Marian Regional Medical Center

Community Benefit 2020 Report and 2021 Plan

Adopted October 2020

Dignity Health
Marian Regional Medical Center

A message from

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

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs 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 shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2020 Report and 2021 Plan describes much of this work. This report meets requirements in California state law (*Senate Bill 697*) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health 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 2020 (FY2020), Marian Regional Medical Center provided $27,417,819 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $62,569,634, in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its October 14, 2020 meeting.

Thank you for taking the time to review our report and plan. We welcome any que ns or ideas for collaborating that you may have by reaching to out to Patty Herr S, at 805 39- 5 3.

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President and CEO
Marian Regional Medical Center

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At-a-Glance Summary

Community Served	Marian Regional Medical Center which includes Arroyo Grande Community Hospital serves the communities of the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434), Nipomo (93444), Arroyo Grande (93420), Grover Beach (93433), Oceano (93445), and Pismo Beach (93449).
Economic Value of Community Benefit	$27,417,819 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $ 62,569,634 in unreimbursed costs of caring for patients covered by Medicare
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Educational attainment for adults in the community; • Access to primary health care, including behavioral health; • Aging, more mature population; and, • Chronic disease prevention and management
FY20 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; Care Transitions for discharged patients with heart disease, pneumonia, and chronic obstructive pulmonary disease; Chronic Disease Self-Management workshops; Diabetes Prevention and Management and Diabetes Education Empowerment Program (DEEP). A total of $ 271,892 was awarded in the Dignity Health Community Grants program to Accountable Care Communities that address Access to Healthcare including Behavioral Health and Homelessness/Housing
FY21 Planned Programs and Services	For FY21, the hospital plans to increase the number of chronic disease and diabetes self-management workshops offered, increase cancer awareness on the importance of early detection for colon and cervical cancer, and continue the Spanish speaking support groups for women who have been diagnosed with perinatal mood and anxiety disorder and individuals with diabetes. Establish a chronic disease self-management program support group and implement Faith Community Nursing/Health Ministry program digest to help identify and serve the needs of the more mature population in our community.

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 and Education Office at 1400 E. Church Street, Santa Maria, CA 93454 or by email to CHNA-CCSAN@DignityHealth.org.

Our Hospital and the Community Served

About Marian Regional Medical Center

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

Marian Regional Medical Center (MRMC) is located at 1400 East Church Street in Santa Maria, California, and is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Between 1940 and present day, MRMC has transformed into a state-of-the-art, 191-bed facility, that is well positioned to serve a continuously growing patient population. MRMC is designated a STEMI Receiving Center in Santa Barbara County, and is designated a Level III Trauma Center by Santa Barbara County's Emergency Medical Services Agency. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. Our cancer care program is accredited as a Comprehensive Community Cancer Center by the American College of Surgeons' Commission on Cancer, and is one of only three programs between Los Angeles and San Francisco to receive an Outstanding Achievement Award. This year MRMC has completed Phase I of their Emergency Department expansion which no includes a total of 42 exam rooms. The campus houses a comprehensive perinatology/ neonatology program, providing specialized care to the tiniest of patients.

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

Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

Marian Regional Medical Center which includes Arroyo Grande Community Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of our mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.

A plain language summary of the policy is at the end of this report. The financial assistance policy and plain language summary are on the hospital's web site.

Description of the Community Served

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

Marian Regional Medical Center

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

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

Arroyo Grande Community Hospital
The AGCH serves the community of the "Five Cities" area which includes the neighboring cities of Arroyo Grande, Grover Beach, Nipomo, Oceano, and Pismo Beach. Demographics of the AGCH service area indicate 66% of the residents are non-Hispanic white and an estimated 26% are Hispanic or Latino (a). The AGCH service area has a high school graduation rate of 89.3% for those aged 25 and older. Approximately, one in five residents (21.1%) are 65 years and older. The community MRMC-AG serves is host to a reported 359 homeless individuals.

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

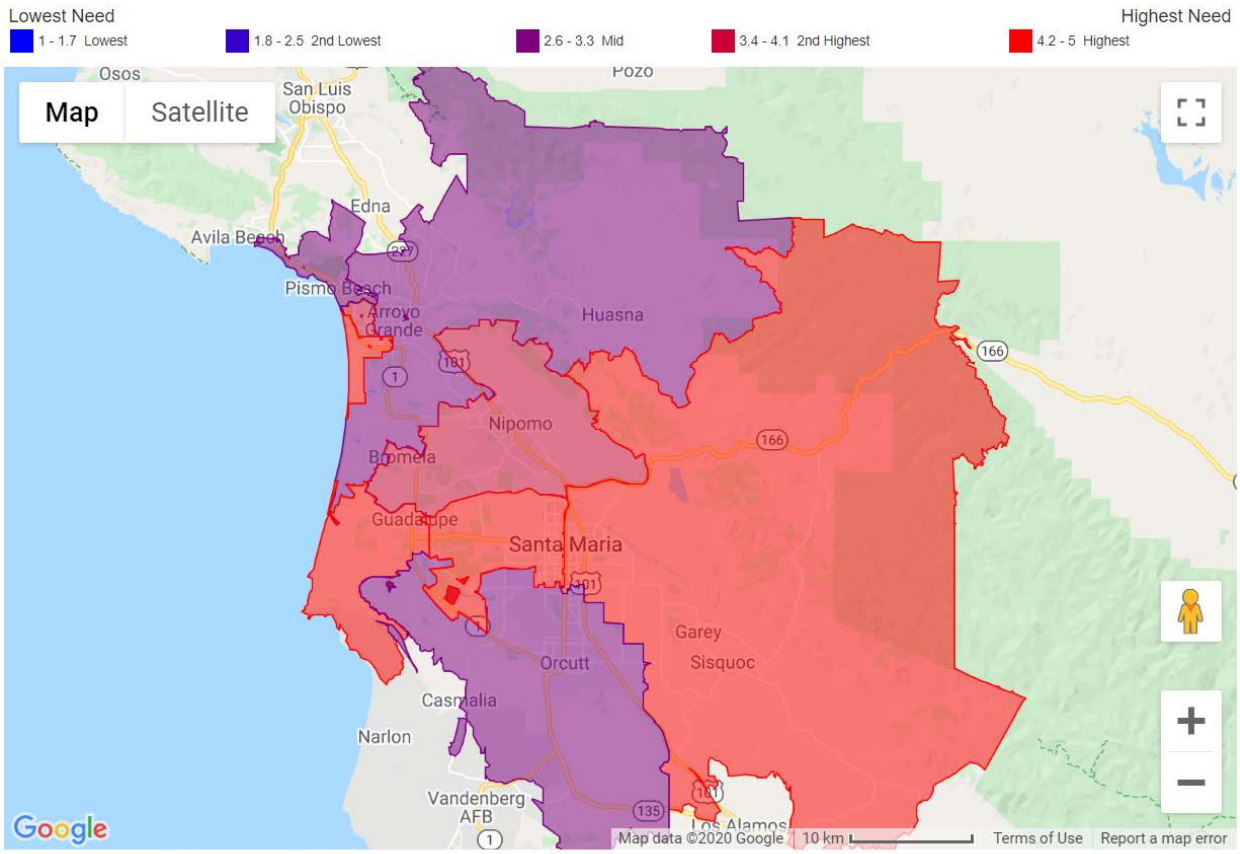
Demographic information for the MRMC which includes AGCH was taken from Claritas Pop-Facts 2020; SG2 Market Demographic Module provides data on the following:

- **Total Population:** 235,641
- **Race:**
  - 38.5% White
  - 1.1% Black/African American,
  - 53.2% Hispanic or Latino
  - 4.6% Asian/Pacific Islander
  - 2.6% All Others
- **% Below Poverty** 8.6%
- **Unemployment:** 4.9%
- **No HS Diploma:** 23.3%
- **Medicaid (household):** 7.2%
- **Uninsured (household):** 4.6 %

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 3.7 / Mean(person): 3.7 CNI Score Median: 3.8 CNI Score Mode: 2.8,3.8,4.2

Zip Code	CNI Score	Population	City	County	State
93420	2.8	30100	Arroyo Grande	San Luis Obispo	California
93433	3.8	13387	Grover Beach	San Luis Obispo	California
93434	4.2	7679	Guadalupe	Santa Barbara	California
93444	3.8	21834	Nipomo	San Luis Obispo	California
93445	4.4	7170	Oceano	San Luis Obispo	California
93449	2.8	8013	Pismo Beach	San Luis Obispo	California
93454	4.2	40399	Santa Maria	Santa Barbara	California
93455	3	44988	Santa Maria	Santa Barbara	California
93458	4.4	62071	Santa Maria	Santa Barbara	California

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

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

The CHNA contains several key elements, including:

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

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/central-coast/locations/marianregional/about-us/community-benefits or upon request at the hospital's Community Health office.

Significant Health Needs

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

- Low adult educational attainment. Santa Maria City zip code 93458 is home to over 56,000 people, where one out of every two adults over the age of 25 have not completed high school. According to the U.S. Census, the rate of high school educational attainment in Santa Maria ranks 4th lowest compared to 608 other cities' in the United States. Educational attainment is one of the five social determinants of health, and low educational attainment levels are linked with poor health, more stress, higher poverty, and lower self-efficacy.
- Improve access to primary health care, including behavioral health for the low-income migrant farmworker population in Santa Maria, CA, and Guadalupe, CA. Individuals with limited resources have the most difficulty accessing health care, including the homeless adults and school-aged children within MRMC's primary service area.
- The underserved needs of the aging, more mature population residing in MRMC's primary service area. The greatest population of mature adults resides the furthest from MRMC facilities. Arroyo Grande has been identified as a medically underserved community by HRSA, where almost 30% of the population is 62 years and over.
- Chronic disease prevention and management was the fourth identified need within the CHNA Report. Cancer and heart disease are the leading causes of death at local, state, and national levels. Multiple findings on residents' health indices found over 50% of the community members surveyed never had their cholesterol checked. Diabetes rates in the MRMC primary service area were found to be over 7% points higher than state and national levels.

Significant Needs the Hospital Does Not Intend to Address

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

2020 Report and 2021 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 FY2020 and planned activities for FY2021, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

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

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

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

Rooted in Dignity Health's mission, vision and values, Marian Regional Medical Center the Community Board and the Community Benefit Committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see page 45). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

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

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

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

MRMC will continue to partner with community-based organizations, community health clinics and other community partners providing services and activities dependent by the current COVID-19 situation such as health fairs, free health screening events, and health education programs to promote, educate, and help bridge the gap between services and the underserved. Continue collaborating with the Santa Barbara County Promotores Coalition and Herencia Indígena will support both MRMC and AGCH to increase awareness and attendance among the Latino/Hispanic and Mixteco community for nutrition, chronic disease management, health screenings, diabetes, cardiovascular disease, and stroke and cancer awareness.

Impact of the Coronavirus Pandemic

As the stay home orders and State started to shut down due to COVID-19 Marian Regional Medical Center and Arroyo Grande Community Hospital acted proactively by engaging staff in activating the Incident Command Center, collaborating with Santa Barbara County Public Health, and accessing the needs of our community partners. A bilingual COVID-19 Information line was establish staffed by the Community Health Department. Financial support, in-kind staff hours, hygiene and quiet kits which consisted of ear plugs, eye masks, and hand sanitizers, and thermometers where donated to various community partners. Bilingual PSAs were developed and aired on the local radio stations and television stations. Dignity Health's Community Health Education Department, Pacific Central Coast Health Centers, Community Health Centers of the Central Coast, Santa Barbara County Foodbank, and the Promotoras Collaborative of Santa Barbara County join in a collaborative effort to educate those most impacted by COVID-19 in the community. The collaborative effort included providing emergency food, coronavirus prevention education and prevention kits to 800 households reaching over 1200 individuals. The prevention education included coronavirus transmission, mask use, no sharing of personal items, cleaning and disinfecting during pandemic, and the correct use of household cleaning products. These collaborative efforts were implemented in neighborhoods which were considered "hot spots" for COVID-19 in the city of Santa Maria.

Report and Plan by Health Need

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

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

Health Need: Educational Attainment

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is encourage higher education, adult literacy and medical literacy.	☒	☒
Bilingual Support Groups	• Free Cancer, diabetes, and grief support groups offered.	☒	☒
Spanish & Mixteco Interpreters	• Providing bilingual bicultural interpreter services to hospital departments for non-English speaking patients.	☒	☒

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

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

Health Need: Access to Primary Health Care including Behavioral Health

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, medical prescriptions, and behavioral health care.	☒	☒

Bilingual Support groups	• Free cancer, diabetes, and grief support groups offered.	☒	☒
Transitional Care Management Program	• Provide smooth transitions for discharged patients by providing follow up calls and follow up appointments to primary medical homes and other services.	☒	☐
Financial assistance programs	• Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.	☒	☒
Street Medicine Program	• Offering very basic health and needs assessments to unsheltered individuals	☐	☒

Impact: Increase access to free and low cost medical care and 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.

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

Health Need: Aging ,more mature Population

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal improve the health of the aging population by providing access to health care, medical prescriptions, and behavioral health care.	☒	☒
Transitional Care Management Program	• Provide smooth transitions for discharged patients by providing follow up calls, visits, and follow up appointments to primary medical homes and other services.	☒	☐
Financial assistance programs	• Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.	☒	☒
Dignity Health Wellness programs	• Free evidence based self-management disease workshops.	☒	☒

Faith Community Nurse program	• Free program which approaches care as a "whole person" to address the spiritual, physical, mental and social health of the person in their faith community.	☒	☒

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

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

Health Need: Chronic Disease and Management

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Wellness programs	• Free evidence based self-management disease workshops.	☒	☒
Transitional Care Management Program	• Provide smooth transitions for discharged patients by providing follow up calls, visits, and follow up appointments to primary medical homes and other services.	☒	☐
Free Cancer Screening clinics	• Cancer Care program offers free cancer screening for colon, lung, and breast to those who are uninsured or underinsured.	☒	☒
Faith Community Nurse program	• Free program which approaches care as a "whole person" to address the spiritual, physical, mental and social health of the person in their faith community.	☐	☒

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

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

Community Grants Program

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

In FY20, the hospital awarded the grants below totaling $ 271,892. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Family Service Agency	Senior and Caregiver Support	$80,000
Future Leaders of America, Inc	A-G for All!	$90,948
Los Osos Cares Inc.	Basic Needs and Resource Navigation for the Estero Bay Community	$49,946
SLO Noor Foundation	Dental Care Access and Service Expansion for Uninsured and Underinsured Adults	$50,998

Program Digests

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

Cancer Prevention and Screening Program	
Significant Health Needs Addressed	❑ Education Attainment ❑ Access to Primary Health Care including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	Marian Cancer Care Program at both Arroyo Grande and Santa Maria campuses addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurse, social worker, certified cancer exercise trainer and registered dietician.
Community Benefit Category	A1a, d, e – Community Health Improvement Services; A1e-Health Care Support Services; A2d Community Based Clinical Services; E3d-Financial and In-Kind Donations
FY 2020 Report	
Program Goal / Anticipated Impact	The goal of the Marian Cancer program at both Arroyo Grande and Santa Maria campuses is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase in participation of rehabilitation and psychosocial support services as well as cancer awareness and prevention activities, including screenings and genetic counseling.
Measurable Objective(s) with Indicator(s)	1. Increase the number by 5% of target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services. 2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving screening services: Colonoscopy-5% (130); Prostate-10% (34); Skin-10% (31); Lung-5% (1016); Genetic Counseling-5% (185) 3. Track and describe the under/uninsured population requesting financial assistance for cancer care needs. Track the number of medically underserved patients transported for cancer care. 4. Increase by 10% (257) monthly nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). Ensure at least 40% of returning education participants identify at least one healthy behavior from nutrition classes they have adopted into their lifestyle over the past month. 5. Ensure at least 50 under/uninsured women identified as having missed an annual breast screening, return for a mammogram service. 6. Increase the number of new patients from target population (under/uninsured, medically underserved Latinos and seniors), enrolled

	in the Cancer Rehabilitation Program by 5% (140). Ensure at least 80% of patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion. 7. Improve awareness among community youth about cancer prevention and screening for skin, lung and cervical cancers. Ensure 70% of youth reached are aware of risky behaviors link to cancer. 8. Educate 20 local cosmetology and hair salon professionals on skin cancer screening and referral system.
Intervention Actions for Achieving Goal	1. Maximize the use of both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to available psychosocial support services. 2. Provide cancer prevention and screening information through counseling and support services, outreach events, social media platforms, radio and print material. 3. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance. 4. 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. 5. Coordinate with Marian Residency Program and Radiology Department to develop a breast cancer outreach strategy that removes identified barriers and provides access for under/uninsured women who have not returned for annual mammogram screenings. 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. 7. Offer 1 educational forum for local youth with an expert panel and develop and distribute targeted materials in both English and Spanish at local clinics and youth events. 8. Provide at least 2 tailored educational events on skin cancer screening tools and referral processes for local cosmetology or hair salon professionals.
Collaboration	Community Health Centers of the Central Coast, SLO Noor Free Clinic, Planned Parenthood (Santa Barbara, Ventura San Luis Obispo County), Community Action Partnership of San Luis Obispo County, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, Wisdom Center, Community Partners in Caring, local Latino barber shops and beauty parlors, local Latino markets and laundry mats, Employment Development Department (EDD) Santa Maria, *El Show de La Revista OKEY* Magazine, *La Buena* Radio, local ranches/ wineries, California Farm Labor Contractors, St John's Newman Church, St Joseph's Church, St Mary's Church, Sunny Country

	Radio, Every Woman Counts (EWC) program, Jack Helping Hand, Alan Hancock Community College, Lucia Mar Unified School District, Bonipak Produce and New Tech High School.
Performance / Impact	1. 1,774 medically underserved patients have been screened and referred to social support services this fiscal year (23% increase from FY19): 97 received free counseling services with follow up assessments and 1,667 were connected to other psychosocial supportive services, including financial support, exercise rehab, nutritional counseling, nurse navigator support and spiritual guidance. 2. Patients assisted with screening services this fiscal year: 100 (SM:89/FC:11) colorectal screenings (23% decrease from FY19 March 28th screening cancelled due to COVID-19, 5 new cancer cases have been identified through screening this fiscal year); 64 (SM:43/FC:21) prostate screenings (88% increase from FY19, due to additional screening done in Five Cities). 119 (SM:62/FC:57) skin screenings; 1,144 (SM:761/FC:383) lung screenings (13% increase from FY19) and 87 (SM:57/FC:30) genetic counseling sessions (53% decrease from FY19) 83 were assisted financially. 3. 262 under/uninsured patients have been provided financial assistance for cancer care needs: (69%) female; (45%) Hispanic; (40%) unemployed; (26%) laborers; (54%) under 60 years of age; and (19%) supporting 2 or more children. Additionally, 3,270 medically underserved patients have been transported for cancer care and another 532 (SM: 370/FC: 162) patients were supported with financial assistance for transportation needs, totaling $30,700 (SM: $21,350/ FC:$9,350). 4. 1,328 (SM:1,222/FC:106) medically underserved patients were supported through the nutrition counseling program this fiscal year (95% increase from FY19). 5. Management was coordinating with the new Radiology Team, PHC and Family Residency Program to offer a free mammography screening event in the third quarter, but this did not occur due to COVID-19. 6. 87 new patients enrolled in the Cancer Rehabilitation Program this fiscal year (38% decrease from FY19 due to classes being cancelled due to COVID-19). 72% of patients contacted four weeks following their cancer rehabilitation program completion reported the use of continued exercise. 7. Mission Hope collaborated with SLOCOE and TUPE to supplement their awareness campaigns around the dangers of vaping and lung cancer prevention. The MHCC logo was added to SLOCOE's flyer and local Pulmonologist Dr. Reagle's article on vaping-related lung diseases was distributed at an event at Nipomo High School on vaping concerns. Mission Hope's outreach team provided the flyers to all local junior high and high school officials. A second vaping outreach event in April was cancelled due to COVID-19. 8. Cosmetology and Beauty professional outreach education was held with an event “Skin Cancer Mindfulness” by Dr. Johanna Moore in January, with 22 patients attending.

Hospital's Contribution / Program Expense	Program Expense: $1,482,596
FY 2021 Plan	
Program Goal / Anticipated Impact	The goal of the Marian Cancer program at both Arroyo Grande and Santa Maria campuses is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase in participation of rehabilitation and psychosocial support services as well as cancer awareness, prevention activities, screenings and genetic counseling.
Measurable Objective(s) with Indicator(s)	1. Increase the number by 5% of target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services. 2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving cancer prevention and screening services: Colonoscopy-5% (100); Prostate-5% (64); Skin-5% (119); Lung-5% (1,144); Smoking Cessation-5% (150); Survivorship Care Plans-5% (95); Emmi services-5% (350); 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track number of patients needing financial assistance to participate: Genetic Counseling-5% (83) 4. Track and describe the under/uninsured population requesting financial assistance for cancer care needs. Track the number of medically underserved patients transported for cancer care. 5. Increase by 5% (1,328) monthly nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). Ensure at least 35% of returning education participants identify at least one healthy behavior from nutrition classes they have adopted into their lifestyle over the past month. 6. Increase the number of new patients from target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 5% (87). Ensure at least 50% of patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion.
Intervention Actions for Achieving Goal	1. Maximize the use of both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to available psychosocial support services. 2. Provide cancer prevention and screening information through counseling and support services, outreach events, social media platforms, radio and print material. 3. Provide the necessary financial support for genetic counseling to medically underserved patients in need of assistance. 4. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance.

	5. Continue to utilize the support of the lay patient navigator and dietitian to educate participants in medically underserved communities on healthy behaviors that can assist in cancer prevention, mitigating cancer symptoms and decrease the incidence of chronic illness. Encourage target population patients to seek further support through one-on-one nutrition counseling. 6. Identify medically eligible patients to enroll in the Cancer Rehabilitation Program; conduct a 4 week post program, telephonic follow-up to track how many patients continue to utilize the exercise activities and knowledge gained, thereby lowering the risk of recurrence.
Planned Collaboration	Community Health Centers of the Central Coast, SLO Noor Free Clinic, Community Action Partnership of San Luis Obispo County, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, Wisdom Center, Community Partners in Caring, local Latino barber shops and beauty parlors, local Latino markets and laundry mats, Employment Development Department (EDD) Santa Maria, *El Show de La Revista OKEY* Magazine, *La Buena* Radio, local ranches/ wineries, California Farm Labor Contractors, St John's Newman Church, St Joseph's Church, St Mary's Church, Sunny Country Radio, Every Woman Counts (EWC) program, Jack Helping Hand, Alan Hancock Community College, Lucia Mar Unified School District, Bonipak Produce and New Tech High School.

Cardiovascular Disease and Stroke Program	
Significant Health Needs Addressed	❑ Education Attainment ☒ Access to Primary Health Care including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	Cardiovascular disease/stroke is one of the leading causes of death in the north Santa Barbara and San Luis Obispo County. As the leading cardiac hospital in SLO County FHMC strongly emphasizes early dictation and prevention. Through a risk assessments and education program of cardiovascular and stroke it can enable community members to take control of their health and encourage follow-up and treatment of risk factors by their health care provider.
Community Benefit Category	A1a – Community Health Education; A2d- Community Based Clinical Services; A1d – Community Health Education: Support Group
FY 2020 Report	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase cardio/stroke screening by 5% (682) at target population health fair events. 2. 80% of the participants deemed at-risk and identified with no primary care provider, and/or become aware for the first time they have an elevated blood pressure reading will self-report at 3 months appropriate lifestyle changes 3. Increase number of participants in the Healthier Living (8) and the Diabetes Empowerment Education program (DEEP-35) by 5% 4. Provide 4 FAST Friday events for target populations (Spanish and elderly) 5. Present Explaining Stroke 101 class in Spanish twice and to an elderly population two times.
Intervention Actions for Achieving Goal	1. All screened participants will be referred to all Dignity Health Wellness Programs. 2. At-risk individuals will be provided appropriate education, referrals, and follow-up and will be placed on a 3 month follow up call list. 3. At –risk individuals will self-report lifestyle modification at their 3 month follow up call. 4. Maximize usage of current referral pipelines to increase enrollment in the Healthier Living and DEEP workshops.
Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education. Local partner invitations for health fair events.

Performance / Impact	1. A total of 541 cardio/stroke risk assessments were done at 10 health fair events. The goal of increasing to 5% was not reached due to the sudden halt of health fairs due to COVID-19. 2. A total of 78 individuals were screened and deem at risk through our cardiac/stroke risk assessment. 3. Less than 1 % of those deemed high risk also indicted not having a medical home. Over 97% of the immediate follow up recommendation was re-taking their blood pressure and making a follow up appointment with their primary provider. At 3 month follow up 93% self-reported that they had retaken their blood pressure medication and were complying with their primary providers' orders. 4. A total of 17 participants attended the Healthier Living workshop indicating a 7% increase in attendance. A total of 33particpants attended the DEEP workshop which did not see an increase of 5% this has due to the sudden halt of workshops due to COVID-19, 5. Two FAST Fridays were completed. 6. Two Spanish Stroke 101 presentations were completed.
Hospital's Contribution / Program Expense	Program Expense: $78,567
FY 2021 Plan	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention education, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase attendance in our Healthy for Life (HFL) Nutrition Class and Diabetes Education Empowerment Program (DEEP) by 5%. 2. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 risk factors for cardiovascular disease and stroke. 3. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 ways to reduce their risk of cardiovascular disease and stroke. 4. Forty percent of the participants attending our DEEP workshops will self-report taking their blood pressure during the course of the 6 week workshop.
Intervention Actions for Achieving Goal	1. Promote our ZOOM HFL and DEEP workshops on social media, hospital website, and other printed media outlets. 2. Recruit participants using Octavia. 3. Ask participants the 4 post workshop questions on cardiovascular disease and stroke at the 3rd session for HFL and at the post survey phone call for DEEP participants. 4. Track responses of the post workshop questions on cardiovascular disease and stroke on spreadsheet after each workshop. 5. Ask DEEP participants to take their blood pressure and weight on the 1st, 3rd, and 6th session and record in their body measurement form in their manual. 6. Instructors will track the blood pressure reading and weights on a spreadsheet of each participant that self-reports to them.

Planned Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, Community Partners, and Pacific Health Centers of the Central Coast.

Care Transitions Program	
Significant Health Needs Addressed	❑ Education Attainment ❑ Access to Primary Health Care including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	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
Program Goal / Anticipated Impact	Decrease hospital readmissions and decrease unnecessary emergency department use for all participants with all high risk and complex patients discharged from the hospital – to include diagnosis of COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure enrolled in the program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage
Measurable Objective(s) with Indicator(s)	1. 95% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis. 2. 95% of participants enrolled in the program will self-report that they keep follow-up appointments with their physician(s) on an ongoing basis. . 3. Readmission rate for CHF and COPD patients enrolled in Care Transitions (CT) will be at 6% or less on a quarterly basis. 4. Emergency Room use of patients on CT will be tracked quarterly to identify the % of patients using ER on a monthly basis, reported quarterly. 5. Utilizing available communication tools (Octavia) send at least 45% of patients SCREENED OUT/ DISPOSITIONED and 50% of appropriate mobile patients enrolled in Care Transition to Community Benefit Education Department for enrollment in CDSMP workshop. 6. Those referred to the Community Benefits department 5% will register for one or more of the programs offered and 70% will complete the workshop
Intervention Actions for Achieving Goal	1. Patients referred to Care Transitions (CT) from hospital discharge, and who are referred by the Discharge Call RN, or identified as appropriate for Care Transition, will be called to enroll into the

	program, nurse will identify any problems or symptoms they may have and intervene with education and medication reconciliation. 2. CT will utilize Medical Social Worker support by phone or home visit to assist with patient barriers to success with their plan of care. 3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their meds. 4. Identify patients who are having difficulty with physician follow up and assist in locating MD and getting appointments. 5. Provide information to patients and their caregivers on home safety, Family Caregiver Program, community based palliative care program, medication and disease information specific to their needs and identify those needing support. 6. A quarterly statistical summary will be conducted to identify Emergency Room (ER) use for patients with COPD, CHF and all cause readmissions to tract ER use/readmission rate. 7. For those patients who are discharged, the CT RN, will ask about the effectiveness of the program, and if the patient needs have been met. The CT nurse will fill out a telephonic survey form and turn in for statistical analysis. Included will be any comments made.
Collaboration	Will work with Discharge Call RN, Care Coordinators at the Dignity Health Hospitals; Home Health, Hospice, Cardiac Rehab; Family Caregiver Program; Octavia program; CCN dept; QI dept; ER, hospitalists and MSW staff. As well as the Readmission Committees.
Performance / Impact	**MRMC** - For the FY 2020 MRMC was under goal for patient self-reporting of medication compliance and just under for follow up with their MD. Med compliance for FY = 89% and MD follow up =91%. (Goals were 95% for both). For Readmission rate for CHF, the FY CHF = 15.7% and for COPD = 4.73%. For the FY, MRMC was over for CHF and under for COPD readmission rates. We were unable to track the ER usage as initially identified in the Digest. For all the patients who were followed by the Care Transition RN, 58.6% graduated with goals met or partially met; 12.2% were referred to Community Education department and 2.2% were referred to the community based palliative care program. All patients who were followed by the Care Transition team were connected with available resources and services that they were either available to and/or those the patient/caregiver accepted. Of the patients followed, 76.1% had a chronic illness (CHF, COPD, DM); 37.9% had a diagnosis of Diabetes or an elevated A1C; **AGCH** – for the FY 2020 AGCH was just under the goal for patient self-reporting of medication compliance and over the goal for Follow up with PCP. Med compliance for FY = 91% and MD follow up = 97%. (Goal is 95% for both metrics). For readmission rates for CHF the FY readmission rate = 5.38% and for COPD = 6.27%. Goals for both = 6% or less. COPD just over goal. We were unable to track the ER usage as initially identified in the Digest. For all the patients who were followed by the Care Transition RN, 58.3& graduated with goals met or partially

	met; 25.8% were referred to Community education and 1.7% were referred to the community based palliative care program. Ot the patients who were on the Care Transition Program 72% had a chronic illness (CHF, COPD, DM) and 29.3% had a diagnosis of Diabetes or an elevated A1C. For both MRMC and AGCH, the patient satisfaction was only calculated in the 3rd quarter, due to a variety of reasons, and all 3 programs were combined. The statistics show that 100% would recommend the program; 74.*% felt the program was excellent/very good; 83.3% felt the program information on illness was excellent/very good; 87.5% found information on managing illness excellent/very good; 74% found written materials excellent/very good and 87.3% evaluation of services excellent/very good. 79% found needs met excellent/very good.
Hospital's Contribution / Program Expense	Program Expense $505,722
FY 2021 Plan	
Program Goal / Anticipated Impact	Program will be merging into the Transitional Care Center which focuses on Population Health.
Measurable Objective(s) with Indicator(s)	
Intervention Actions for Achieving Goal	
Planned Collaboration	

Diabetes Prevention and Self-Management Program	
Significant Health Needs Addressed	❑ Education Attainment ☒ Access to Primary Health Care including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	Provide a comprehensive evidence-based diabetes management program for the ADA recognized program providing education with registered dietitian and nurse specializing in diabetes management. The program will improve behavior and self-management practices of diabetic patients; enhance and improve the access and delivery of effective preventive health care services
Community Benefit Category	A1-c Community Health Improvement Services
FY 2020 Report	
Program Goal / Anticipated Impact	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
Measurable Objective(s) with Indicator(s)	1. Improve community awareness of Diabetes Education available. 2. Increase pre-diabetes education visits offered thru Diabetes Empowerment Education Program classes, diabetes support groups and, physician referrals by 3% in 2020 Fiscal Year. 3. Increase Diabetes Support group attendance by 2.5%. 4. Increase diabetes education visits offered thru diabetes support groups and, physician referrals and, recent hospitalizations by 3% in 2020 Fiscal Year. 5. Individuals with uncontrolled diabetes that are at high risk of complications will be contacted via telephonic services and services offered and/or telephonic support will be provided.
Intervention Actions for Achieving Goal	1. Participate in 4 Community Health events for seniors/underserved populations. Providing diabetes education, prevention information and programs available through center. 2. Identify pre-diabetes population in need of individual education and counseling as well as classes available on management of diabetes available from Diabetes Empowerment Education Program classes, community outreach, diabetes support groups and, physician referrals Octavia and, recent hospitalizations. 3. Invite and educate community about English and Spanish Diabetes Support groups available at community events, physician offices / clinics, and lab clinics.

	4. Identify diabetes individuals in need of individual nutritional and/or diabetes nursing education from Diabetes Empowerment Education Program classes, community outreach, diabetes support groups, physician referrals and, recent hospitalizations. 5. Assess progress of individuals at high risk for complications by follow-up phone calls that are identified via recent hospitalizations or, recent
Collaboration	MRMC /AG CT teams, Discharge Call RN. Dignity Health Comm. Benefit team, Pharmacy, Alliance of Pharmaceutical Access, CenCal, Medicare, Dignity Health Medical Group, Dignity Health Nutrition Services, Dignity Health Business Services, Dignity Health Marketing, Physician offices (all Central Coast) , Dignity Health clinics, CHCCC, underserved / uninsured/ underinsured / seniors in the community at high risk for chronic disease.
Performance / Impact	1. Community Education presentations fell below desired outcome of 4. 2 were held in the 2nd Quarter. This was due to lack of Diabetes staff for part of the FY and then COVID impacted starting Quarter 3 and 4. 2. Total of 33 Pre-Diabetics were identified in need of individual education and counseling and classes to help manage their diabetes. This is an average of 8.2/quarter. 3. English Support Groups were well attended, with an average of 28 participants. This excluded 2 months in Q2 and then the 4th quarter due to COVID. 4. For Q 1-3, there were an average of 59 patients who were provided Diabetes education and counseling through Community Benefit, for an average of 19.6 pts/quarter. In Q 4 there were 182 patients all through Community Benefit. For the FY then, a total of 241 patients benefitted from diabetes education and counseling through Community Benefits. – All patients are now provided this education through Community Benefit due to COVID and all visits / counseling on telephone by RN and RD.
Hospital's Contribution / Program Expense	Program expense: $233,114
FY 2021 Plan	
Program Goal / Anticipated Impact	The program goals include improved self-management practices and lifestyle changes for patients with diabetes. The program also works to enhance and improve access to care and delivery of effective clinical services.
Measurable Objective(s) with Indicator(s)	1. Improve community awareness by participating in one target area each quarter. Provide Diabetes Education currently via phone and/or ZOOM due to COVID. 2. Increase pre-diabetes education visits with telephonic visits, by 3% in quarters 2, 3, and 4.

	3. Develop a Diabetes Support Group to be provided by telephone and/or by ZOOM for each quarter. 4. Develop a Diabetes Self-Management Education and Support (DSMES) (4 series) classes and provide these through ZOOM, each quarter. 5. Individuals with uncontrolled diabetes that are at high risk of complications, will be contacted via telephone and education services will be offered/provided. Increase the calls by 5 % for each quarter.
Intervention Actions for Achieving Goal	1. Provide diabetes education information through phone or ZOOM to referral sources such as the Transitional Care Center, Dignity Health Clinics, other PCP's, Community Health Centers, Hospital Care Coordinators, and Labs. 2. Identify pre-diabetes population in need of individual education and counseling, via ZOOM. DEEP classes via community outreach, diabetes support groups, pcp referrals, recent hospitalizations per Octavia, Hospital Care Coordinators, TCC care workers, and pharmacy. 3. Invite and educate community about English and Spanish Diabetes Support groups available via hospital staff and identified community locations such as, pcp offices, clinics, and labs. 4. Offer option of ZOOM, DSMES classes to current individualized authorizations and referrals for ADA recognized program for MNT and DSMES. Also, encourage referrals from Diabetes Empowerment Education Program ZOOM classes, community outreach, diabetes support groups, pcp referrals and, recent hospitalizations per Octavia, Hospital Care Coordinators, TCCstaff, pharmacy and nutrition services. 5. Access progress of individuals at high risk for complications by follow-up phone calls that are identified via recent hospitalizations or, recent ED visits
Planned Collaboration	MRMC /AG CT teams, discharge call RN, Dignity Health Clinics, Community Benefit team, Pharmacy, Alliance of Pharmaceutical Access, CenCal, Medicare, Nutrition Services, Dignity Health Marketing, Physician offices, CHCCC, and CAC. An increased focus with seniors who are underserved, uninsured, underinsured who are at high risk for chronic disease.

Dignity Health Community Grants Program	
Significant Health Needs Addressed	☒ Education Attainment ☒ Access to Primary Health Care including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospitals health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.
Community Benefit Category	E2-Cash and In-Kind Contributions
FY 2020 Report	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address Access to Behavioral Health and Educational Attainment.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year. 2. Build richer ACCs that are focused on multiple significant health needs. 3.100% of funded ACCs will update local community benefit committees on their project. 4.100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained
Intervention Actions for Achieving Goal	1. Community Education Coordinator will work closely with agencies to form a more succinct "Accountable Care Community" (ACC) for services the hospital is unable to address itself. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACCs will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Collaboration	Santa Maria and Orcutt School Districts, Transitions Mental Health Association, and other community organizations addressing the community health needs.
Performance / Impact	1. Community Health Manager worked closely with local community agencies in forming Accountable Care Communities that would meet the needs of the hospitals prioritized health needs. 2. Both ACC were scheduled to present at the quarterly Community Benefit meetings to give updates on their projects.

	3. Community Health Manager continues to work with ACC to provide concise descriptive quarterly outcomes for committees review. 4. 100% of funded ACCs have scheduled mid-year meeting to ensure outcomes are accomplished and they continue their work with the local hospital.
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and, $ 271,892 in grant money awarded to the community for the purpose of improving the quality of life of the residents of Santa Barbara County.
FY 2021 Plan	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address with Access to Behavioral Health and Dental Care. Due to the current COVID-19 Pandemic 25% of the funds will be granted to single non for profit organization whose daily operations has been affected by COVID-19.
Measurable Objective(s) with Indicator(s)	1. 100% of funded Coronavirus Pandemic Impact Grants will address an emerging need due to COVID-19 situation. 2. 100% of the funded ACC will schedule at least quarterly meetings to ensure outcomes are attained.
Intervention Actions for Achieving Goal	1. Send an information letter to community partner announcing the criteria to apply for Coronavirus Pandemic Impact Grants. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Planned Collaboration	Santa Maria and Orcutt School Districts, Transitions Mental Health Association, and other community organizations addressing the community health needs.

Faith Community Nursing/Health Ministry Program	
Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, Dental Care including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	The faith community nursing program uses the nursing process to address the spiritual, physical, mental, and social health of the healthcare consumer. With the intentional focus on spiritual health, the Faith Community Nurse primarily uses intervention of education, counseling, prayer, presences, active listening, advocacy, referral, and wide variety of resources available to the faith community.
Community Benefit Category	A1-c Community Health Education
FY 2020 Report	
Program Goal / Anticipated Impact	FY 2020 pilot program was launched.
Measurable Objective(s) with Indicator(s)	
Intervention Actions for Achieving Goal	
Collaboration	
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2021 Plan	
Program Goal / Anticipated Impact	The approach to care is "whole person" and addresses the spiritual, physical, mental and social health of the members and the greater community.
Measurable Objective(s) with Indicator(s)	There is an intentional focus on spiritual health, the FCN/HM will use active listening, consultation, counseling, decision making support, education, emotional and spiritual support, presence and referral. The individual interactions will be collected and recorded in a secure documentation system. Each FCN will have a Collaborative Agreement with the Faith & Health Partnership and make 20 contacts per quarter.
Intervention Actions for Achieving Goal	1. Promote growth of the FCN/Health Ministry Concept in the community, which will enhance the link between hospital and the community.

	• Commission, Hospital Staff/ Chaplains and Spiritual/Church communities 2. Provide Faith Community Nurse (FCN) Course for RNs that are interested in Health Ministry to become FCN in their own congregation/place of worship • Offer 2 FCN courses per year 3. Establish a team of health ministers/health advocates that have a combined knowledge, experience and willingness to serve to implement programs that respond to the unique needs of the congregation and surrounding community. • Each FCN will Survey his/her Church community and provided the identified programs/support for that population. • The Program Coordinator will be available to the team and have quarterly Support meetings. 4. Partner with other Community Benefit participants (i.e. Health and Wellness Programs – Health for Nutrition class, Healthier Living - Your life Take Care, DEEP and Fall Prevention) • Consult with Community Benefit Program Manager Monthly to Coordinate identified programs.
Planned Collaboration	Work with Catholic Health Initiatives on the Mission and Ministry Grant Project. The purpose of the project is to establish quality documentation of the value added by the services provided by Faith Community Nursing and Health Ministers (FCN/HM).

Pacific Central Coast Health Centers Program	
Significant Health Needs Addressed	❑ Education Attainment ☒ Access to Primary Health Care including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	The Pacific Central Coast Health Centers (PHC) ensures access to quality primary health care for the residents of Santa Barbara County and San Luis Obispo County. PHC will address health disparities for all individuals regardless of age and socioeconomic status.
Community Benefit Category	C3-Hospital Outpatient Services
FY 2020 Report	
Program Goal / Anticipated Impact	Increase healthcare access by providing free health screenings and appropriate health care community referrals.
Measurable Objective(s) with Indicator(s)	1. PHC will refer all patients that present with a diagnosis of Diabetes or Obesity with a BMI greater than 28 to the following programs: • CDSMP Self-Management Program • DEEP (Diabetes Empowerment Education Program • Healthy for Life Wellness Program (HLW) 2. Increase Blood Pressure screenings and random glucose testing at all Community Outreach Events that PHC participates. 3. Participate in 10 Community Outreach Events annually. 4. Increase flu shots by 5% for each flu season. 5. Continue to offer sports physicals and health screenings and build on Youth Health Fair for local schools and organizations, such as Special Olympics and Scout Troops. 6. PHC will implement an annual Homeless Outreach event to include our community partners. Health screenings and resource referrals to all participants. 7. PHC will continue to work with Community Partners to collaborate on Mental Health Services and Outreach. 8. Establish and monitor Walk with the Doc Program for success in provider- patient relationships and improved healthy lifestyles within our communities.
Intervention Actions for Achieving Goal	1. Utilize data from Electronic Health Care System (Cerner) to identify poorly controlled diabetic patients to ensure proper referral is made. Explore opportunities within Cerner to capture referrals made to the Community Resources. This information will allow us to partner with Marian Regional Medical Center and other outside non-profits to provide education. 2. Utilize data from Cerner to create a workflow to identify patients with a >BMI of 28 and ensure proper referrals are provided.

	3. Continue partnership with outside non-profit organizations to provide diabetic education workshop. 4. Partner with local community organizations to identify flu vaccine outreach opportunities 5. Identify the opportunities to expand on the sports physicals by collaborating with Community Partners to create a Youth focused Health Fair. 6. Work with Community Partners to establish an Annual Homeless Outreach Event. 7. Work with Community Partners to determine opportunity and resources available for Mental Health and Substance Abuse issues in our community. 8. Collaborate with Physician Leadership to develop a sustainable Walk with the Doc Program.
Collaboration	Dignity Health Community Education Center, Dignity Health Diabetic Center, local School Districts, Special Olympics, Scouts of America, SB County Mental Health Services, SLO Mental Health Services, Community Homeless Shelters, Veterans Administration, Salvation Army and Community Health Clinics
Performance / Impact	1. **YTD 15 Outreach - Total served YTD 612** Marian Community Clinic - Day of the Farm Worker – 12/2/2019 Clinic Consultations **310 with 69 flu shots** • Marian Community Clinic and Food Bank – **5** A1C Outreach events with a total of **45** patients served. Locations were Guadalupe, Santa Maria and Lompoc and Marian Community Clinic • DEEP Program – **1** Health Screenings A1C with a total of **6** at Marian Community Clinic for Arroyo Grande patients • Marian Community Clinic – **7** Flu Outreach with **201** flu shots administered to include Wisdom Center, Texiera Farms, Toyota of SM, Honda, Salvation Army and Guadalupe/Food Bank • Family Medicine – Pismo Open – (**50**) Random Glucose and BP screenings 2. **YTD 201 Flu vaccines** administered - Wisdom Center 21, Toyota of Santa Maria 20, Honda of Santa Maria 23, Texiera Farms 40, Salvation Army 19, Food Bank 9 3. **YTD 568** Provide local schools with a total of 50 free or low cost physicals, health screenings and the newly requested concussion clinic. • Family Medicine Center and Marian Community Clinic have implemented and provided screenings for sports physicals. • Athletes from Special Olympics, SMHS, PVHS, Orcutt Academy and Righetti High School participated in sports health screenings occurring every Thursday during the month of May 2020.

Hospital's Contribution / Program Expense	No expenses were documented due to the ongoing discussion among the system office: Community Health and Finance departments determining the recommended percentage of expense to be claimed as a community benefit expense.
FY 2021 Plan	
Program Goal / Anticipated Impact	Due to the COVID-19 situation this program will be out on hold until further notice.
Measurable Objective(s) with Indicator(s)	
Intervention Actions for Achieving Goal	
Planned Collaboration	

Perinatal Mood and Anxiety Disorder Program	
Significant Health Needs Addressed	❑ Education Attainment ☒ Access to Primary Health Care including Behavioral Health ❑ Aging, More Mature Population ❑ Chronic Disease Prevention and Management, including Cancer
Program Description	This program provides mental health support for families in Santa Barbara county who are impacted by Perinatal Mood and Anxiety Disorder (PMAD) by engaging pediatricians, obstetricians, primary care providers, community-based organizations, and other key stakeholders in maternal health to address the needs of a woman's mental health during and after pregnancy.
Community Benefit Category	A1-a Community Health; A2-d Community-Based Clinical Services
FY 2020 Report	
Program Goal / Anticipated Impact	Reframe postpartum depression as a common part of postpartum recovery to help lessen the stigma associated with getting help. See above
Measurable Objective(s) with Indicator(s)	1. Provide 150 pregnant and postpartum Spanish and Mixteco moms with PMAD education to reduce the stigma of mental health. 2. Increase attendance by 5% in monthly Spanish support groups. 3. Refer 40 mothers to the appropriate community resources.
Intervention Actions for Achieving Goal	1. Using Octavia Spanish and Mixteco postpartum moms will be contacted and invited to participate in Cambio de Vida con un Bebé; our culturally sensitive program name to be more discerning of the stigma attached to depression. 2. Those mothers that have attended Cambio de Vida con un Bebé will be invited to participate in monthly support groups. 3. Provide education to Spanish moms on the use of 211.
Collaboration	Santa Barbara County Public Health Dept; SBC Promotores Coalition; CALM; Behavioral Wellness, PMAD Stakeholders Group
Performance / Impact	
Hospital's Contribution / Program Expense	Program Expense;$23,884
FY 2021 Plan	
Program Goal / Anticipated Impact	To support pregnant and postpartum women and their families by facilitating access to social and behavioral health services
Measurable Objective(s) with Indicator(s)	1. Ten workshops will be held for Spanish and Mixteco -speaking women and their families to increase awareness and understanding of perinatal mood and anxiety disorders.

	2. Increase attendance by 5% in monthly Spanish support groups. 3. Refer 40 Spanish and Mixteco-speaking women and 100 English-speaking women to the appropriate community resources. 4. Provide system navigation for at least ten women per month, helping connect them to behavioral health support and community resources. 5. Help expand the capacity of two provider offices each month to better screen and refer women for mental health support
Intervention Actions for Achieving Goal	1. Using Octavia Spanish and Mixteco speaking postpartum women will be contacted and invited to participate in Cambio de Vida con un Bebé; our culturally sensitive program name to be more discerning of the stigma attached to depression. 2. Those women who have attended Cambio de Vida con un Bebé will be invited to participate in monthly support groups. 3. Offer an English-speaking support group at least once a month by January 31, 2021. 4. Provide education to Spanish women on the use of 211 and the PMAD Community Resource Guide. 5. Connect women to psychiatric care, individual counseling and/or support groups and community resources to help strengthen the family system 6. Provide technical assistance to provider offices and community programs via phone, email, and in-person meetings to help enhance coordination of care for their patients.
Planned Collaboration	Santa Barbara County Public Health Deptartment; SBC Promotores Coalition; CALM; Family Service Agency; Community Action Commission of Santa Barbara; Santa Barbara County Behavioral Wellness; PMAD Stakeholders Group; private therapists; CHC

Other Programs and Non-Quantifiable Benefits

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

- Medically Fragile Respite Care – Patients discharged from MRMC or AGCH- that are homeless need a secure place to stay while recovering from their hospital stay. Good Samaritan Shelter in Santa Maria provides respite beds for these homeless medically fragile patients. The shelter has an in-house clinic that facilitates the patient's limited medical care.

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

- The Marian Family Medicine Residency Program is an Accreditation Council of Graduate Medical Education (ACGME) approved three-year post-graduate primary care training program for Family Medicine physicians. The Marian Family Medicine program has achieved great success in its mission of training and recruiting new primary care physicians to care for the patients of the Central Coast. The Marian Hospital Community Board and the Medical Staff at MRMC has also created a new ACGME approved program in Obstetrics and Gynecology (OB/GYN). This 4 year program started during the 2018-19 academic year and currently has 9 new resident physicians in the first, second, and third years of the program. The OB/GYN program will ultimately have 12 total residents when it reaches its full complement of residents in July of 2021. The Marian OB/GYN program will address the critical need of projected shortages of OB/GYN physicians both in our region and throughout the nation. All of our residents benefit from the privilege of providing care for the patients in our communities, and the supervision, expertise, and teaching from our outstanding medical staff at MRMC. The Marian Family Medicine and OB/GYN programs are proud to be producing the next generation of outstanding physicians for the benefit of our Central Coast communities and our Nation

- The Marian Family Residency and the Community Health Department are in the initial stages of piloting a Street Medicine Program which will offer very basic health and basic needs assessments to unsheltered individuals in the service area of MRMC.

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

- DOVE Self Esteem Dignity Health: MRMC started their DOVE Self Esteem program for girls in August 2016. The program focuses on girls who are between the ages of 8 to 12 years of age. Girls are referred by school counselors and school program coordinators. They identify girls who have difficulties in social interaction with their peers, have been bullied, or are the bullies. The free program is a week-long series

in which the session are 2 hours long. Workshops provide a combination of activities and communication tools that encourage conversation on difficult subjects: body confidence and self-esteem. Sixty- six young women attended the DOVE program before halting the program due to COVID-19.Monthly support groups were implemented as a request by DOVE graduates. The support groups was implemented at one elementary school site with a total of 7 DOVE graduates attending. Plans to implement support groups in other elementary schools were halted due to COVID-19.

- Human Trafficking(Suspected Abuse Task Force) – This initiative was launched in FY 2015 with an emergency response team established and a roll out of the first phase of education and training for hospital clinical staff to increase awareness. Training has been expanded to include other hospital departments. Since the launch the task force has decided to include and address all types of suspected abuse. The task force was able this year to update the Community Resources guide for both Santa Barbara and San Luis Obispo counties. Dr. David O. Duke and other team members including from the system office with lived experience have developed a computer algorithm which can automatically and in real time detect patterns associated with potential abuse (Human Trafficking, Domestic Violence, etc.,) which has been combined with a refined outreach program for consistent trauma-informed navigation for potential victims, which can occur during a visit (*e.g.*, ED or Hospital), and after

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

Economic Value of Community Benefit

10/1/2020
364 Marian Regional Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2019 through 6/30/2020

	Persons	Net Benefit	% of Expenses
Benefits for Poor			
Financial Assistance	**7,869**	**7,295,211**	**1.2%**
Medicaid	**90,327**	**8,858,300**	**1.5%**
MIA	**1**	**76**	**0.0%**
Community Services			
A - Community Health Improvement Services	30,037	4,541,389	0.8%
E - Cash and In-Kind Contributions	3,818	838	0.0%
F - Community Building Activities	0	3,239	0.0%
G - Community Benefit Operations	0	175,557	0.0%
Totals for Community Services	**33,855**	**4,721,023**	**0.8%**
Totals for Poor	**132,052**	**20,874,610**	**3.4%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	3,391	501,255	0.1%
B - Health Professions Education	732	5,735,464	0.9%
D - Research	0	290,171	0.0%
G - Community Benefit Operations	0	16,319	0.0%
Totals for Community Services	**4,123**	**6,543,209**	**1.1%**
Totals for Broader Community	**4,123**	**6,543,209**	**1.1%**
Totals - Community Benefit	**136,175**	**27,417,819**	**4.5%**
Medicare	**106,915**	**62,569,634**	**10.3%**
Totals with Medicare	**243,090**	**89,987,453**	**14.9%**

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.

Hospital Board and Committee Rosters

HOSPITAL COMMUNITY BOARD FISCAL YEAR 2020

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

Carolyn Baldiviez, DDS
Dentist

Debbie Blow, PhD
Superintendent, Orcutt Union School District

Michael Bouquet
Businessman
Business Manager, Toyota of Santa Maria

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

Kevin Ferguson, MD (Secretary)
Physician / Pathologist

Terry Fibich
Retired Fire Chief

Steve Flood, DDS
Dentist

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

Angelica Gutierrez
Finance / Banking Institution Executive
Rabobank America

Tom Martinez
Architect
Martinez & Associates

Jason Diani
Construction Executive /
Chair, Marian Foundation Board

Juan Reynoso, MD
Physician / Emergency Medicine

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

Kevin G. Walthers, PhD (Chair)
College Superintendent / Educator
Allan Hancock College

James Wesner
Agriculture Business Owner

Joseph Will (Vice Chair)
Businessman / Construction Executive
CalPortland

Elaine Yin, MD
Physician / OB-Gyn

Jeff Zambo
Business Owner /
Chair, Arroyo Grande Foundation Board

Hospital Representatives
Mark Allen
Vice President / Chief Operating Officer

Sue Andersen
President & CEO

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

Kenneth R. Dalebout
Administrator, Marian Arroyo Grande

Bill Finley
Vice President / Chief Financial Officer

Hospital Representatives *(Continued)*

Alex Harrison, MD
President of the Medical Staff
Cardiology

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

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

Candice Monge, MSN RN
Division VP / Chief Nursing Officer
Dignity Health CA Central Coast

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

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

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

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

Founding Sisters Representative
Sr. Pat Rayburn, OSF
Dignity Health

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

MARIAN REGIONAL MEDICAL CENTER
COMMUNITY BENEFIT COMMITTEE FY2020

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

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

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

Terry Fibich
Member, Hospital Community Board

Bill Finley
VP / Chief Financial Officer

Katherine Guthrie
Senior Regional Director, Cancer Services

Dr. Melvin Lopez
Family Medicine Physician
Pacific Central Coast Health Centers

Chelsea Leitcher, MDiv, BCC
Chaplain, Spiritual Care Department

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

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

Dora Robles
Manager, Clinical Operations
Pacific Central Coast Health Centers

Tina McEvoy, RN
Care Transitions, Service Area Coordinator

Anne Rigali
Member, Marian Foundation Board of Directors

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

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

Edward Lowe
Senior Regional Director
Homecare & Hospice Services

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

Tim Rohan, RN MSN CEN CFRN
Director, Patient Care Services
Administration

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

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 250% 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 250-350% 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