Marian Regional Medical Center

Community Benefit 2022 Report and 2023 Plan

Adopted November 2022

Dignity Health
Marian Regional Medical Center

A message from

Sue Andersen, President and CEO, and Kevin Ferguson, MD, Chair of the Dignity Health Marian Regional Medical Center and Arroyo Grande Community Hospital Community Board.

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

Marian Regional Medical Center and Arroyo Grande Community Hospital share a commitment with others to improve the health of our community, and deliver programs and services to help achieve that goal. The Community Benefit 2022 Report and 2023 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntarily produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2022 (FY22), Marian Regional Medical Center and Arroyo Grande Community Hospital provided $ 58,493,398 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospitals also incurred $ 21,520,216 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its November 9, 2022 meeting.

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

Sue Andersen
President

Kevin Ferguson, MD
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Marian Regional Medical Center and Arroyo Grande Community Hospital serve the communities of the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434), Nipomo (93444), Arroyo Grande (93420), Grover Beach (93433), Oceano (93445), and Pismo Beach (93449).
Economic Value of Community Benefit	$ 58,493,398 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $ 21,520,216 in unreimbursed costs of caring for patients covered by Medicare
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Educational attainment for adults in the community; • Access to primary health care, including behavioral health and dental health; • Health Promotion and Prevention
FY22 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: Cancer Prevention and Screenings; Cardiovascular Disease and Stroke lectures and screenings; Chronic Disease Self-Management workshops; Diabetes Prevention and Management and Diabetes Education Empowerment Program (DEEP). The Street Medicine Program was expanded to two outings a month to address the health concerns of the unsheltered. The Faith Community Nursing/Health Ministry program was launched to focus on identifying and serving the needs of the more mature population in our community. The Perinatal Mood and Anxiety Disorder (PMAD) program provided mental health support for families in the Santa Maria Valley. A total of $287,661 was awarded in the Dignity Health Community Grants program to Accountable Care Communities that address educational attainment and basic needs for the aging and more mature population
FY23 Planned Programs and Services	For FY23, the hospital plans to continue to offer the chronic disease and diabetes self-management workshops via the ZOOM platform due to the uncertainty of COVID infection. Increase cancer awareness on the importance of early detection for colon, breast, and cervical cancer. Continue offering our mental health support to families impacted by PMAD. Our Faith Community Nursing/Health Ministry will continue to access the needs of the more mature population. Continue with our Street Medicine rounds among the unsheltered. Highlight our Physician Mentoring program to address educational attainment.

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

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

Our Hospital and the Community Served

About Marian Regional Medical Center

Marian Regional Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

Marian Regional Medical Center (MRMC) is located at 1400 East Church Street in Santa Maria, California, and is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Between 1940 and present day, MRMC has transformed into a state-of-the-art, 191-bed facility that is well positioned to serve a continuously growing patient population. MRMC is designated a STEMI Receiving Center in Santa Barbara County, and is designated a Level III Trauma Center by Santa Barbara County's Emergency Medical Services Agency. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. Our cancer care program is accredited as a Comprehensive Community Cancer Center by the American College of Surgeons' Commission on Cancer. The campus houses a comprehensive perinatology/ neonatology program, providing specialized care to the tiniest of patients. Marian Regional Medical Center is proud to announce that the hospital's inaugural class of Obstetrics & Gynecology (OB-GYN) Residency Program physicians will graduate on June 25, 2022..Marian welcomed its first class of OB-GYN physician residents in 2018. Marian has long been a local health leader in Santa Maria and delivers the highest number of infants throughout the Central Coast with more than an average of 257 deliveries a month.

Arroyo Grande Community Hospital (AGCH) is located at 345 South Halcyon Road in Arroyo Grande, California and is approximately 15 miles north of Santa Maria. It operates under one hospital license with Marian Regional. The AGCH has been serving the health care needs of the Five Cities area since it became a member of Dignity Health in 2004. AGCH is rated a top Joint Replacement Center by Blue Shield and among the top in the Nation for Joint Replacement, offering the latest in robotic and other technologically advanced orthopedic procedures. The hospital also has a 20 bed acute rehab center.Arroyo Grande Community Hospital's (AGCH) acclaimed Acute Rehabilitation Center is the only facility on the Central Coast to utilize the Andago®, a robot-assisted therapy device that helps patients with stroke or brain injury regain their ability to walk. The Acute Rehabilitation Center is also home to the Armeo®Spring, an ergonomic and adjustable exoskeleton that guides arm and hand training through tailored arm weight support. The Armeo can help improve the quality of movement, arm function, muscle strength, range of motion, pain and spasticity,
activities of daily living, and cognitive function.

Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

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

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

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

The MRMC community is a culturally diverse area with the majority of residents (67.2%) considering themselves Hispanic or Latino(a) origin. In the MRMC community, 26.6% of individuals over the age of five speak English less than "very well." Educational attainment for adults age 25 and older continues to be a challenge for the MRMC community. Overall, 31.1% of the MRMC community residents age 25 and over did not complete high school. Furthermore, over half (53.2%) of the adults (age 25 and over) residing in zip code 93458 (Santa Maria), and 44.3% of adults residing in 93434 (Guadalupe) have less than a high school education. Conversely, the highest levels of education can be found in the adult population (age 25 and over) residing in zip code 93455 (Santa Maria/Orcutt) where 69.1% reported having at least some college/associates degree or higher.
According to the U.S. Census, 2016-2020 American Community Survey 5-Year Estimates, poverty levels exceed state (12.6%) and national levels (12.8%) in the following MRMC community locations:

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

In addition to the residents captured by the formalized data sources above, the transient farmworker population drawn to work in the fields of Santa Barbara County and San Luis Obispo County are supported by indigenous migrants from the Mexican states of Oaxaca and Guerrero. These indigenous migrants are often monolingual in their native pre-Hispanic indigenous language of Mixtec or Zapotec. According to the National Center for Farmworker Health in 2017, there were an estimated 32,066 farmworkers in Santa Barbara County and 17,771 farmworkers in San Luis Obispo County.
The 2022 Point in Time Count for Santa Barbara County reported 457 persons experiencing homelessness in Santa Maria and 2 in Guadalupe. The homeless population in Santa Maria in 2022 is similar to the 2019 total of 464 and higher than the 2020 total of 382. Table 2 below provides additional population characteristics for the MRMC community.

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

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

Due to the COVID-19 pandemic, in 2021 the local homeless population count in San Luis Obispo County was not completed and delayed to 2022. The 2022 Homeless Census and Survey for San Luis Obispo County was completed in February 2022 and their results should be referenced and utilized for any future programming once released. According to the 2019 Homeless Census and Survey for San Luis Obispo County, 211 persons experiencing homelessness were encountered in South County.

Demographic information for the MRMC which includes AGCH was taken from Claritas Pop-Facts 2022; SG2 Market Demographic Module provides data on the following:

Marian Regional Medical Center

- **Total Population:** 147,176
- **Race:**
    - 22.1 % White
    - 1.0% Black/African American,
    - 69.3 % Hispanic or Latino
    - 4.1 % Asian/Pacific Islander
    - 3.5 % All Others
- **% Below Poverty** 7.1 %
- **Unemployment:** 4.9 %
- **No HS Diploma:** 30.8%
- **Medicaid (household):**34.6 %

- **Uninsured (household)**: 9.3 %

Arroyo Grande Community Hospital

- **Total Population:** 119,298
- **Race:**
  - 56.1 % White
  - 1.0% Black/African American,
  - 33.2 % Hispanic or Latino
  - 3.7 % Asian/Pacific Islander
  - 6.0 % All Others
- **% Below Poverty:** 4.4%
- **Unemployment:** 3.0%
- **No HS Diploma:** 8.7 %
- **Medicaid (household):** 26.6 %
- **Uninsured (household):** 6.5 %

Community Assessment and Significant Needs

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

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in May 2022

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

The CHNA contains several key elements, including:

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

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

Significant Health Needs

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

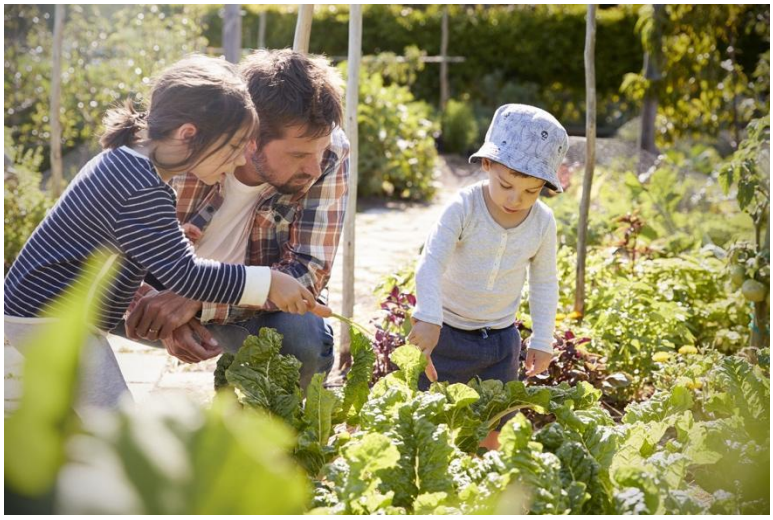
Significant Health Need	Description	Intend to Address?
Educational Attainment	Adults with a lower educational attainment level have an increase in encountering barriers in obtaining quality health care and are more prone to being negatively impacted by other social determinants of health.	yes
Access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

2022 Report and 2023 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 FY22 and planned activities for FY23, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

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

Creating the Community Benefit Plan



The hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

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

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

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

Community Health Strategic Objectives

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

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

Advance Community Health Alignment and Integration

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

Expand Clinical - Community Partnerships and Linkages

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

Build Capacity for More Equitable Communities

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

Inspire, Innovate and Scale High Impact Initiatives

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

Report and Plan by Health Need

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

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

Health Need: Educational Attainment

Strategy or Program	Summary Description	Active FY22	Planned FY23
Community Health Improvement Grant program	• Fund Accountable Care Communities (ACC)whose goal is to encourage higher education, adult literacy and medical literacy.	☒	☒
Physician Mentoring Program	• Provides local high school and college students the opportunity to participate in a rotation which introduces them to the many multidisciplinary facets of medicine.	☐	☒
Spanish & Mixteco Interpreter/Advocacy	• Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. • Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	☒ ☒	☒ ☒

Health Professions Education	• The hospital provides a clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, and pharmacists. Nursing students conduct their clinical rounding at the hospital. • The hospital provides the local community colleges financial support to further address community wide workforce issues, such as school-based programs for health care careers.	☒ ☒	☒ ☒
Goal and Impact:Increase awareness of the different careers in health care and to encourage students toward the field of medicine**.**			
Collaborators: Planned collaboration San Luis Coastal School District, San Luis Lucia Mar School District Allan Hancock College, Cuesta College,Future Leaders of America Inc.			

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

Strategy or Program	Summary Description	Active FY22	Planned FY23
Community Health Improvement Grant program	• Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, dental care, medical prescriptions, and behavioral health care.	☒	☒
Street Medicine Program	• In collaboration with the Marian Family Residency program, basic health and needs assessments are provided to unsheltered individuals in the MRMC community.	☒	☒
Chronic Disease Prevention and Self-Management Programs	• Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program (DEEP) are offered to community members	☒	☒
Diabetic Prevention and Self-Management Program (English and Spanish) & After-hour clinic	• A new comprehensive, evidence-based, diabetes management program will be offered to the community. The after hour clinic program will include access to a registered dietician and a nurse specialized in diabetes management. These services will be added at a primary care site so the patient can experience multi-disciplinary, bi-lingual providers at one location.	☐	☒
Farming for Life	• A new partnership with Tally Farms has been formalized to launch a program called Farming for Life. Farming for Life will provide free fresh produce for 12 weeks to diabetics enrolled in the program. Participants will undergo four bio/psycho/social evaluations during the twelve weeks.	☐	☒

Behavioral Wellness Support Groups	• Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). • Medically vulnerable population "MVP" for infants born with special medical needs, have a monthly support group. • Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. • Prenatal education programs are offered in Spanish and English to expectant mothers. • A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	☒ ☒ ☒ ☒ ☒	☒ ☒ ☒ ☒ ☒
Behavioral Wellness Center (Crisis Stabilization Unit)	• The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.	☐	☒
MRMC Medical Safe Haven Clinic for Human Trafficking	• Provides a safe space where medical providers can offer a full spectrum of health services for victims and survivors of human trafficking.	☐	☒
Community Health Navigator Program	• The Community Health department will coordinate with the Transition Care Center to develop a "whole person" approach, for example, the MVP Program or DEEP participants, in helping those patients navigate access to medical, behavioral health, and basic needs services.	☐	☒
Faith Community Nurse Program	• Further develop and expand the FCN program throughout the CA Central Coast market. • The FCN program will support the whole person including their spiritual, physical, mental and social well-being.	☒ ☒	☒ ☒
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening. • Provide financial support to medically underserved patients for transportation and genetic counseling.	☒ ☒ ☒	☒ ☒ ☒
Spanish & Mixteco Interpreter/Advocacy	• Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. • Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	☒ ☒	☒ ☒
Substance Use Navigation Program	• Dedicated social workers assist patients presenting with Substance Use Disorder to link with appropriate resources. A naloxone distribution program is also part of the program.	☒	☒

Goal and Impact: Increase access to free medical care and community resources to provide early detection, prevention, and management of illness. Increase smooth transitions for discharged patients by providing access to "medical homes" and pharmaceutical patient assistance programs.

Collaborators: Planned collaboration with SLO Noor free medical and dental clinics, FHMC care coordination and social work departments, Alliance for Pharmaceutical Assess (APA Inc.), Hearst Cancer Resource Center, Pacific Central Coast Health Centers, and FHMC Community Health Department.

Health Need: Health Promotion and Prevention

Strategy or Program	Summary Description	Active FY22	Planned FY23
Community Health Improvement programs	• Free evidence based self-management disease workshops.	☒	☒
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening. • Provide financial support to medically underserved patients for transportation, genetic counseling.	☒	☒
Faith Community Nurse Program	• Further develop and expand the FCN program throughout the CA Central Coast market. • The FCN program will support the whole person including their spiritual, physical, mental and social well-being	☒	☒
Behavioral Wellness Support Groups	• Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). • Medically vulnerable population "MVP" for infants born with special medical needs, have a monthly support group. • Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. • Prenatal education programs are offered in Spanish and English to expectant mothers. • A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	☒ ☒ ☒ ☒ ☒	☒ ☒ ☒ ☒ ☒
Diabetic Prevention and Self-Management Program (English and Spanish) & After-hour clinic	• A new comprehensive, evidence-based, diabetes management program will be offered to the community. The after hour clinic program will include access to a registered dietician and a nurse specialized in diabetes management. These services will be added at a primary care site so the patient can	☐	☒

	experience multi-disciplinary, bi-lingual providers at one location.		
Farming for Life	• A new partnership with Tally Farms has been formalized to launch a program called Farming for Life. Farming for Life will provide free fresh produce for 12 weeks to diabetics enrolled in the program. Participants will undergo four bio/psycho/social evaluations during the twelve weeks	☐	☒
Mixteco Pregnancy Education	• Culturally appropriate education for Indigenous women to foster healthy pregnancy and maternal outcomes.	☐	☒
Spanish & Mixteco Interpreter/Advocacy	• Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. • Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	☒ ☒	☒ ☒
Chronic Disease Prevention and Self-Management Programs	• Promote to the community and provide Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program to community members. Conduct post workshop testing to determine efficacy of the program.	☒	☒
Goal and Impact: Increase cancer cardiovascular disease, diabetes, and stroke awareness, prevention, and management to the most vulnerable populations in SLO county and to increase early detection and management.			
Collaborators: Planned Collaboration with the Latino Health Coalition. Community Clinics of the Central Coast, Pacific Central Coast Health Centers, SLO Noor free clinics and SLO Public Health Department. FHMC Women's Imaging center, Hearst Cancer Resource Center,			

Community Health Improvement Grants Program

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

In FY22, the hospital awarded the grants below totaling $ 287,661. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Good Samaritan Shelter	Santa Maria Stabilization Center	$ 80,000

Family Service Agency of Santa Barbara County	Senior and Caregiver Support	$ 65,000
Future Leaders of America (FLA)	A-G For All!	$ 55,796
Community Counseling Center	MARBLE- Multi-tiered Youth Mental Wellness Project	$ 20,000
Los Osos Cares, Inc.	Basic Needs and Resources for Vulnerable & Seniors	$ 40,000
SLO Noor Foundation	Dental Care Access and Service Expansion for Uninsured and Underinsured	$ 26,865

Program Highlights

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

Behavioral Wellness Support	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Program provides mental health support through individualized and group support.
Population Served	Underserved population that are seeking mental health support
Program Goal / Anticipated Impact	To support individuals living with a chronic illness and/ or pregnant and postpartum women and their families by facilitating access to needed medical, social and behavioral health services to achieve a healthier self.
FY 2022 Report	
Activities Summary	Program to be implemented in FY 2023.
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2023 Plan	
Program Goal / Anticipated Impact	1. A total of 20 unduplicated individuals for the fiscal year will participate in the monthly chronic illness support group and the Spanish Diabetic support group. 2. A total of 25 individuals will be referred to appropriate community resources upon request. 3. At least five PMAD workshops will be held for Spanish and Mixteco-speaking women and their families to increase awareness and knowledge of perinatal mood and anxiety disorders. 4. Increase attendance by 5% in both monthly PMAD Spanish and English PMAD support groups. 5. Refer 40 Spanish and Mixteco-speaking women to the appropriate community resources.
Planned Activities	1. Recruit and invite participants that completed the Chronic Disease Self Management program (CDSMP) and/or Diabetes Empowerment Education Program (DEEP) to the monthly support groups. 2. Using Cerner Spanish and Mixteco speaking postpartum women will be contacted and invited to participate in Cambio de Vida con un Bebé, our culturally sensitive program name to be more discerning of the stigma attached to depression.

	3. Assist at least 25 patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs.

Cancer Prevention and Screening Program	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Marian Cancer Care Program at both Arroyo Grande and Santa Maria campuses addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurse, social worker, certified cancer exercise trainers and registered dietician.
Population Served	Underserved population emphasizing outreach to seniors.
Program Goal / Anticipated Impact	The goal of the Marian Cancer program at both Arroyo Grande and Santa Maria campuses is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase in participation of rehabilitation and psychosocial support services as well as cancer awareness, prevention activities, screenings and genetic counseling.
FY 2022 Report	
Activities Summary	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.
Performance / Impact	1. 3,290 Medically underserved patients have been screened and referred to social support services this fiscal year(48% increase from FY21): 190 received free counseling services with follow up assessment and 3,208

	were connected to other psychosocial supportive services including financial support, psychosocial support nutritional counseling nurse navigator support and spiritual guidance. 2. Patient assisted with screening services this fiscal year:173 (SM:79/FC/:11) colorectal screenings (37% increased from FY21) 2 new cancer cases have been identified through screening this fiscal year); 68 prostate, 2 new cancer cases have been identified through screening this fiscal year); 1,069 (SM:530/FC:530) lung screening, 11 new cancer cases have been identified through screening this fiscal year)(6% increase form FY21); 526 smoking cessations (60% increase from FY21); 535 survivorship care plans (88% increase from FY21) and 649 Emmi participants (5% increase from FY21). 3. 224 under/uninsured patients were saved by the genetic counseling program (53% increase from FY21) 202(SM: 140/FC: 62) were assisted financially, totaling $51,136 (SM: $36,594/FC: $14,638). 4. 513 under/uninsured patient have been provided financial assistance for cancer care needs: (66%) female; (50%)Hispanic; (46%) unemployed; (26%) laborers; (39%) under 60 years of age; and (21%) supporting 2 or more children. Additionally, 6,035 medically underserved patients have been transported for cancer care and another 545 (SM: 402/FC: 143) patients were supported with financial assistance for transportation needs, totaling $27,300 (SM: $20,150/FC: $7,150). 5. 2, 333 (SM: 1,982/FC: 351) medically underserved patients were supported through the nutrition counseling program this fiscal year (38% decrease from FY21), while 88% of nutrition. Participants demonstrated at least one healthy behavior change they have adopted into their lifestyle. 6. 147 new patents enrolled into the Cancer Rehabilitation Program this fiscal year (6% decreases from FY21). 94% of patents contacted four weeks following their cancer rehabilitation program completion reported the use of continued exercise.
Hospital's Contribution / Program Expense	MRMC provided in kind space, nutritional services, advertisement, and printing. Program Expense: $1,375,791
FY 2023 Plan	
Program Goal / Anticipated Impact	1. Track target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services. 2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving cancer prevention and screening services: Colonoscopy-5% (109); Prostate-5% (64); Skin-5% (119); Lung-5% (1,002); Smoking Cessation-5% (213); Survivorship Care Plans-5% (95); Emmi services-5% (617). 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic

	counseling program and track number of patients needing financial assistance to participate: Genetic Counseling-5% (107). 4. Track and describe the under/uninsured population requesting financial assistance for cancer care needs. Track the number of medically underserved patients transported for cancer care. 5. Increase by 5% (1,328) monthly nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). Ensure at least 50% of patients nutritionally counseled identify at least one healthy behavior in follow-up visit, which they have adopted into their lifestyle. 6. Increase the number of new patients from target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 5% (87). Ensure at least 50% of patients who complete the cancer rehabilitation are continuing to exercise 4 weeks after program completion.
Planned Activities	1. Maximize the use of both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to available psychosocial support services. 2. Provide cancer prevention and screening information through counseling and support services, outreach events, social media platforms, radio and print material. 3. Provide the necessary financial support for genetic counseling to medically underserved patients in need of assistance. 4. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance. 5. Continue to utilize the support of the lay patient navigator and dietitian to educate participants in medically underserved communities on healthy behaviors that can assist in cancer prevention, mitigating cancer symptoms and decrease the incidence of chronic illness. Encourage target population patients to seek further support through one-on-one nutrition counseling. 6. Identify medically eligible patients to enroll in the Cancer Rehabilitation Program; conduct a 4 week post program, telephonic follow-up to track how many patients continue to utilize the exercise activities and knowledge gained, thereby lowering the risk of recurrence.

Cardiovascular Disease and Stroke Program	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Cardiovascular disease/stroke is one of the leading causes of death in 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.
Population Served	Underserved populations emphasizing outreach to seniors.
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention education, and management of risk factors for heart attack and stroke.
FY 2022 Report	
Activities Summary	1. Promote our ZOOM HFL and DEEP workshops on social media, hospital websites, and other printed media outlets. 2. Recruit participants using Octavia. 3. Track responses of the post workshop questions on carbohydrates and diabetes control.
Performance / Impact	1. At total 135 of participants combined attended the ZOOM Healthy for Life and ZOOM DEEP workshops. Demographics of the participants were 134 Latino, 1 white, 102 females, and 32 males. 2. 100 % of the participants attending either our HFL or DEEP workshop were able to identify 2 risk factors for cardiovascular disease and stroke post completion of the workshop. (Baseline 80%) 3. 92 % of the participants attending the DEEP workshop were able to answer correctly on their posttest survey that carbohydrates break down to glucose .(baseline 80%) 4. 99 % of the participants attending our DEEP workshops answered yes on the ability of them to identify goals to help control their diabetes which can affect their risk of heart disease and stroke. (baseline 85%)
Hospital's Contribution / Program Expense	MRMC provided advertisement, and printing. Program Expense: $95,121
FY 2023 Plan	
Program Goal / Anticipated Impact	Program discontinued will be part of the Chronic Disease Prevention & Self Management program digest for FY2023.
Planned Activities	

Chronic Disease Prevention & Self-Management	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Dignity Health evidenced based Wellness workshops offer the participant the ability to learn skills that will enhance their capability of managing their chronic disease and help others identify tools that will help them make healthier life choices to prevent/ reduce the acute/long term complications from chronic disease.
Population Served	Underserved populations
Program Goal / Anticipated Impact	Improve the confidence level of the workshop participants in their self-management and/or prevention of their chronic disease.
FY 2022 Report	
Activities Summary	New program to start in FY 2023.
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2023 Plan	
Program Goal / Anticipated Impact	1. 80% of the Chronic Disease Self Management Program(CDSMP) and Diabetes Education Empowerment Program (DEEP) participants will self-report 1 month after completion of the program 2 self management skills that they have continued to practice. 2. Increase DEEP series class participation by5 % from FY2022 results. (total for FY 22 was 31) 3. 80% of the Healthy for Life participants will identify 2 risk factors for heart disease, stroke, and diabetes, 1 month after completion of the program .
Planned Activities	1. Promote the Dignity Health Wellness workshops on community health quarterly newsletter, social media, hospital website, and other media outlets. 2. Contact and ask workshop CDSMP and DEEP participants at 1 month after completion of the workshop to self-report 2 self-management skills that they have continued to practice. 3. Contact and ask workshop HFL participants at 1 month after completion of the workshop to identify 2 risk factors for heart disease, stroke, and diabetes type 1. 4. Track the responses of the HFL, CDSMP, and DEEP on a spreadsheet.

Community Health Improvement Program	
Significant Health Needs Addressed	• Educational Attainment • Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospital's health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.
Population Served	Underserved populations
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the hospital service area to "Accountable Care Community" which align with the hospital's most recent Community Health Needs Assessment report.
FY 2022 Report	
Activities Summary	1. Community Education Coordinator will work closely with agencies to form a more succinct "Accountable Care Community" (ACC) for services the hospital is unable to address itself. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit a timely quarterly sustainability report to the Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Performance / Impact	1. Community Health Manager worked closely with local community agencies in forming Accountable Care Communities that would meet the needs of the hospitals prioritized health needs. 2. All ACC were scheduled to present at the quarterly Community Benefit meetings to give updates on their projects. 3. 100% of funded ACCs have scheduled mid-year meetings 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 $287,661 in grant money awarded to the community for the purpose of improving the quality of life of the residents of Northern Santa Barbara County.
FY 2023 Plan	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities : Educational Attainment, Access to Health Care, Behavioral Health, and Dental Care, Health Promotion and Prevention.
Planned Activities	1. A Grant Writers workshop will be held in the month of August.

	2. 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. 3. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 4. Funded ACCs will present at Community Benefit Committee meetings.

Diabetes Prevention and Self-Management Program	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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.
Population Served	Underserved Populations
Program Goal / Anticipated Impact	The program goal is to add the diabetes treatment services to a primary care site in order for the patient to experience a total wrap-around approach with multi-disciplinary providers, bi-lingual, and bi-cultural staff under a single location and medical record. It is anticipated that this goal will achieve long term wellness in a culturally appropriate clinical environment.
FY 2022 Report	
Activities Summary	1. Move program to clinic at MMC-Bunny by Oct 1, 2021 2. Train RD staff to effectively use Cerner ambulatory and understand practices of the clinic. 3. Link treatment services better with DEEP program 4. Partner with Sansum Diabetes center and Talley Farms for the Farming For Life Program by Nov 1, 2021 5. Set up regular meetings with Sansum and Talley Farms.
Performance / Impact	Program has no performance/Impact to report due to shift in program direction under the Transitional Care Center.
Hospital's Contribution / Program Expense	Program Expense: No expense to report due to restructure of program
FY 2023 Plan	
Program Goal / Anticipated Impact	Program discontinued will be part of the Chronic Disease Prevention & Self Management program digest for FY2023
Planned Activities	

Faith Community Nursing/Health Ministry Program	
Significant Health Needs Addressed	● Access to Health Care, Behavioral Health, and Dental Health ● Health Promotion and Prevention
Program Description	The Faith Community Nurse (FCN) program utilizes a Dignity Health employed Faith Community Nurse Coordinator who develops a faith community nursing program throughout the central coast market area. Faith community nurse programs use the nursing process to address the spiritual, physical, mental, and social health of those part of a local faith community.
Population Served	Persons from the congregation of the faith nurse belong to emphasizing outreach to seniors.
Program Goal / Anticipated Impact	To support growth of the individual(s) by enhancing the health of the "whole person" (spiritual, physical, mental and social) through the FCN/HM Program.
FY 2022 Report	
Activities Summary	1. Formalize the relationships and expectations-Signed Collaborative Agreements a.Coordinator to meet with each FCN to understand the unique need and expectations of each community. b.Coordinator to set up quarterly coalition meetings that can be in person and via zoom. Rotation in person locations so different areas can "host" the meeting. Set an agenda, allow new items to be added from the FCN as needs arise. A special speaker at each meeting to share about "resources" within the community or some other development type of activity. Start with a presentation on advanced care planning. 2. Offer additional training for other nurses interested in FCN. Develop a timeline for next training with location (keep as in person and also zoom). Advertise to local DH nurses, to community board members, to local parishes, etc. Target poor areas (high CNI's) as well as Spanish speaking congregations. 3. Coordinator will work with each FCN and share tools that can be used at the local faith community level to do a needs assessment. After needs assessment Coordinator will meet with the FCN's and review their annual plan based on each unique needs assessment.
Performance / Impact	1) A) 2 churches in the Santa Maria area with FCN (Orcutt Christian Church, Lutheran Church of our Savior). B) 3 churches in San Luis Obispo County with FCN (St. William's Parish in Atascadero, Mission San Luis Obispo de Tolsa, Trinity United Methodist Church in Los Osos) C) 0 churches in Arroyo Grande with FCN 2) 0 of 6 trained: No additional training classes. There are continued discussions with the Mission about a FCN class in the fall.

	3) From 1a) of the 2 churches in the Santa Maria area, there has been 1 needs assessment. From 1b) of the 3 churches in SLO county, there has been 3 needs assessment From 1c) no FCN so as of to date no needs assessment 4) # of Partnerships and shared resources= 10; FYI-Hospice SLO, Meals-That Connect, Geriatric Care Management, San Luis Obispo Public Health, the Long Term Care Ombudsman Program, the San Luis County Library and Dignity Health have been working on a National Healthcare Decision Day project. In addition, attend monthly meetings of the Adult Services Policy Council, where local Non Profit Agencies share information about available resources. Currently working with Wilshire Home Health and Hospice – Provided a Grief Education and Healing Program at St. Williams. This program is available for others in the FCN/HM Network. Also have made contact with the local Alzheimer's Association for shared resources. The Regional Common Spirit Faith Community Nurses are meeting in the Common Spirit Englewood, CO office in July to review the FCN grant, examine documentation, equity, and Social Determinants of Health. Health interventions at each site: 1a) Santa Maria locations- 488 1b) SLO locations-926 1c) AG locations-0 By Zip Code: Current FCN/Health Minister have provided outreach/interventions by the following zip codes: 93401 - 117, 93402 - 169 , 93422 - 640 , 93454 - 263, 93455 – 225 When talking with the FCN network members – Most of the 1-1 visits are provided for the older adult population. We have been part of a national program - Age-Friendly Health Systems which uses the 4Ms Framework (What Matters, Medication, Mentation and Mobility) to guide the Care of the Older Adult
Hospital's Contribution / Program Expense	MRMC provided advertisement, and printing. Program Expense: $20,336
FY 2023 Plan	
Program Goal / Anticipated Impact	1) Improve health literacy in the designated faith community(s) as evidenced by individuals ability to define health status and resources (count number per site). 2) Participate in the identified two programs per site to promote health in the faith community (count number of participants per program per site). 3) Provide education on Advance Directives at each site (count number educated per site).

	4) The Faith Community Coordinator will build relationships/coalitions/agencies in the community and share the resources with FCN/HM (count number of relationships).
Planned Activities	1)Improve health literacy in the community ● Assess the health literacy of individual/church ● Partner with individuals/community members – Document concerns ● The individual will verbalize health status and willingness to participate in programs 2)Identify programs to promote health in each community settings ● Assess resources available for the identified concern ● After needs have been identified, each FCN/Health Minister (HM) will develop a plan with the individual/agency and data submitted by category and zip code ● Link with identified health programs 3)Clarify the value of Advance Directives ● Provide education about Advance Directive (include directions, support – the discussion continues since this is a living document and may change over time) ● Document those who were given the information and those who completed the document. 4)Build relationships/coalitions with individuals and Agencies in the community ● Identify resources available and share with FCN/HM ● Participate in established Coalitions that provide Healthcare and Education ● Support individuals/agencies in navigating the health care options based on Health Related Social Needs (HRSN)

Perinatal Mood and Anxiety Disorder Program

Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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.
Population Served	Mother who has or had PMAD symptoms.
Program Goal / Anticipated Impact	To support pregnant and postpartum women and their families impacted by PMAD by facilitating access to social and behavioral health services

FY 2022 Report

Activities Summary	1. Using Octavia Spanish and Mixteco speaking postpartum women will be contacted and invited to participate in Cambio de Vida con un Bebé, our culturally sensitive program name to be more discerning of the stigma attached to depression. 2. Flyers for the English-speaking PMAD support group will be distributed to the community, at OB clinics, and directly to patients during their hospital stays. 3. Assist patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs. 4. Connect women to psychiatric care, individual therapy, and/or support groups.
Performance / Impact	1. Eight PMAD workshops were conducted in FY 2022 with 142 mothers attending all Latinas. (FY 2021 no workshops were conducted) 2. Four Spanish support groups were conducted in FY 2022 with 44 Mothers attending. FY 2021 55 attended which indicates a decrease of 8% for FY 2022. 3. 87 Spanish speaking mothers were referred to community resources in FY 2022. Did not reach the goal of 125 due to the PMAD english program on hold due to the program coordinator on medical leave. 4. 4-6. No data available due to coordinator on medical leave.
Hospital's Contribution / Program Expense	MRMC provided advertisement, and printing. Program Expense: $29,357

FY 2023 Plan

Program Goal / Anticipated Impact	Program restructured into the Behavioral Wellness Support digest

Physician Mentorship Program	
Significant Health Needs Addressed	• Educational Attainment
Program Description	Local central coast students shadow physicians and other healthcare professionals from various specialties to give them an opportunity to see the variety and importance of the medical profession.
Population Served	High School students interested in pursuing a career in healthcare.
Program Goal / Anticipated Impact	To encourage local high school and college students to pursue a career in the medical health field.
FY 2022 Report	
Activities Summary	Program will be implemented in FY 2023.
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2023 Plan	
Program Goal / Anticipated Impact	To encourage local high school and college students to pursue a career in the medical health field.
Planned Activities	1. Increase outreach to high school, colleges and alternative schools throughout the Central Coast service area. 2. Contact high school and college counselors asking them for student referrals to the program. 3. Increase recruitment of local physicians and obtain referrals to gain participation. 4. Collaborate with the hospital department managers, directors, and administration to gain participation of the patient care nurses. 5. Highlight program in the Community Health electronic newsletter which is distributed to community partners including medical facilities throughout the central coast area. 6. Outreach to one middle school to pilot the Career Day: Medical field event . 7. Coordinate with the residency program on the format of the Career Day: Medical field event.

Other Programs and Non-Quantifiable Benefits

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

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

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

- The Marian Family Medicine Residency Program is an Accreditation Council of Graduate Medical Education (ACGME) 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, MRMC, and the dedicated Medical Staff at MRMC has also sponsored and created an additional ACGME approved training program in Obstetrics and Gynecology (OB/GYN). This 4 year program started during the 2017-18 academic year and currently has 10 resident physicians in the program. The OB/GYN program will have 12 total residents when it reaches its full complement of residents in July of 2023. The future graduates of the Marian OB/GYN program will help address the critical need of projected shortages of OB/GYN physicians both in our region and throughout the nation. The OB/GYN program had its first graduation of 2 senior residents on July 1, 2022. Our community will have the benefit of a new locally trained OB/GYN physician as one of our graduates has stayed to practice locally here in Santa Maria. 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 continue with their Street Medicine Program which has offered very basic health and basic needs assessments to 361 unsheltered individuals in the service area of MRMC. The Street Medicine conducts two monthly outings every month covering several homeless encampments in the community.

- Dignity Health announced that is has introduced the Medical Safe Haven (MSH) program at The Family Medicine Center at Marian Regional Medical Center, an area highly impacted by human trafficking. Within the Family Medicine Center, the Marian Family Medicine Residency Program - a three-year post-graduate program for physicians – offers training in the broad spectrum of

family medicine. Resident physicians will now be trained to recognize and treat trafficked patients.The MSH program creates a safe space where medical providers can offer ongoing care for victims and survivors of human trafficking, sex and/or labor, through the use of survivor-informed practices that help to minimize further trauma. This integrated-care model offers survivors the full spectrum of health services, including: primary care, prenatal and obstetrical care, newborn, pediatric and adolescent care, mental health support, vaccinations, STI testing and treatment, PrEP, telehealth, and other essential services. MSH will be serving victims and survivors of human trafficking, sex and/or labor in both Santa Barbara and San Luis Obispo counties.

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

- Human Trafficking(Suspected Abuse Task Force) – This initiative was launched in FY 2015 with an emergency response team established and a roll out of the first phase of education and training for hospital clinical staff to increase awareness. Training has been expanded to include annual training, training of all new employees, and training to other hospital departments. Since the launch the task force has decided to include and address all types of suspected abuse. The task force includes Marian, Arroyo Grande, and French Hospitals. The manager of community health represents the hospital at the county human trafficking task force acting as their community liaison.

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

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

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

- Employees donated to the following drives: Salvation Army Angel Tree and Vitalant Blood drives

- Hospital staff serves on many community committees and boards in the service area such as: Santa Maria Boys and Girls Club, Area Agency on Aging, YMCA of Santa Maria Valley, Community Partners in Care, 1st Five Advisory Board, Live Well Santa Barbara County, Active Aging Committee, CALM, Santa Barbara County Education Office's Promotoras Coalition, Children & Family Resource Services, Family Service Agency, SB County Human Trafficking Task Force, and The Salvation Army.

Economic Value of Community Benefit

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

364 Marian Regional Medical Center					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2021 through 6/30/2022					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Poor					
Financial Assistance	**21,578**	**10,421,375**	**0**	**10,421,375**	**1.6%**
Medicaid	**106,213**	**178,089,265**	**152,468,470**	**25,620,795**	**3.9%**
Community Services					
A - Community Health Improvement Services	15,801	4,426,533	0	4,426,533	0.7%
E - Cash and In-Kind Contributions	3,121	601,166	200	600,966	0.1%
F - Community Building Activities	0	5,000	0	5,000	0.0%
G - Community Benefit Operations	0	128,135	0	128,135	0.0%
Totals for Community Services	**18,922**	**5,160,834**	**200**	**5,160,634**	**0.8%**
Totals for Poor	**146,713**	**193,671,474**	**152,468,670**	**41,202,804**	**6.3%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,934	381,940	0	381,940	0.1%
B - Health Professions Education	861	16,696,927	0	16,696,927	2.6%
D - Research	0	194,944	17,815	177,129	0.0%
G - Community Benefit Operations	0	34,598	0	34,598	0.0%
Totals for Community Services	**2,795**	**17,308,409**	**17,815**	**17,290,594**	**2.6%**
Totals for Broader Community	**2,795**	**17,308,409**	**17,815**	**17,290,594**	**2.6%**
Totals - Community Benefit	**149,508**	**210,979,883**	**152,486,485**	**58,493,398**	**9.0%**
Medicare	**103,274**	**161,480,671**	**139,960,455**	**21,520,216**	**3.3%**
Totals with Medicare	**252,782**	**372,460,554**	**292,446,940**	**80,013,614**	**12.3%**

Hospital Board and Committee Rosters

HOSPITAL COMMUNITY BOARD FISCAL YEAR 2023

Sue Andersen
President & CEO

Phil Alvarado **(Secretary)**
Superintendent, Ret.
Santa Maria Bonita School District

Michael Bouquet**,(Immediate Past Chair)**
Business Manager, Toyota of Santa Maria

Chief Michael Cash
City of Guadalupe Police/Fire Chief, Director of Public Health

Lorena Chavez
Agricultural Business Owner
DL Farm Management, Inc.

Jason Diani
Businessman / Construction Executive
Diani Building Corporation

Holly Edds, EdD **(Vice Chair)**
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Sister Pius Fahlstrom, OSF
Finance Religious Sponsor
Sisters of St. Francis

Kevin Ferguson, MD **(Chair)**
Physician | Pathologist

Hon. Rogelio Flores, Ret.
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Michael Galloway, CPA
Accountant
Andrews, Galloway & Associates

Mario Juarez, ESQ
Attorney

Melvin Lopez M.D.
Physician / Family Medicine

Brett Lebed, MD
President of the Medical Staff
Urologist

Tom Martinez
Architect / Businessman

Sister Michele,OSF
Religious Representative, Sisters of St. Francis

Ijeoma, Ofjeoma, M.D.
Physician / Hospitalist

Margaux Snider, MD
Physician / Emergency Services

Kevin G. Walthers, PhD
College President/ Superintendent

Tim Ritchie
General Manager, Car Dealership / MRMC Foundation Board Chair

Joseph Will **(Immediate Past Chair)**
Construction Professional

Elaine Yin, MD
Obstetrics / Gynecology Physician

Sandra Dewar
Philanthropist / AGCH Foundation Board Chair

Marvin O'Quinn,(CommonSpirit Health Representative)
Senior Executive Vice President / Chief Operating Officer

Sister Pat Rayburn (Religious Sponsor Representative)
Member, Sisters Founding Council

MARIAN REGIONAL MEDICAL CENTER
COMMUNITY BENEFIT COMMITTEE FY2023

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

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

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

Terry Fibich
Retired

Katherine Guthrie
Senior Regional Director, Cancer Services

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

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

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

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

Anne Rigali
Member, Marian Foundation Board of Directors

Heidi Summers, MN RN
Senior Director, Mission Integration

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

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

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