tree and Vitalant Blood drives

- Hospital staff serves on many community committees and boards in the service area such as: Cencal Health, Santa Maria Boys and Girls Club, Community Partners in Care, Santa Barbara Community Conversation Health Equity Task Force,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.

09/21/2023					
364 Marian Regional Medical Center					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare and Bad Debt)					
For period from 07/01/2022 through 06/30/2023					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Poor					
Financial Assistance	**23,376**	**$10,921,920**	**$0**	**$10,921,920**	1.5%
Medicaid	**112,918**	**$293,318,207**	**$284,379,106**	**$8,939,101**	1.2%
Community Services					
A - Community Health Improvement Services	17,598	$4,919,607	$0	$4,919,607	0.7%
E - Cash and In-Kind Contributions	3,185	$1,399,031	$0	$1,399,031	0.2%
G - Community Benefit Operations	Unknown	$105,205	$0	$105,205	0.0%
Totals for Community Services	**20,783**	**$6,423,843**	**$0**	**$6,423,843**	0.9%
Totals for Benefits for Poor	**157,077**	**$310,663,970**	**$284,379,106**	**$26,284,864**	3.7%
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	11,899	$333,905	$0	$333,905	0.0%
B - Health Professions Education	902	$16,923,662	$2,174,529	$14,749,133	2.1%
D - Research	Unknown	$173,034	$4,953	$168,081	0.0%
G - Community Benefit Operations	Unknown	$2,133	$0	$2,133	0.0%
Totals for Community Services	**12,801**	**$17,432,734**	**$2,179,482**	**$15,253,252**	2.1%
Totals for Broader Community	**12,801**	**$17,432,734**	**$2,179,482**	**$15,253,252**	2.1%
Totals - Community Benefit	**169,878**	**$328,096,704**	**$286,558,588**	**$41,538,116**	5.8%
Medicare	**104,335**	**$170,532,733**	**$148,340,003**	**$22,192,730**	3.1%
Totals Including Medicare	**274,213**	**$498,629,437**	**$434,898,591**	**$63,730,846**	8.9%

Hospital Board and Committee Rosters

HOSPITAL COMMUNITY BOARD FISCAL YEAR FY 2024

ANDERSEN, SUE
President & CEO, Marian Regional Medical Center

ALVARADO, PHIL, Vice Chair
Retired School District Superintendent

BOUQUET, MICHAEL
Business Manager, Car Dealership

CASH, CHIEF MICHAEL
City of Guadalupe Police/Fire Chief, Director of Public Health

CHAVEZ, LORENA
Agriculture Business Owner

EDDS, HOLLY, EdD, Chair
Superintendent / Educator, Orcutt School District

FAHLSTROM, SISTER PIUS, OSF
Religious Representative, Sisters of St. Francis

FERGUSON, KEVIN, M.D., Immediate Past Chair, Pathologist

FIBICH, TERRY
Retired Fire Chief

FLORES, HON. ROGELIO FLORES, Ret.
Retired Superior Court Judge

FROST, JUDY
Finance / Organizational Management

DHAGASH JOSHI, M.D.
Hospitalists / MRMC Foundation Board Chair

JUAREZ, MARIO, ESQ.
Attorney

LOPEZ, MELVIN, M.D.
Physician / Family Medicine

MANGAN, SISTER MICHELE, OSF
Religious Representative, Sisters of St. Francis

MARTINEZ, TOM
Architect / Businessman

MATENS, RICHARD W., M.Div.
Chief Health Officer, Santa Ynez Band of Chumash Indians

OFIEALI, IJEOMA, M.D.
Physician / Hospitalist

SNIDER, MARGAUX, M.D., Secretary
Physician / Emergency Services

WALTHERS, KEVIN G., Ph.D.
College President/Superintendent

ZINNER, ELI, M.D.
OB/Gyn / President of the Medical Staff

DEWAR, SANDRA
Philanthropist / AGCH Foundation Board Chair

RAYBURN, SISTER PAT, OSF (Religious Sponsor Representative)
Member, Sisters Founding Council

SPRENGEL, JULIE (CommonSpirit Health Representative)
Division President, CommonSpirit Health, Southern California

MARIAN REGIONAL MEDICAL CENTER
COMMUNITY BENEFIT COMMITTEE FY2024

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
Retired

Katherine Guthrie
Senior Regional Director, Cancer Services

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

Anne Rigali
Member, Marian Foundation Board of Directors

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Senior Director, Mission Integration

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

Holly Edds, PhD
Superintendent, Orcutt School District
Member, Hospital Community Board

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