Dignity Health
Marian Regional Medical Center

Santa Maria Campus

Arroyo Grande Campus

Marian Regional Medical Center

Community Health Implementation Strategy FY2017–FY2019

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EXECUTIVE SUMMARY

Marian Regional Medical Center's (MRMC) two campuses, one in Santa Maria (MRMC-SM) and the other in Arroyo Grande (MRMC-AG), serve the northern portion of Santa Barbara County and the southern-most section of San Luis Obispo County. The Santa Maria campus is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis of Penance and Christian Charity in 1940. MRMC-SM campus serves communities within the Santa Maria Valley, and has a defined primary service area which includes the City of Santa Maria (93454, 93455, and 93458), Guadalupe (93434), and Orcutt (93455). There is a large Hispanic or Latino(a) population living in this service area, over 60%, with a Caucasian population of approximately 30%. Also, MRMC-SM has a secondary service area extending into Buellton (93427), Lompoc (93436 & 93437), Los Alamos (93440), Los Olivos (93441), and Santa Ynez (93460). According to U.S. Census, MRMC-SM primary and secondary service areas serve over 200,000 individuals. The MRMC-AG campus, situated 15-miles north of the MRMC-SM campus, has been serving the community since 1962 and became a member of Dignity Health in 2004. MRMC-AG serves the health care needs of Arroyo Grande (93420), Grover Beach (93433), Nipomo (93444), Oceano (93445), and Pismo Beach (93449). The MRMC-AG service area has a total population of 75,953 individuals. Demographics of the MRMC-AG service area indicate 67% of the residents are Caucasian and an estimated 26% are Hispanic or Latino(a). The MRMC-AG service area has about a 90% high school graduation rate, and also serves a mature population with those over the age of 65 accounting for 16.7% of the service area.

The significant community health needs that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at http://www.dignityhealth.org/marianregional/about-us/community-benefits. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report. The top five significant community health needs identified through the CHNA are education, access to mental health, homelessness or housing, cardiovascular disease and stroke, and cancer screenings.

For the next three year time period the hospital will address cardiovascular disease, stroke, and mental health by implementing new programs and continue with the planning process for the inpatient behavioral health center expected to open in 2019. There are plans to enhance the Cancer Awareness Program by increasing screenings and access for those identified as the target population in the CHNA. Stanford University School of Medicine's Chronic Disease Self –Management Program has been integrated into existing applicable programs. The Pacific Central Coast Health Centers (clinics) will continue to provide access to healthcare for those underserved, uninsured and underinsured by providing preventative services, medical care for adults, and children's well visits and immunizations. One of the clinics will participate in the Reach Out and Read program that promotes early literacy and school readiness. The Community Grants Program continues to offer opportunities for funding to community based organizations that can assist us with current health priorities such as mental health, homelessness or housing and education.

This document is publicly available at http://www.dignityhealth.org/marianregional/about-us/community-benefits. Written comments on this report can be submitted to the Marian Regional Medical Center's Community Education Department at 1400 East Church St., Santa Maria, CA 93454 or by e-mail to CHNA-CCSAN@dignityhealth.org.

MISSION, VISION AND VALUES

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

OUR HOSPITAL AND OUR COMMITMENT

Marian Regional Medical Center's (MRMC) two campuses, one in Santa Maria (MRMC-SM) and the other in Arroyo Grande (MRMC-AG), serve the northern portion of Santa Barbara County and the southern-most section of San Luis Obispo County. The Santa Maria campus is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. MRMC-SM is situated on a 25-acre campus with a fully integrated healthcare delivery system. The combination of a growing patient population, technology advancements and the desire to provide the highest level of care led MRMC-SM to open the doors to a new state-of-the-art, 191-bed facility in the May of 2012. The new facility houses a 21-bed NICU, the largest and most comprehensive perinatology/ neonatology service on the Central Coast. MRMC-SM also has a 99-bed Extended Care Center, Homecare/Hospice and Infusion Service, and over 30 outpatient health centers. MRMC-AG is located in Arroyo Grande approximately 15 miles north of the Santa Maria campus and has been serving the health care needs of the Five Cities area since it became a member of Dignity Health in 2004. MRMC-AG has a 67-bed acute care facility and is well known for providing top level medical-surgical, acute rehab and emergency care services. The MRMC-AG campus' 20-bed Acute Rehabilitation unit serves patients who suffer functional loss from illnesses such as stroke, neurological and brain injury, spinal cord injury or other impairments requiring rehabilitation. MRMC's combined campuses have over 2,196 employees, 527 active physicians and approximately 500 volunteers.

Rooted in Dignity Health's mission, vision and values, Marian Regional Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and the Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

The Hospital Community Board, Community Benefit Committee, Senior Leadership and Community Benefit Staff responsibilities related to oversight of community benefit activities are indicated below:

- Hospital Community Board is responsible for ensuring the hospital develops and supports programs that address the disproportionate unmet health-related needs of the community. The Community Board approves the Annual Community Benefit Report and Plan as well as the triennial Community Health Needs Assessment (CHNA) and Implementation Strategy.
- Community Benefit Committee provides oversight for the Community Benefit Programs (program digests), Community Health Needs Assessment and the Community Grants Program. Community Benefit committee members provide input for program design, content, goals and objectives ensuring appropriate focus on the poor, underserved, and disadvantaged in the community as well as being aligned with the most recent CHNA. Program Coordinators are accountable for meeting their programs community benefit goals and reporting outcomes to the Community Benefit Committee on a quarterly basis. The Community Benefit Committee is made up of members of the Hospital Community Board, members of the hospital's senior management team, physicians and Community Benefit Program Coordinators (see Appendix A, roster of Hospital Board and Community Benefit Committee members, with affiliations).
- Community Benefit staff work with senior management, clinicians, physicians and community organizations to plan, develop, implement and evaluate outreach services in accordance with the hospital's strategic plans. The Senior Community Benefit Coordinator has responsibility to monitor and ensure collection of quarterly data and outcomes identified for all outreach programs. The Senior Director for Community Benefit reports to the Vice President of Post-Acute Care Services

and attends monthly Senior Leadership meetings for the Service Area to keep leadership updated on Community Benefit activities.

- The CHNA is completed every three years and is reviewed by the Community Benefit Committee with a final draft for approval to the Hospital Community Board.
- Senior leadership approves the Community Benefit annual budget.

Marian Regional Medical Center's community benefit program includes financial assistance provided to those who are unable to pay the cost of medically necessary care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services, and health professions education. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report.

DESCRIPTION OF THE COMMUNITY SERVED

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

Marian Regional Medical Center defines the community's geographic service area based on hospital patients discharged data. The Community Needs Index (CNI) is utilized to identify the target population and to assess the health need. The CNI was created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

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

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

In addition to the residents captured by the U.S. Census discussed above, the Santa Maria Valley attracts a transient farm-worker population drawn to work in the fields. According to published reports, it is estimated that Santa Maria is home to a population of 15,000 to 25,000 indigenous Indians from the state Oaxaca and neighboring Guerrero many of whom are monolingual in one of the many native

Mixteco, Zapotec languages (County of Santa Barbara Community Profile, 2015-2016). Lastly, the 2016 homeless preliminary count for Santa Maria is an estimated 283 sheltered individuals (County of Santa Barbara, 2016).

Demographic information taken for the MRMC-SM primary service area from ©2016 The Nielsen Company, ©2016 Truven Health Analytics Inc., provides data on the following:

- Total Population: 152,552
- Hispanic or Latino: 64.0%
- Race: White 27.7%, Black/African American 1.3%, Asian/Pacific Islander 4.7%, Other 2.3%
- Median Income: $58,879
- Uninsured: 5.4%
- Unemployment: 6.4%
- No HS Diploma: 32.6%
- CNI Score: 3.6
- Medicaid Population: 28.0%
- Other Area Hospitals: 0
- Medically Underserved Areas or Populations: Yes

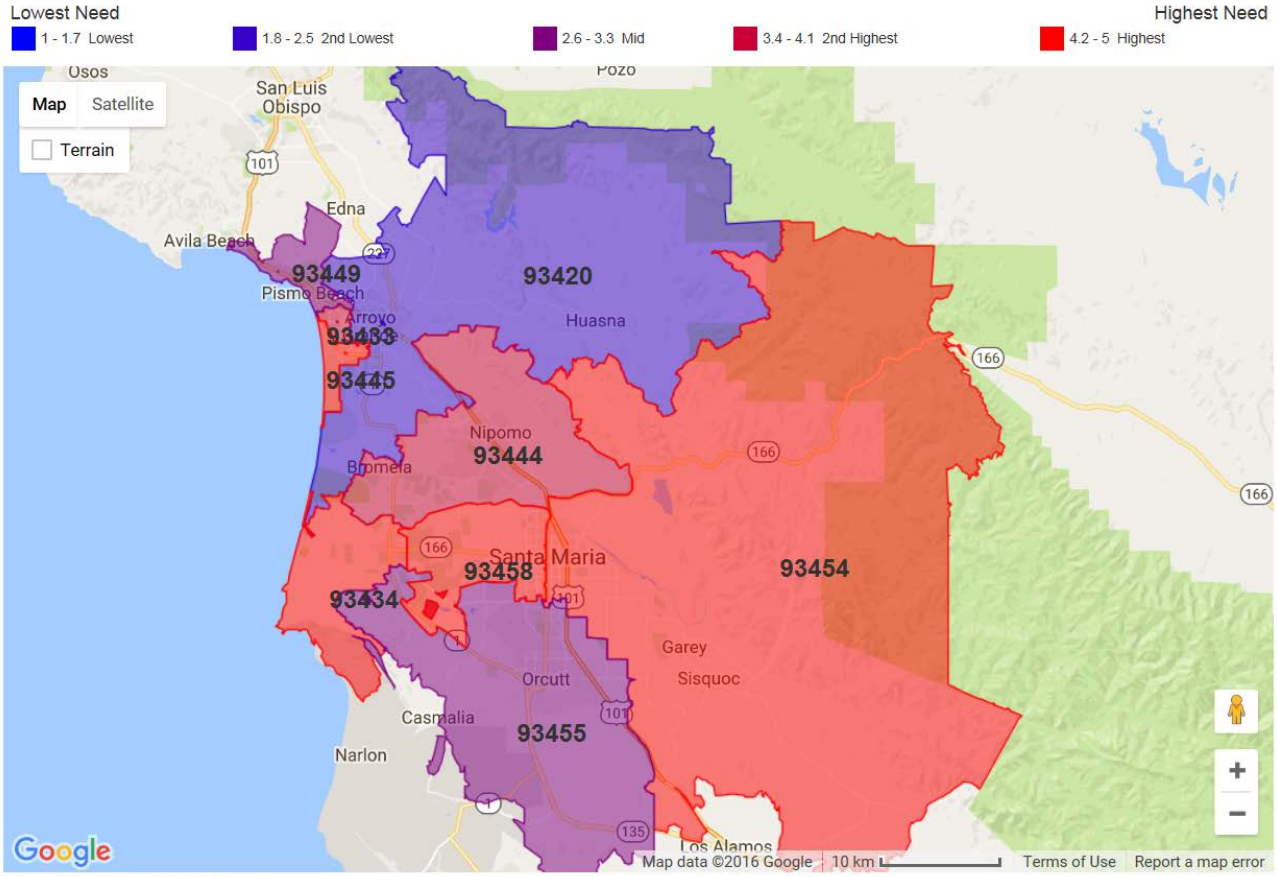
Arroyo Grande Campus

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

Demographic information for the MRMC-AG service area taken from ©2016 The Nielsen Company, ©2016 Truven Health Analytics Inc., provides data on the following:

- Total Population: 75,953
- Hispanic or Latino: 27.2%
- Race: White 65.3%, Black/African American 0.7 %, Asian, Pacific Islander 3.5%, Other 3.3%
- Median Income: $64,253
- Uninsured: 5.2%
- Unemployment: 3.9%
- No HS Diploma: 11.3%
- CNI Score: 3.8
- Medicaid Population: 19.3%
- Other Area Hospitals: 0
- Medically Underserved Areas or Populations: Yes

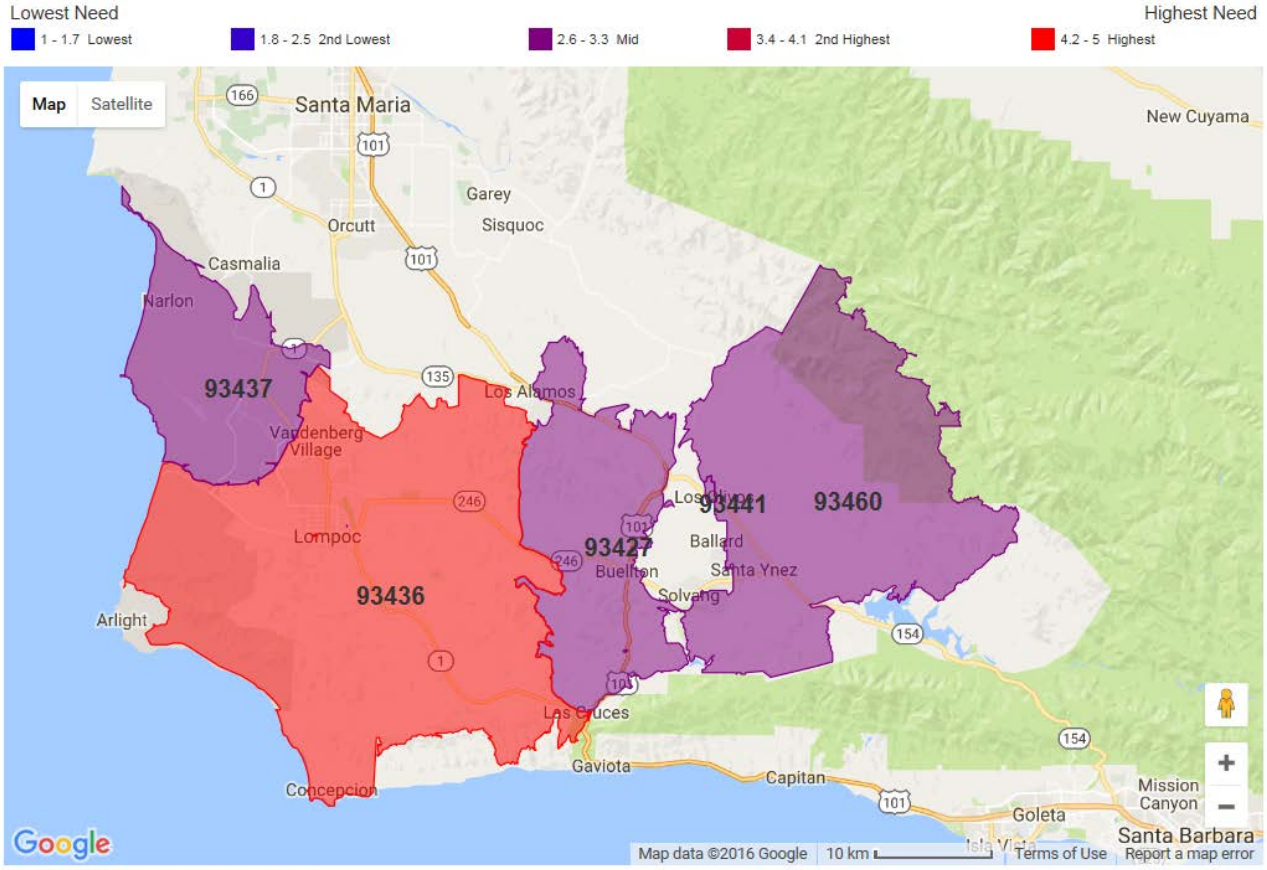
2016 Community Needs Index Map
MRMC-SM and MRMC-AG Primary Service Area



Mean(zipcode): 3.7 / Mean(person): 3.7 CNI Score Median: 3.8 CNI Score Mode: 4.4

Zip Code	CNI Score	Population	City	County	State
93420	2.4	29844	Arroyo Grande	San Luis Obispo	California
93433	3.8	13087	Grover Beach	San Luis Obispo	California
93434	4.2	7652	Guadalupe	Santa Barbara	California
93444	3.4	21002	Nipomo	San Luis Obispo	California
93445	4.4	7219	Oceano	San Luis Obispo	California
93449	3	7801	Pismo Beach	San Luis Obispo	California
93454	4.4	39403	Santa Maria	Santa Barbara	California
93455	2.8	45102	Santa Maria	Santa Barbara	California
93458	4.6	60395	Santa Maria	Santa Barbara	California

2016 COMMUNITY NEEDS INDEX MAP
MRMC-SM SECONDARY SERVICE AREA



Mean(zipcode): 3.2 / Mean(person): 3.9 CNI Score Median: 3 CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
93427	3.2	7507	Buellton	Santa Barbara	California
93436	4.2	56776	Lompoc	Santa Barbara	California
93437	2.6	3453	Lompoc	Santa Barbara	California
93441	2.8	1095	Los Olivos	Santa Barbara	California
93460	3	5563	Santa Ynez	Santa Barbara	California

IMPLEMENTATION STRATEGY DEVELOPMENT PROCESS

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

Community Health Needs Assessment Process

The most recent Community Health Needs Assessment (CHNA) was adopted in June 2016 and was completed through a compilation of primary and secondary data sources, including an original health needs assessment survey, key stakeholder focus groups, community leader interviews, as well as established secondary public health statistics and U.S. Census data. The CHNA aimed to capture the health status of the medically underserved, low income, and minority populations living in each primary service area.

Primary data was collected from an original health behavior survey that was developed based upon select questions from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey Questionnaire (BRFSS), previous CHNAs prepared by Dignity Health, and input provided by those representing community benefit/outreach activities at MRMC. The community health survey was designed to try and gain a perspective of each individual's social determinants as well as their health behavior and health conditions The final survey contained a total of 44 questions, was made available in both Spanish and English and was administered in person by Spanish speaking lay health educators (Promotoras). Two distinct data sets were collected from the primary service area served by MRMC-SM's campus and MRMC-AG's campus. The original health survey was completed by a combined 1,067 individuals from MRMC-SM and MRMC-AG service areas. Using a convenience sampling (non-probability) approach, locations were selected based on the perception of being able to encounter our medically underserved, low-income and minority populations.

In addition to the health behavior survey, two community stakeholder focus groups were held, one at MRMC-SM and the other at MRMC-AG. Over 60 individuals from known community organizations were invited. Participants included individuals who work with low-income, minority, or medically underserved populations. Qualitative data was collected during interviews with key community stakeholders, community leader interviews, community organizations, political leaders, emergency department staff and public health departments.

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

- Center for Disease Control Behavioral Risk Factor Surveillance System
- California Department of Public Health
- Healthcare Utilization Data
- Healthy People 2020
- Prevention Quality Indicators
- U.S. Census

While potential resources are available to address the needs of the community, the needs are too significant for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and institutions. The greater Santa Maria Valley and Five Cities area are home to a wealth of organizations, businesses, and non-profits, including a local community college. MRMC formulated an inventory of community resources potentially available to help address the needs. A list of these resources can be found on page 27 and 28 of the Community Health Needs Assessment (http://www.dignityhealth.org/marianregional/documents/community-benefit-reports/2016-chna).

CHNA Significant Health Needs

Community health needs were prioritized based upon need, duplication in the qualitative data (community interviews, key stakeholder interviews) and quantitative data. In addition, the community health survey results were compared (when available) to state and national rates, as well as the Healthy People (HP) 2020 benchmark.

Key community leaders were invited to participate in a nominal group process to identify, prioritize, and discuss health issues for the community, based on their knowledge of the community. Based on these discussions and subsequent discussions with key community leaders, the three greatest needs facing our community were substantiated. Community leaders and key stakeholders mentioned homelessness, access to mental health, and education (crime was mentioned, but it relates back to educating our youth). Educational attainment level is again the one independent variable that closely correlates with an increase in health and wellness. Numerous findings on residents' health indices and health disparities based on educational attainment were found. While educational attainment varies depending on the survey participants' race /ethnicity and place of residence, just under half of all survey participants did not receive a high school diploma and almost 30% reported having a sixth grade education or less. Currently, the least educated are under the age of 50, may lack health insurance, and are parenting the youngest generation. Preventative health care is most likely not being obtained by these individuals, which may eventually lead to a wave of unmanaged chronic disease.

In 2016, the community benefit committee reviewed the identified needs. In accordance with Dignity Health policy, the following criteria were also utilized to evaluate the prioritization of community needs:

- Size of problem (i.e., number of people affected);
- Seriousness of problem (i.e., health impact at the individual, family and community level);
- Economic feasibility (i.e., program cost, internal and potential external resources);
- Available expertise (i.e., can we make an important contribution);
- Time commitment (i.e., overall planning, implementation, and evaluation); and,
- External salience (i.e., evidence that it is important to community stakeholders).

The top five significant community health needs identified through the CHNA are:

- Education;
- Access to mental health;
- Homelessness or housing;
- Cardiovascular disease and stroke; and,
- Cancer screenings.

Time and time again community leaders and key stakeholders mentioned homelessness, access to mental health, and education as the greatest challenges affecting our communities. Educational attainment level is the one independent variable that closely correlates with an increase in health and

wellness. Numerous findings on residents' health indices and health disparities based on educational attainment were found. While educational attainment varies depending on the survey participants' race /ethnicity and place of residence, just under half of all survey participants did not receive a high school diploma and almost 30% reported having a sixth grade education or less. Secondary data identified cardiovascular disease as well as cancer as significant health concerns for our community. According to the California Vital Statistics, in 2012, the leading cause of death for every 1 out of every 4 people residing in the combined service was diseases of the heart. Based upon State of California Death Profiles, the second leading cause of death in the combined service area is cancer.

Education, access to mental health and homelessness/housing are each a significant heath need the hospital has chosen not to address alone. The hospital is limited in resources to address education and homelessness/housing independent of our community partners. Considerable investigation revealed education and homelessness/housing are being addressed but there is still work to be done. By invitation to community-based organizations we hope to facilitate a seamless continuum of care and develop relationships that can be addressed through the Dignity Health Community Grants Program. MRMC-SM in partnership with the County of Santa Barbara plans to open an inpatient behavioral health unit in north Santa Barbara County in 2019 to help address the critical mental health needs of the community.

Creating the Implementation Strategy

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

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

The Implementation Strategy process began with the review of the Community Health Needs Assessment (CHNA). Program planning for the next three years 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 either developed (new programs) or enhanced (existing programs) by utilizing current literature, expert advice or evidence based protocols (e.g., Healthy People 2020). When developing or enhancing current programs, specific attention was given to the program's ability to address the identified needs from the most recent CHNA, incorporate the five core principles noted above and serve the vulnerable population. Collaboration with community partners also led to improved program design, best practices and effective interventions. Program development includes a plan for monitoring for performance and quality to find areas of improvement to facilitate their success. The Community Benefit Committee, senior leadership, Community Board and the system office (Dignity Health) receive regular program updates.

MRMC will continue to partner with community-based organizations, community health clinics and other community partners providing services and activities such as health fairs, free health screening events, and health education programs to promote, educate, and help bridge the gap between services and the underserved. Working together with Promotoras (Santa Barbara County Promotora Coalition) will continue to increased awareness and attendance among the Latino community for nutrition, chronic disease management, health screenings, diabetes, cardiovascular disease, stroke and cancer awareness.

Planning for the Uninsured/Underinsured Patient Population

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

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

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

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

FY2017-2019 Implementation Strategy

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

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

STRATEGY AND PROGRAM PLAN SUMMARY

Education

- Community Grants -- Encourage partners of accountable care community to have an education aspect to their program
- Reach out and Read Program -- Pacific Central Coast Health Center Clinic to promote early literacy and school readiness during well child visits
- Medical Literacy -- Explore utilization of medical literacy tool that will help providers assess the appropriate level to teach their patients about health related matters (discharge instructions, prevention, etc.)

Access to Mental Health

- Community Grants -- Encourage partners of accountable care community to include access to mental health in their program
- Maternal Mood Disorder Pilot Program -- Implementing at the MRMC-SM campus
- Support Groups -- Cancer, Diabetes, Stroke and Grief; offered at a variety of locations throughout the service area
- Caregiver Workshops and Support Groups --The Santa Barbara Foundation funded MRMC-SM and partners with the Santa Barbara County Promotora Coalition to work together to provide support to caregivers by training promotoras
- Zumba and Yoga Classes -- Free classes offered to underserved population to help relieve stress and enhance wellbeing

Homelessness or Housing

- Community Grants -- Encourage partners of accountable care community to have an aspect to their program regarding homelessness and/or housing
- Respite Care Services -- MRMC collaborates with Good Samaritan Shelter and The Five Cities Homeless Coalition to streamline the process for offering respite care services to homeless medically fragile patients discharged from the hospital
- Case Management of Chronically Homeless Individuals: MRMC social workers and care coordinators collaborate with community partners (Central Coast Collaborative on Homelessness, Good Samaritan Shelter, Five Cities Homeless Coalition, etc.) to find critical services (housing & food) for chronically homeless patients as well as to offer other services such as access to mental health treatment, outpatient case management, access to health insurance, food and nutrition services and job training and placement.

Cardiovascular Disease and Stroke

- Community Education -- Education in Spanish and English that includes prevention, detection, and management of risk factors for heart attack and stroke
- Assessment of Cardiovascular Risk Status -- At targeted locations in the community (such as health fairs, shopping centers, low cost housing units) to assess and identify those medical or lifestyle conditions that may lead to development of the disease
- Partners with American Heart Association -- Annual Heart and Stroke Walk
- Heart Aware Program -- Online screening tool
- Care Transitions Program -- Includes those with heart failure for telephonic nursing support
- Chronic Disease Self-Management Program -- Empowering individuals to effectively manage their chronic disease (Diabetes, Heart, Stroke, etc.)
- Nutrition Programs -- Heart healthy diet education

Cancer Prevention and Screenings

- Cancer Awareness -- Community education at outreach events and local schools
- Cancer Screenings -- An enhancement of the existing Cancer Care Program reflective of the CHNA will address increasing cancer screenings (such as colonoscopies, lung, mammogram, prostate and skin) in the target population.
- Hereditary Cancer Risk Assessment and Genetic Counseling
- Cancer Experience Registry Program
- Mission Hope Cancer Rehabilitation Program
- Cancer Support Groups

Anticipated Impact

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

Planned Collaboration

The recent Community Health Needs Assessment has led to a search and discovery step; a search of existing services and programs and a discovery of the opportunities available to develop relationships with other community based organizations who with us can address the health needs of the community. While the hospital has available resources to address Cancer, Cardiovascular Disease and Stroke, the identified needs of Education, Access to Mental Health and Homelessness and Housing are too significant for any one organization. Making a substantial and upstream impact will require collaborative efforts. The following is a list of the community-based organizations with which the hospital can work to deliver programs specifically related to Education, Access to Mental Health and Homelessness and Housing.

Education:

- Fighting Back Santa Maria Valley and Good Samaritan funded to assist kids Pre-K to 3rd grade with "Power of Reading" program and to perhaps expand this program to other locations.
- Allan Hancock College and Cuesta College
- Discovery Museum
- Boy's and Girl's Club
- United Way
- Local School Districts
- Public Library
- Santa Maria Work Force Development Program
- City of Santa Maria, Recreation and Parks Department

Access to Mental Health:

- County of Santa Barbara- Planning the inpatient behavioral health unit in north Santa Barbara County
- Santa Maria Valley Youth and Family- Mental health services for children ages 0-18
- Fighting Back Santa Maria Valley- Conflict Mediation Services; Drug Free Community Coalition and Safe Havens-Anti-Bullying Programs.
- Transitions Mental Health Association- Emergency Department Lay Navigator for mental health
- Local Police Department

Homelessness / Housing

- Five Cities Homeless Coalition, Lucia Mar Unified School District and Cuesta College: To specifically address the needs of the 18-24 year old homeless young adults to lift their education attainment
- Central Coast Collaborative on Homelessness (C3H)
- Good Samaritan Shelter
- People Self-Help Housing
- Local Churches
- Salvation Army
- Local Police Department

PROGRAM DIGESTS

The following pages include program digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Cancer Prevention and Screenings
Cardiovascular Disease and Stroke
Care Transitions
Diabetes Prevention and Self-Management
Dignity Health Community Grants
Maternal Mood Disorder
Pacific Central Coast Health Centers

Cancer Prevention and Screenings	
Significant Health Needs Addressed	❑ Education ❑ Access to Mental Health ❑ Homelessness or Housing ❑ Cardiovascular Disease/Stroke X Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention X Contribute to a Seamless Continuum of Care X Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Marian Cancer Care Program at both Arroyo Grande and Santa Maria campus 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
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	Increase cancer awareness, screenings, genetic counseling and survivorship programs in the target population. The target population being served targets two groups: the first group is seniors typically live on fixed, limited incomes, underinsured and financially distressed. (Cancer is a disease associated with aging and it is expected by 2030 that 67% increase in cancer in the 65 plus age group.) The second group is the working class Latino(a) residents with lower levels of education attainment and many under and uninsured.
Measurable Objective(s) with Indicator(s)	1. Increase the number of patients by 10% who are utilizing the cancer education program (Emmi Solutions) to improve patient knowledge of disease, procedures, treatment and drive cancer screening. (year 1, 2, 3) 2. Increase awareness of cancer prevention and available screenings within the community by tracking event locations and pamphlet utilized during teaching interactions within target population. (year 1, 2, 3) 3. Increase number of patients needing assistance for screening by disease site (Colonoscopies-32/10%; Lung-315/10%; Mammograms-28/10%; Prostate-12/10%; Skin-121/10%). (year 1, 2, 3) 4. Track number of patients transported. Track number of patients financially assisted for transportation. (year 1, 2, 3) 5. Track number of people who complete Hereditary Cancer Risk Survey and were referred for genetic counseling. (year 1, 2, 3) 6. Increase by 15% the number of cancer patients served by the genetic counseling program and track number of patients needing financial assistance (125/15%). (year 1, 2, 3) 7. Track number of patients and caregivers enrolled in a Cancer Experience Registry program to identify qualify of life issues. (year 1, 2, 3) 8. To improve health and reduce recurrence of risk in cancer survivors, track core health strategies (diet, movement, environment, rejuvenation and

	spirit). (year 1, 2, 3) 9. Enhance psychosocial support in target population by tracking number of patients that are financially assisted (156/10%) (year 1, 2, 3) 10. Increase the number of target population enrolled in the cancer rehabilitation program by 25%. (year 1, 2, 3)
Intervention Actions for Achieving Goal	1. Assign patient education modules from Emmi Solutions. 2. Develop a bilingual pamphlet outlining cancer prevention and screening by disease site, and utilize developed cancer education pamphlet to educate community about screening opportunities. 3. Identify patients in the target population needing transportation assistance. 4. Implement a cancer risk program to identify people with family history and environmental influences. 5. Establish and implement a Cancer Experience Registry program. Enroll patients living with cancer and family caregivers into this registry to identify quality of life issues. 6. Establish, implement and engage cancer survivors in "I Thrive Program" focused on five key lifestyle areas most likely to improve health and reduce recurrence risk. Patients will be identified who need psychosocial support, financial assistance and medically eligible to attend the Cancer Rehabilitation Program.
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, City of Santa Maria, Santa Barbara and San Luis Obispo County Health Department, Good Samaritan Homeless Shelter, Catholic Charities, St. Cecilia Society, Okerblom Clinic, Area Agency on Aging, Community Action Commission, Teddy Bear Foundation, SBCEO Health Linkages, Wisdom Center, Santa Barbara County Promotores Coalition, Community Partners in Caring, local ranches/ wineries, Alan Hancock Community College and Lucia Mar Unified School District.

Cardiovascular Disease and Stroke	
Significant Health Needs Addressed	❑ Education ❑ Access to Mental Health ❑ Homelessness or Housing X Cardiovascular Disease/Stroke ❑ Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention X Contribute to a Seamless Continuum of Care X Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Cardiovascular disease/stroke is one of the leading causes of death in the north Santa Barbara and San Luis Obispo County. Assessment of cardiovascular risk status will be implemented to identify those medical or lifestyle conditions that may lead to development of the disease. This program can enable community members to take control of their health and encourage follow-up and treatment of risk factors by their health care provider.
Community Benefit Category	A1a – Community Health Education; A2d- Community Based Clinical Services; A1d – Community Health Education – Support Group
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. All Healthy for Life Nutrition participants contact information will be forwarded to program digest owner and a minimum 50% will receive cardiovascular and stroke education. (year 1, 2, 3) 2. Screen a minimum 15 people for cardiovascular disease (free blood pressure and glucose screening) at each of 6 target population health fair events. (year 1, 2, 3) 3. Educate 50 screened at-risk individuals regarding healthy lifestyle to reduce cardiovascular risk in the target population. (year 1, 2, 3) 4. Increase 25% FAST Fridays to target population by providing CV Risk, BP, Stroke Screening and identifying potential at risk to conduct blood pressure check and document. (year 1, 2, 3) 5. 60% of participants in Explaining Stroke 101 identified as at risk will be provided telephonic support post 30 days to self-report they had an appointment with their physician. (year 1, 2, 3) 6. 80% of participants enrolled in CDSMP program will complete the workshop.(year 1, 2, 3)
Intervention Actions for Achieving Goal	1. Identify a Program Champion 2. Cardiologists have a consensus of blood pressures for seniors (120/80 or 150/90) 3. Train promotoras on Cardiovascular Risk Assessment Tool and how to record results on web. 4. Use Cardiovascular Risk Assessment tool at health events to identify risk levels of target population. 5. Train promotoras to conduct BP and glucose finger stick checks. 6. High risk screened individuals whose criteria are the following: no primary care provider, aware for the first time they have elevated glucose and blood pressure will self-report lifestyle modifications at 6 and 12 months.

	7. RN will train promotora on risk factors for conducting 6 and12 month telephonic support for participants to self-report 8. Track monthly results of HeartAware 9. Conduct a blood pressure awareness campaign for target population. 10. Establish baseline for target population's use of Cardiac Risk Assessment Tool (to have comparative results of target population between fiscal year 2017 and 2018) (# of people assessed # of people at risk) 11. Provide "Explaining Stroke 101" for target population in English and Spanish. 12. Schedule and facilitate Stroke Support Group in English and Spanish. 13. FAST Friday facilitator will document number of people served for each event. 14. Train promotoras on process of FAST Friday and "Explaining Stroke 101". 15. All patients participating in program are referred to CDSMP program via programs sign in sheets (email name and telephone #).
Planned Collaboration	Vision y Compromiso, American Heart Association, Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education

Care Transitions	
Significant Health Needs Addressed	❑ Education ❑ Access to Mental Health ❑ Homelessness or Housing X Cardiovascular Disease and Stroke ❑ Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention X Contribute to a Seamless Continuum of Care X Build Community Capacity ❑ Demonstrate Collaboration
Program Description	The Care Transitions program provides consistent telephonic patient follow-up and education thereby decreasing the number of participant admissions to the hospital focusing on COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure.
Community Benefit Category	A3-e Health Care Support Services
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	Avoid hospital and emergency department re-admissions for all participants with COPD, diabetes, pneumonia, cardiac event sepsis and heart failure and other high risk diagnosis enrolled in the program
Measurable Objective(s) with Indicator(s)	1. 85% of participants enrolled in the program will verbalize they take their medications as prescribed. (year 1) 2. 85% of participants enrolled in the program have a follow-up appointment within one week of discharge from hospital. (year 1) 3. 80% of participants enrolled in the program kept their follow-up appointment after being discharged. (year 1) 4. 98% of identified patients for tele-monitoring were placed on the monitors within 4 days of documented need by physician. (year 1) 5. Using secure email, make referral for 40% of low risk patients to CDSMP. (year 1)
Intervention Actions for Achieving Goal	1. Intervention will include question on patient ability to get follow up physician appointment, involve MSW to assist with additional resources and services. 2. Provide home visit by the physician as temporary solution until long term plans can be arranged. 3. Identify barriers for those patients unable to make their appointment. 4. Work with IT to request changes to Case Management software program to include fields for reporting patient complaints of medications and keeping physician appointment. 5. Patients identified on Dashboard as appropriate for Care Transition and are not contacted due to capacity limit, will all be referred/triggered to Community Education for CDSMP program. 6. Lay navigators will be identified for help in Care Transition program for English and Spanish patients. Lay navigator to help make non-critical calls. 7. The Lay Navigators will be trained for making follow up calls and will follow script/documentation, and notification of RN for any identification of problems requiring RN follow up. 8. Home visits from physician and medical social worker will be tracked for

	effectiveness in meeting social needs of patient and for preventing complications from their chronic illness. 9. Measure visits, access to community resources, and for compliance with any recommendations from the physician and any evidence of physician communication to primary care physician. 10. Describe or list the specific, principal program/initiative activities planned. 11. Evaluate program objectives annually and make necessary changes/enhancements to meet program goal.
Planned Collaboration	Collaborative with CenCal and the community resources that provide care transition interventions – post acute care services. Family Caregiver Program at MRMC with the MSW Navigator working in collaboration with 5 community partners to support the caregiver providing care to a patient in SB County.

Diabetes Prevention and Self-Management	
Significant Health Needs Addressed	❑ Education ❑ Access to Mental Health ❑ Homelessness or Housing X Cardiovascular Disease and Stroke ❑ Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention ❑ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Provide a comprehensive evidence-based diabetes management program for the ADA recognized program providing education with registered dietitian and nurse specializing in diabetes management. The program will improve behavior and self-management practices of diabetic patients; enhance and improve the access and delivery of effective preventive health care services.
Community Benefit Category	A1-c Community Health Improvement Services
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	Increase diabetes self-management skills in the target population for pre diabetic and diabetics.
Measurable Objective(s) with Indicator(s)	1. 90% of participants enrolled in the ADA recognized Diabetes Self-Management Education Program will maintain program goal by decreasing A1c 0.5% or maintain 7% or below through telephonic support at 3 months post intervention. (year 1) 2. 50% of group participants in ADA recognized Diabetes Self-Management Education Program will join support group. (year 1) 3. 75% of support group participants will self-report a decreasing A1c 0.5% or maintain 7% or below 3 months after joining support group. (year 1) 4. English and Spanish Community Health Workers will be identified and trained to lead support groups. (year 1)
Intervention Actions for Achieving Goal	1. RN, RD will provide Diabetes Self-Management Program for MRMC-SM and MRMC-AG campuses. 2. Explore how to standardize the ADA program throughout the central coast service area. 3. Work with patients and physician offices for a timely lab response. 4. Improve data base and, intake methods to increase productivity and tracking for the Diabetes Education Center program. 5. Expand Diabetes ADA recognized program by adding clerical support to enhance customer service of patients. 6. Offer four English diabetes education class series (ADA recognized) (4 per series) 7. Identify and training promotoras to provide 2 Spanish diabetes education class series (ADA recognized) (4 per series). 8. Identify time and location participants are able to attend English and Spanish Support Group for Diabetes and schedule monthly. 9. All patient face sheets will be forwarded to CDSMP Coordinator (30 days post intervention) for enrollment in CDSMP and support groups. 10. Evaluate program objectives annually and make necessary

	changes/enhancements to meet program goal.
Planned Collaboration	Santa Barbara and San Luis Obispo FoodBank; Pacific Central Coast Health Centers, SLO Noor, Alliance for Pharmaceutical Access, Inc., Central Coast Patient Care Coordinators, CenCal, CHCCC, Dr. Lai

Dignity Health Community Grants Program	
Significant Health Needs Addressed	X Education X Access to Mental Health X Homelessness or Housing ❑ Cardiovascular Disease and Stroke ❑ Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention X Contribute to a Seamless Continuum of Care X Build Community Capacity X Demonstrate Collaboration
Program Description	This program provides 501(3)c "accountable care communities" the opportunity to apply for funds designed to meet the hospitals health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.
Community Benefit Category	E2a - Financial and In-Kind Donations
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address such as Education, Homelessness/Housing and Access to Mental Health.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year. (year 1, 2, 3) 2. Build richer ACC that are focused on multiple significant health needs. (year 1, 2, 3) 3. 100% of funded ACC will update local community benefit committees on their project. (year 1, 2, 3) 4. 100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained. (year 1, 2, 3)
Intervention Actions for Achieving Goal	1. Funded ACC will present at Community Benefit Committee meetings. 2. Coach ACC to provide more concise, comprehensive quarterly measurable outcomes 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee
Planned Collaboration	Good Samaritan, 5 Cities Homeless Coalition; Central Coast Collaborative on Homelessness, school districts, Santa Barbara County Promotora Coalition, Transitions Mental Health Association, Santa Barbara County Food Bank and other community organization addressing the community health needs

Maternal Mood Disorder	
Significant Health Needs Addressed	☐ Education X Access to Mental Health ❑ Homelessness or Housing ❑ Cardiovascular Disease/Stroke ❑ Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention X Contribute to a Seamless Continuum of Care X Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Improve screening and treatment for postpartum depression (PPD) by engaging pediatricians, obstetricians, mother's primary care providers, and other key stakeholders in health care to address the link between maternal and child health.
Community Benefit Category	A1-a Community Health Education; A2-d Community Based Clinical Services
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	Reframe postpartum depression as a common part of postpartum recovery to help lessen the stigma associated with getting help.
Measurable Objective(s) with Indicator(s)	1. Create a web-based resource director for providers to use and refer at-risk mothers for appropriate services. 2. Outreach with PPD assessment tool to 896 English, Spanish and Mixteco moms that are 200% below poverty level.
Intervention Actions for Achieving Goal	1. Identify community stakeholders (year 1) 2. Create a Community Action Plan (year 1) 3. Decide on PPD screening tool (year 1) 4. Conduct a workshop for health care providers (year 1) 5. Engage Dignity Health providers in education about PPD, using PPD screening tool and the web-based resource directory. (year 1) 6. Create curriculum for training promotoras (year 1) 7. Train promotoras on curriculum and PPD assessment tool (year 1) 8. Identify data sharing tool analyze PPD assessments (year 1, 2) 9. Work with System Office to identify other sources of funding.(year 2)
Planned Collaboration	Santa Barbara County Maternal Child, Adolescent Health Department, Santa Barbara County Promotoras Network (Health Linkages) Santa Barbra County Division of Adult Mental Health Services, First 5 Santa Barbara County, Child Abuse Listening and Mediation, Santa Barbara County Promotora Network

Pacific Central Coast Health Centers	
Significant Health Needs Addressed	X Education ❑ Access to Mental Health ❑ Homelessness or Housing X Cardiovascular Disease and Stroke X Cancer Screenings
Program Emphasis	X Focus on Disproportionate Unmet Health-Related Needs X Emphasize Prevention ❑ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	The Santa Maria, Family Medicine and Higuera Clinics assure access to quality primary health care for the residents of North West Santa Maria and San Luis Obispo, focusing on the underserved, uninsured/underinsured. These Community Clinics address health disparities, with a focus on patients who are homeless.
Community Benefit Category	C3-Hospital Outpatient Services
Planned Actions for FY2017 - 2019	
Program Goal / Anticipated Impact	The Pacific Central Coast Health Center locations of Bunny Street, Family Medicine and Higuera Street will provide top quality comprehensive accessible and affordable healthcare, customer friendly service with easy access to services in our community. We will promote wellness and provide necessary care for illnesses while achieving a high level of quality and compassion we want for our own families.
Measurable Objective(s) with Indicator(s)	1. Enroll a total of 50 uncontrolled diabetic patients in Stanford Diabetes Self-Management Program. 2. Enroll 100 assigned CenCal or uninsured children in Reach out and Read program during the well child visit. 3. Enroll 50 patients with a BMI of 28 or greater in Healthy for Life Lecture Series (HFL). 4. Extend evening hours including Saturday. To be implemented by January 2017. 5. In collaboration with the SB Food Bank provide a series of education to 75 patients with uncontrolled diabetes. 6. Participate in a minimum of 10 outreach events throughout the year where education and health screenings can be performed. 7. Provide local schools with free or low cost physicals, and health screenings.
Intervention Actions for Achieving Goal	1. Identify poorly controlled diabetic patients in order to ensure proper referral is made. Partner with Marian Regional Medical Center to provide education series. 2. Apply and launch Read Out and Reach program at the MCC-SM Clinic and Family Medicine Center 3. Create protocol to identify patient with a >BMI of 28 to ensure proper referral is provided. 4. Expand all 3 clinics (MCC-SM, FMC, and Higuera) to 1 Saturday a month, at minimum. 5. Continue to partner with The Santa Barbara Food Bank to provide diabetic education series.

	6. Partner with local community organizations to identify outreach events. 7. Partner with local schools to identify community needs. 8. Evaluate program objectives annually and make necessary changes/enhancements to meet program goal.
Planned Collaboration	Santa Barbara County Food Bank, Community Education Dept., Diabetes Prevention and Management Program, Mission Hope Cancer Center

APPENDIX A: HOSPITAL COMMUNITY BOARD FY2016

Rebecca Alarcio (Vice Chair)
Community Educator

Lupe Alvarez
Businessman

Carolyn Baldiviez, D.D.S.
Dentist

Michael Bouquet
Businessman

Peggy Blough
Real Estate

Kathy Castello
Business Finance / Communications

Sister Pius Fahlstrom, OSF
Religious Sponsor

Terry Fibich (Immediate Past Chair)
Retired Fire Chief

Kevin Ferguson, M.D.
Physician / Pathologist

Steve Flood, D.D.S.
Dentist

Jacqueline Frederick, Esq.
Attorney / Community Leader

Angelica Gutierrez (Chair)
Finance / Banking

Mike McNulty
Businessman

Juan Reynoso, M.D.
(President of Medical Staff & Board Member)
Physician / Emergency Medicine

Sister Carol Snyder, OSF
Religious Sponsor

Kevin G. Walthers, Ph.D. (Secretary)
College Superintendent / Educator

Joseph Will
Businessman / Construction

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

Hospital Representatives
Sue Andersen
Vice President / Service Area Chief Financial Officer

Paul Castello, M.D., Chief of Staff
Orthopedic Surgery

Charles J. Cova
Vice President, Operations Dignity Health

Kenneth R. Dalebout
Administrator, Marian Arroyo Grande Campus

Villa Infanto, MBA, RN
Vice President, Patient Care Services

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

Kerin A. Mase
President & CEO

Charles Merrill, M.D., FACEP
Chief Medical Officer
Marian Santa Maria Campus

Candice Monge, MSN, RN
Chief Nurse Executive Officer

J. Trees Ritter, D.O.
Chief Medical Officer
Marian Arroyo Grande Campus

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

Denise Valente
MRMC Foundation Board Chair

Kathy Tompkins
AGCH Foundation Board Chair

Sponsor Representative
Sr. Pat Rayburn, OSF
Chair, Sponsorship Council
Dignity Health

Dignity Health Representative
Marvin O'Quinn, EVP / COO
Dignity Health

APPENDIX A: COMMUNITY BENEFIT COMMITTEE FY2016

Carolyn Baldiviez, D.D.S.
Dentist

Kathy Castello
Hospital Community Board Member

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

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

Terry Fibich
Hospital Community Board Member

Bill Finley
Chief Financial Officer

Katherine Guthrie
Cancer Center Regional Director

Matt Kronberg
Service Area Director, Spiritual Care

Tina McEvoy, RN
Care Transitions Coordinator

Mary Oates, M.D.
Osteoporosis Program Director
Dignity Health Central Coast Service Area

Anne Rigali
Foundation Board Member

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

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

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

Sandy Underwood
Senior Community Education Coordinator

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

Medically Fragile Respite Care – Patients discharged from either the Santa Maria or Arroyo Grande campus that are homeless need a secure place to stay while recovering from their hospital stay. Good Samaritan Shelter in Santa Maria provides respite beds for these homeless medically fragile patients. At the end of their stay we are billed a day rate. The shelter has an in-house clinic that facilitates the patient's limited medical care. The same is true for those patients needing this service from the Arroyo Grande campus which is about 18 miles north of Santa Maria.

Human Trafficking – This initiative was launched in FY 2015 with an emergency response team established and a roll out of the first phase of education and training for hospital clinical staff to increase awareness of this System initiative. Subsequent trainings were held for non-clinical staff. An algorithm was developed that engages community resources to partner with several non-profit organizations, law enforcement and the Santa Maria Court System. Plans are underway to model this response team at the Arroyo Grande campus.

Janet's Closet/Pediatric Closet – When NICU babies are required to stay at the hospital for weeks and months at a time, mommies and daddies have a difficult time leaving their new family members. The Santa Maria campus offers High Risk Infant Assessments for these little ones and at the same time offering the vulnerable population access to premie clothing for their newborn. Partnering with Children's Resource Network has been

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

Hospital staff serves on many community committees and boards in the service area such as: Santa Maria Boys and Girls Club, Area Agency on Aging, Community Partners in Care, 1st Five Advisory Board, Live Well Santa Barbara County, Active Aging Committee, Guadalupe Family Resource Center, develop relationships and awareness of other resources

The Arroyo Grande campus serves 100 box lunches a month through the local Catholic Church; provides the Salvation Army four weekly milk deliveries for those homeless using their facility and serves monthly meals to homeless adults in a local park.
Lucia Mar Unified School District and the 5 Cities Homeless Coalition identified more than 1400 "homeless" children in the LMUSD in need of services and education. Connected with Cuesta College's Mimi Feliciano-Hix, Economic Development Community Programs Supervisor to investigate feasibility of connect homeless the one hundred and fifty 18-24 year olds to program certifications or

acquiring GED. The Lucia Mar Unified School District is committed to providing an Independent Study Classroom for teen pregnant moms; the Arroyo Grande campus supported these efforts through a donation to the program.

Marian Regional Medical Center donated funding for "Free for the Weekend"; this valley-wide event gathers 7th and 8th graders from the Santa Maria Valley and allowed them to interact in a safe and secure environment.

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

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

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

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Summary Of Financial Assistance Programs

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

Free Care

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

Discounted Care

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

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

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

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

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

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

Arroyo Grande Community Hospital 345 South Halcyon Road, Arroyo Grande, CA 93420
Financial Counseling 805-489-4261 ext 4411 | **Patient Financial Services** 888-488-7667
www.dignityhealth.org/arroyo-grande/paymenthelp

French Hospital Medical Center 1911 Johnson Ave, San Luis Obispo, CA 93401 | **Financial Counseling** 805-542-6321
Patient Financial Services 888-488-7667 | www.dignityhealth.org/frenchhospital/paymenthelp

Marian Regional Medical Center 1400 East Church St, Santa Maria, CA 93454 | **Financial Counseling** 805-739-3541
Patient Financial Services 888-488-7667 | www.dignityhealth.org/marianregional/paymenthelp

St. John's Pleasant Valley Hospital 2309 Antonio Ave, Camarillo, CA 93010 | **Financial Counseling** 805-389-5616
Patient Financial Services 877-877-8345 | www.dignityhealth.org/pleasantvalley/paymenthelp

St. John's Regional Medical Center 1600 North Rose Ave, Oxnard, CA 93030 | **Financial Counseling** 805-988-7109
Patient Financial Services 877-877-8345 | www.dignityhealth.org/stjohnsregional/paymenthelp

Central Coast_CA2016

Dignity Health.