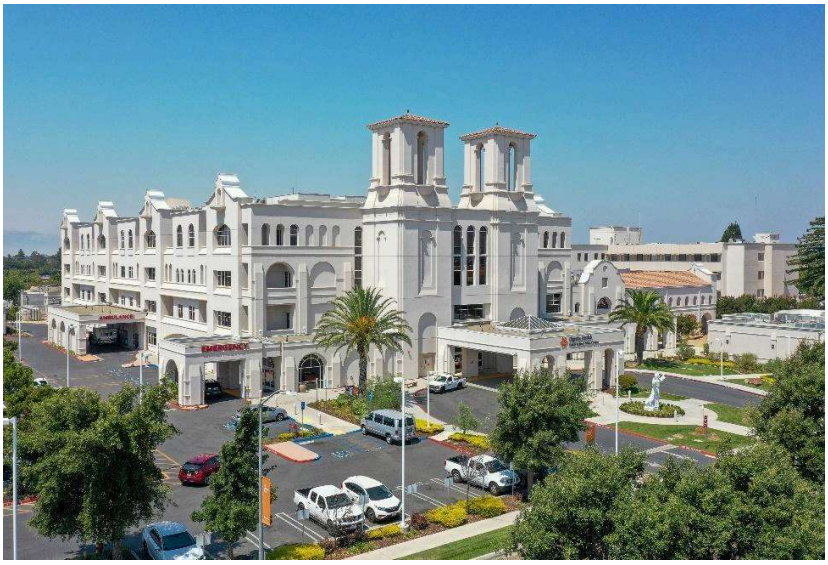
Marian Regional Medical Center

Community Benefit 2024 Report and 2025 Plan



Adopted October 2024

Dignity Health
Marian Regional Medical Center

A message from

Sue Andersen President and CEO, and Phil Alvarado,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 drivers of health.

Marian Regional Medical Center and Arroyo Grande Community Hospital share a commitment with others to improve the health of our community and promote health equity, and deliver programs and services to help achieve that goal. The Community Benefit 2024 Report and 2025 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. 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 2024 (FY24), Marian Regional Medical Center and Arroyo Grande Community Hospital provided $29,067,266 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2024 Report and 2025 Plan at its October 9, 2024 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 & CEO

Phil Alvarado
Chairperson, Board of Directors

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At-a-Glance Summary

Hospital HCAI ID:106420493

Report Period Start Date: July 1, 2023

Report Period End Date: June 30, 2024

This document is publicly available online at: Community Benefits | Marian Regional Medical Center | Dignity Health

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	$29,067,266 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $0 in unreimbursed costs of caring for patients covered by Medicare fee-for-service. The hospital's net community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.
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 care, including behavioral health and oral health. • Health Promotion and Prevention
FY24 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). A Matter of Balance Fall Prevention program. The Street Medicine Program was expanded to three outings a month to address the health concerns of the unsheltered.
FY25 Planned Programs and Services	For FY25, the hospital plans to continue to offer the chronic disease and diabetes self-management workshops via the ZOOM platform. In-person workshops will be highly encouraged during collaboration with community partners.. Increase cancer awareness on the importance of early detection for colon, breast, and cervical cancer. Develop collaborations with community partners to implement the Matter of Balance Fall Prevention workshop in Spanish.

Written comments on this report can be submitted to the MRMC's Community Health Office, 1400 E. Church Street, Santa Maria Ca. 93454 or by e-mail to patty.herrera@commonspirit.com

Our Hospital and the Community Served

About Marian Regional Medical Center

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

Marian Regional Medical Center (MRMC) is located at 1400 East Church Street in Santa Maria, California, and is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Between 1940 and present day, MRMC has transformed into a state-of-the-art, 191-bed facility that is well positioned to serve a continuously growing patient population. Marian Regional Medical Center has been verified as a Level II Trauma Center by the Verification Review Committee (VRC), an ad hoc committee of the Committee on Trauma (COT) of the American College of Surgeons (ACS).

This year MRMC achieved accreditation by the American College of Emergency Physicians (ACEP) Geriatric Emergency Department Accreditation Program (GEDA). The GEDA recognizes Marian Regional Medical Center's commitment to providing high-quality, specialized emergency care for older adults. The Level Three certification ensures the hospital's emergency department meets the interdisciplinary geriatric standards set forth by ACEP, including accessibility requirements and specialized training for the medical staff.

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

Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

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

Description of the Community Served

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

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

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

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

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

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

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

The number of individuals experiencing homelessness counted in the Santa Barbara County 2024 Point in Time Count was 2,119. This represents a 12% increase over the 2023 count of 1,887. Most notable was the increase across the board in the number of persons living in shelters or transitional housing , number of persons living outdoors and in vehicles.The 2024 Point in Time Count for Santa Barbara County reported 424 persons experiencing homelessness in Santa Maria.

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 aged 65 or over and in 93449 (Pismo Beach) this number increases to nearly 32%.

The 2024 San Luis Obispo County Point-in-Time Count counted a total of 1,175 persons experiencing homelessness. This was a decrease of 19% since the last Point-in-time count in 2022 (1,448). The Point in Time Count revealed 111 in Grover Beach, 60 in Arroyo Grande, and 21 in Pismo Beach.

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

Marian Regional Medical Center & Arroyo Grande Community Hospital

- **Total Population:** 237,658
- **Race:**
    - 34.9 % White
    - 1.0% Black/African American,
    - 56.1 % Hispanic or Latino

    - 3.7 % Asian/Pacific Islander
    - 4.3 % All Others
- **% Below Poverty** 6.7 %
- **Unemployment:** 4.0 %
- **No HS Diploma:** 22.8%
- **Medicaid (household):**31.9 %
- **Uninsured (household)**: 6.3 %

Community Assessment and Significant Needs

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

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in May 2022. The hospital makes the CHNA report widely available to the public online at Community Health Needs Assessments and upon request from the hospital's Community Health office.

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.

Community Groups that Attended or Engaged in the CHNA:

- Santa Barbara County Promotoras Collaborative
- Santa Barbara County Food Bank
- Santa Barbara County Public Health
- San Luis Obispo County Food Bank
- San Luis Obispo County Public Health
- Good Samaritan Shelter
- Catholic Charities
- People's Self Help Housing
- Herencia Indígena
- Center for Family Strengthening: Promotoras Collaborative
- Oasis Senior Community Center
- Mussel Senior Center
- The Gala Pride and Diversity Center
- The Link
- St. John Neumann Catholic Church
- Little House By the Park Resource Center

Vulnerable Populations Represented by These Groups:

- Homeless
- Mixteco-speaking community
- LGBTQAI community
- Low income Seniors
- Low income families
- Mexican families-Primary language is Spanish
- Persons with disabilities

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 Oral Health	Adults have barriers in accessing primary health care which also includes behavioral health and oral health.	yes
Health Promotion and Prevention	Adults have barriers accessing preventive health screenings awareness, and education	yes

2024 Report and 2025 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 FY24 and planned activities for FY25, 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 benefits 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, Nursing Education, Trauma Program Services, Quality, and Mission Hope Cancer Center.

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

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

Community Health Core Strategies

Driven by a commitment to equity and social justice, we envision a future where health and well-being are attainable by all regardless of background or circumstance.

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 three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Strengthen community capacity to achieve equitable health and well-being.
- Implement and sustain evidence-based health improvement program initiatives.

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 FY24	Planned FY25
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 Santa Maria Union High School District, Lucia Mar School District, Allan Hancock College, Cuesta College, Future Leaders of America Inc., and One Community Action.			

Health Need: Access to Primary Health Care, Behavioral Health, and Oral Health

Strategy or Program	Summary Description	Active FY24	Planned FY25
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.	☒	☒
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.	☒	☒
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening. • Provide financial support to medically underserved patients for transportation and genetic counseling. • Work with the school district to educate students and to help students understand cancer screening and prevention and so they can go talk to their parents and grandparents. With the goal to reduce cancer-related disparities in a largely rural and medically underserved population through the increase of health education. • Provide bilingual navigation services through the oncology nurse navigator and oncology social worker to facilitate barriers to cancer awareness, prevention activities, screenings, healthcare,high risk cancer genetic counseling, nutritional counseling,	☒	☒

	cancer rehabilitation and psychosocial support service .		
Spanish & Mixteco Interpreter/Advocacy	• Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. • Provide Mixteco speaking individuals advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	☒	☒
Substance Use Navigation Program	• Dedicated social workers assist patients presenting with Substance Use Disorder to link with appropriate resources. A naloxone distribution program is also part of the program.	☒	☒
Financial Assistance Programs	• Financial assistance programs are offered to medically underserved individuals to cover basic needs, hospital bills, transportation vouchers, and hotel vouchers. • The cancer resource center also provides financial assistance for basic needs (mortgage payment assistance, rent, gas cards) to community members affected by cancer.	☒	☒

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 program

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

Health Need: Health Promotion and Prevention

Strategy or Program	Summary Description	Active FY24	Planned FY25
Community Health Improvement Grant program	• Fund Accountable Care Communities (ACC) whose goal is to provide awareness and education on wellness and prevention.	☒	☒
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening.	☒	☒

	• Provide financial support to medically underserved patients for transportation, genetic counseling. • Work with the school district to educate students and to help students understand cancer screening and prevention and so they can go talk to their parents and grandparents. With the goal to reduce cancer-related disparities in a largely rural and medically underserved population through the increase of health education. • Provide bilingual navigation services through the oncology nurse navigator and oncology social worker to facilitate barriers to cancer awareness, prevention activities, screenings, healthcare,high risk cancer genetic counseling, nutritional counseling, cancer rehabilitation and psychosocial support service .		
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.	☒	☒
Chronic Disease Prevention and Self-Management Programs	• Promote to the community and provide Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program to community members. Conduct post workshop testing to determine efficacy of the program.	☒	☒
Goal and Impact: Increase cancer cardiovascular disease, diabetes, and stroke awareness, prevention, and management to the most vulnerable populations in Santa Barbara county and to increase early detection and management.			
Collaborators: Planned Collaboration with the Community Clinics of the Central Coast, Pacific Central Coast Health Centers, SLO Noor free clinics and Santa Barbara Public Health Department , and Mission Hope.			

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 FY24, the hospital awarded the grants below totaling $424,496. The figures below represent grant awards that the hospital made in conjunction with Arroyo Grande Community Hospital and French Hospital Medical Center. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
805 Street Outreach	805 Street Outreach	Health Promotion & prevention	$50,000
Community Environmental Council	Minimizing community health Impacts from air pollution, pesticide exposure and extreme heat inGuadalupe and the Santa Maria Valley	Health Promotion & prevention	$24,496
Community Counseling Center	Grief Awareness Treatment and Education Project (GRATE	Access to behavioral health	$50,000
Good Samaritan	San Luis Obispo Sobering Center	Access to behavioral health	$50,000
Lumina Alliance	Comprehensive Healthcare for Survivors of SexualAssault and Intimate Partner Violence in Rural SanLuis Obispo County	Health Promotion & prevention	$50,000
One Community Action	Mental Health Youth Project : Mi VIDA	Health Promotion & prevention, Educational Attainment	$50,000
Santa Barbara Foodbank	Food Prescription Program	Health Promotion & prevention	$50,000
The Cecilia Fund	Oral Health Program for Cancer Patients	Access to Oral Health	$50,000
The Salvation Army	Street Outreach Program: SLO County	Access to health care, Health Promotion & Prevention	$50,000

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 Primary 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 2024 Report	
Activities Summary	Outreach and recruitment of participants were done in various ways such as: sending electronic support group flyers to community partners, sending our electronic monthly community health newsletter to our networks,and developing a criteria workshop list in Cerner.
Performance / Impact	1. The Chronic Disease monthly support group had 16 unduplicated individuals attend the support group. (FY2023 a total of 20 unduplicated goal were not achieved.) 2. The Diabetes support group had a total of 13 unduplicated individuals attend the sessions.(FY2023 a total of 20 unduplicated goal were not achieved.) 3. A total of 8 PMAD workshops were conducted in Spanish with a total of 190 attending. (FY 2023 goal was 8, goal achieved) 4. A total of 22 mommies attended the English PMAD support group and a total of 30 attended the Spanish PMAD support group. (Both support groups did not have an increase of participation by 5%. FY2023 goal not achieved) 5. A total of 40 individuals received appropriate community resources upon their request. (FY 2023 goal was achieved.)
Hospital's Contribution / Program Expense	MRMC provided in kind space, advertisement, and printing. Program Expense: $ 96,714

FY 2025 Plan	
Program Goal / Anticipated Impact	1. A total of 15 unduplicated individuals for the fiscal year will participate in the monthly chronic illness support group and the Spanish Diabetic support group. 2. At least 8 PMAD workshops will be held for Spanish and Mixteco-speaking women and their families to increase awareness and knowledge of perinatal mood and anxiety disorders. 3. Increase attendance by 5% in both monthly PMAD Spanish and English PMAD support groups. 4. Refer 40 Spanish and Mixteco-speaking women to the appropriate community resources.
Planned Activities	1. Recruit and invite participants that completed the Chronic Disease Self Management program (CDSMP) and/or Diabetes Empowerment Education Program (DEEP) to the monthly support groups. 2. Using Cerner Spanish and Mixteco speaking postpartum women will be contacted and invited to participate in Cambio de Vida con un Bebé, our culturally sensitive program name to be more discerning of the stigma attached to depression. 3. Assist at least 25 patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs.

Cancer Prevention and Screening Program	
Significant Health Needs Addressed	• Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Marian Cancer Care Program at both Arroyo Grande and Santa Maria campuses addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurses, social workers, certified cancer exercise trainers and registered dieticians.
Population Served	Underserved population emphasizing outreach to seniors and uninsured.
Program Goal / Anticipated Impact	The goal of the Marian Cancer program at both Arroyo Grande and Santa Maria campuses is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase of health education as well as cancer awareness, prevention activities, screenings and genetic counseling Additionally patient navigation, nutritional counseling, cancer rehabilitation and psychosocial support services.
FY 2024 Report	
Activities Summary	1. Track target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services. 2. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) receiving cancer prevention and screening services: Colonoscopy-3% (173); Prostate-3% (68); Lung-3% (1,069); Smoking Cessation-3% (201); Survivorship Care Plans-3% (201); Emmi services-3% (649). 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track the number of patients needing financial assistance to participate: Genetic Counseling-3% (224). 4. Track and describe the under/uninsured population requesting financial assistance for cancer care needs. Track the number of medically underserved patients transported for cancer care. 5. Increase by 3% (2,333) nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors).

	6. Increase the number of new patients from the target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 3% (147). Ensure at least 50% of patients who complete cancer rehabilitation are continuing to exercise 4 weeks after program completion.
Performance / Impact	1. 15,202 medically underserved cancer patients have been screened and referred to psychosocial support, nutritional counseling, nurse navigator support, social services support, and support classes this fiscal year (0.3% decrease from FY23). 2. Patients assisted with screening services this fiscal year include:11 (SM: 11/FC:0) colorectal cancer screenings with 1 new cancers being identified (90% decrease from FY23), 28 prostate cancer screening, 1 new cancer cases have been identified through screening this fiscal year (40% increase from FY23); 1,061(SM:662/FC:399) lung cancer screenings with 11 new cancer cases have been identified (7% decrease from FY23); 365 people have been referred for smoking cessations (50% decrease from FY23),631 Emmi participants (14% decrease from FY23). 3. 119 (SM:78/FC:41) under/uninsured patients were served by the genetic counseling program (38% decrease from FY23) 103 were assisted financially, totaling $30,753(SM:$21,544/FC: $9,209). 4. 167 under/uninsured patients have been provided financial assistance for cancer care needs: (38%) male; (62%) female; (52%) Hispanic; (29%) unemployed; (32%)laborers; (57%) under 60 years of age; and (17%) supporting 2 or more children. Additionally, 4,444 medically underserved patients have been transported for cancer care and another 453 (SM:385/FC:68) patients were supported with financial assistance for transportation needs, totaling $22,700 (SM:$19,300/FC: $3,400). 5. 805 (SM:720/FC:85) medically underserved patients were supported through the nutrition counseling program this fiscal year (41% decrease from FY23). 6. 123 new patients enrolled in the Cancer Rehabilitation Program this fiscal year (21% decreases from FY23). 93% of patients contacted four weeks following their cancer rehabilitation program completion reported the use of continued exercise.
Hospital's Contribution / Program Expense	MRMC provided in kind space, nutritional services, advertisement, and printing. Program Expense: $ 1,340,446

FY 2025 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-3% ; Prostate-3% ; Lung-3%; Smoking Cessation-3% ; Survivorship Care Plans-3% ; Emmi services-3% . 3. Increase the number of target population patients (under/uninsured, medically underserved Latinos and seniors) served by the genetic counseling program and track the number of patients needing financial assistance to participate: Genetic Counseling-3% . 4. Track and describe the under/uninsured population requesting financial assistance for cancer care needs. Track the number of medically underserved patients transported for cancer care. 5. Increase by 3%) nutrition counseling and education participation among target population patients (under/uninsured, medically unserved Latinos and seniors). 6. Increase the number of new patients from the target population (under/uninsured, medically underserved Latinos and seniors), enrolled in the Cancer Rehabilitation Program by 3% Ensure at least 50% of patients who complete 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.

Chronic Disease Prevention & Self-management	
Significant Health Needs Addressed	• Access to Primary 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 population emphasizing outreach to seniors.
Program Goal / Anticipated Impact	Improve the confidence level of the workshop participants in their self-management and/or prevention of their chronic disease.
FY 2024 Report	
Activities Summary	Outreach and recruitment of participants were done in various ways such as: sending electronic workshop and support group flyers to community partners, sending our electronic monthly community health newsletter to our networks,and developing a criteria workshop list in Cerner. Follow up calls were completed 1 month after participants graduated from Chronic Disease Self Management Program (CDSMP), Diabetes Education Empowerment Program (DEEP), and/or Healthy For Life (HFL).
Performance / Impact	1. 100% of the DEEP and CDSMP graduates were able to self-report that they were still practicing 2 of the workshop skills in their daily lives. The most popular skills mentioned were increasing the intake of fruits and vegetables along with walking were the two most mentioned self management skills. Self-relaxation such as prayer and meditation were also mentioned. (FY24 goal was achieved) 2. A total of 40 individuals attended the DEEP workshop which was a 7% increase from FY23.(FY24 goal was achieved) 3. 100% of the HFL graduates were able to identify 2 risk factors for heart and stroke.Most mention was obesity/overweight and family history of the disease. (FY 2024 goal was achieved.)
Hospital's Contribution / Program Expense	MRMC provided nutritional services, advertisement, and printing. Program Expense: $ 288,509

FY 2025 Plan	
Program Goal / Anticipated Impact	1. 80% of the Chronic Disease Self-Management Program (CDSMP) and Diabetes Education Empowerment Program (DEEP) participants will self-report 1 month after completion of the program 2 self-management skills that they have continued to practice. 2. Increase DEEP series class participation by 5 % from FY2023 results. (total for FY 23 was 39) 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 HFL participants at 1 month after completion of the workshop to identify 2 risk factors for heart disease, stroke, and diabetes type 1. 3. 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. 4. Track the responses of the HFL, CDSMP, and DEEP on a spreadsheet. 5. Offer four DEEP education class series with Registered Dietitian involvement. 6. Offer ongoing support through quarterly educational group meetings/lectures via ZOOM.

Community Health Improvement Grant Program	
Significant Health Needs Addressed	• Educational Attainment • Access to Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospital's health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.
Population Served	Underserved populations
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the hospital service area to "Accountable Care Community" which align with the hospital's most recent Community Health Needs Assessment report.
FY 2024 Report	
Activities Summary	A press release was sent to the media to inform the central coast of the upcoming Dignity Health Improvement Grant program. A grant criteria informational sheet was posted on the hospital website. The local grant representative facilitated any questions that came from potential applicants. The grantees were invited to present on their project's progress at the quarterly community benefit meetings. Mid-year and final reports were collected from the grantees and sent to the system office by the due date.
Performance / Impact	Nine accountable care communities were funded that help address: Education Attainment, Access to primary health care, behavioral health and oral health, and Health Promotion and Prevention.
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and $424,496 in grant money awarded to the community for the purpose of improving the quality of life of the residents of Northern Santa Barbara County and San Luis Obispo County.
FY 2025 Plan	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities : Educational Attainment, Access to Health Care, Behavioral Health, and Dental Care, Health Promotion and Prevention.
Planned Activities	1. Community Education Coordinator will work closely with agencies to form a more succinct "Accountable Care Community" (ACC) for services the hospital is unable to address itself. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes.

	3. Funded ACCs will present at Community Benefit Committee meetings.

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 2024 Report	
Activities Summary	An outreach flyer was created to increase exposure of the program throughout the central coast. The flyer was distributed electronically to community partners and hard copies were distributed to local high schools and health events. A recruitment signed letter by the CEO/Presidents of the hospitals were sent out internally and external to health care professionals asking for their participation.
Performance / Impact	1. 55 students were accepted to the mentoring program indicating a 5% increase from FY 202 48 students. 2. 60 doctors and medical assistants enrolled to participate in the mentoring program. 3. 20 nurses enrolled to participate in the mentoring program FY 2023 goal achieved.
Hospital's Contribution / Program Expense	MRMC provided in kind space, advertisement, and printing. Program Expense: $ 31,136
FY 2025 Plan	
Program Goal / Anticipated Impact	1. Increased enrollment in the program by 5% baseline for FY 2024 was 55. 2. Increased participation among medical providers by 2% baseline for FY 2024 was 80.
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.

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.

- **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.

- The **Family Medicine Residency Program**, a three-year post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), continues to excel in its mission of training and recruiting new primary care physicians for our communities. With 18 residents, the program boasts a strong academic foundation, consistently achieving a 100% board pass rate and adhering to ACGME and Osteopathic recognition standards. This commitment to excellence ensures high-quality education and program effectiveness.
  The program's leadership is strengthened by the recruitment of experienced Program Director, David Mahoney, who brings stability and expertise to guide the program's future. Furthermore, the program actively promotes diversity, equity, and inclusion through initiatives like the Medical Safe Haven Program and Underserved rotations, aligning with its mission to serve all members of our community. Partnering with institutional DEI programs further strengthens these initiatives and creates a more inclusive learning environment.

- The Marian Regional Medical Center is proud to sponsor our second **ACGME-accredited training program** in **Obstetrics and Gynecology (OB/GYN).** This four-year program, with 12 residents, plays a vital role in addressing the critical need for OB/GYN physicians nationwide. The program's graduates are highly sought after, and we are pleased to report that one of our recent graduates has chosen to stay and practice locally in Santa Maria. This brings the total number of recruited graduates to our program up to 3. The 2024 updates highlight the program's continued success and growth:

    - Faculty Expansion: The program has successfully recruited another graduate to join our faculty, further strengthening the program's expertise and mentorship opportunities for residents.
    - Accreditation Excellence: The OB/GYN program has maintained its ACGME accreditation, demonstrating its commitment to high-quality training and education.
    - Growing Patient Births: OB/GYN labor and delivery patient births have increased, reflecting the program's commitment to providing comprehensive care for expectant mothers in our community.
    - Strong Resident Recruitment: The NRMP Match in 2022 filled all three available PGY1 spots, demonstrating the program's strong reputation and attracting outstanding medical school candidates.

- 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 499 unsheltered individuals in the service area of MRMC. The Street Medicine conducts two monthly outings every month covering several homeless encampments in the community.

- The **Medical Safe Haven (MSH)** program at the Family Medicine Center at Marian Regional Medical Center, an area highly impacted by human trafficking. The MSH program creates a safe space where medical providers can offer ongoing care for victims and survivors of human trafficking, sex and/or labor, through the use of survivor-informed practices that help to minimize further trauma. In FY 2024 MSH has already touched the lives of 52 victims of human trafficking and provided over 111 clinical visits to support their physical and mental health needs.

- **Behavioral Wellness Center (Crisis Stabilization Unit)** The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.

- 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.

- Marian Regional Medical Center received a Common Spirit Health Mission and Ministry Grant for the **Mixteco Birthing Project**. The project will develop culturally appropriate strategies that will improve birth outcomes for both mother and child.

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

- **Homeless Health Initiative**:In September 2020 Marian and Arroyo Grande launched their Homeless Health Initiative program. 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, and works closely with the multi-disciplinary team on care plans for these patients. This social worker has helped to identify numerous mezzo and macro level factors that impact access to care and provision of care to patients experiencing homelessness, and has joined in community wide efforts to address homeless health needs.

- **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.

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

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

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

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Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)
For period from 07/01/2023 through 06/30/2024

	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits for Poor					
Financial Assistance	**7,792**	**$10,681,031**	**$0**	**$10,681,031**	**1.4%**
Medicaid	**117,203**	**$227,385,824**	**$248,563,864**	**$0**	**0.0%**
Community Services					
A - Community Health Improvement Services	19,831	$3,069,987	$0	$3,069,987	0.4%
E - Cash and In-Kind Contributions	3,197	$1,876,014	$0	$1,876,014	0.3%
G - Community Benefit Operations		$141,458	$0	$141,458	0.0%
Totals for Community Services	**23,028**	**$5,087,459**	**$0**	**$5,087,459**	**0.7%**
Totals for Benefits for Poor	**148,023**	**$243,154,314**	**$248,563,864**	**$15,768,490**	**2.1%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	14,746	$1,119,795	$0	$1,119,795	0.1%
B - Health Professions Education	2,035	$14,199,383	$2,148,953	$12,050,430	1.6%
D - Research		$146,435	$17,884	$128,551	0.0%
Totals for Community Services	**16,781**	**$15,465,613**	**$2,166,837**	**$13,298,776**	**1.8%**
Totals for Broader Community	**16,781**	**$15,465,613**	**$2,166,837**	**$13,298,776**	**1.8%**
Totals - Community Benefit	**164,804**	**$258,619,927**	**$250,730,701**	**$29,067,266**	**3.9%**
Medicare	**107,606**	**$180,679,671**	**$182,962,577**	**$0**	**0.0%**
Totals Including Medicare	**272,410**	**$439,299,598**	**$433,693,278**	**$29,067,266**	**3.9%**

*For the Medicaid provider fee program effective for the two-year period of January 1, 2023 - December 31, 2024, the State of California received Centers for Medicare & Medicaid Services approval in December 2023. As such, during the fiscal year July 1, 2023 - June 30, 2024, the hospital recognized provider fee net income of $69,890,289 covering 18 months dating back to January 2023. Subtracting the six months of net provider fee attributable to the prior fiscal year, FY24 Medicaid net benefit would be $2,066,587 and total community benefit including Medicare would be $31,133,853.

**Consistent with IRS instructions and Catholic Health Association guidance, Medicaid and Medicare are reported at $0 net benefit because offsetting revenue was greater than expense in FY24.

Hospital Board and Committee Rosters

Marian Regional Medical Center
Community Board Roster FY 2025

AGUILERA-HERNANDEZ, MARIBEL, Esq.
Attorney / City Public Representative

ANDERSEN, SUE
President & CEO, Marian Regional Medical Center

ALVARADO, PHIL, Chair
Retired School District Superintendent

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

CHAVEZ, LORENA
Agriculture Business Owner

DWORACZYK, MS CFP CLTC, TERRY
Wealth Advisor / Financial Planning / MRMC Foundation Board Chair

EDDS, HOLLY, EdD, Immediate Past / Executive Committee Chair
Superintendent / Educator, Orcutt School District

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

FERGUSON, KEVIN, M.D., Board Quality Committee Chair
Pathologist

FIBICH, TERRY
Retired Fire Chief

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

FROST, JUDY
Finance / Organizational Management

JUAREZ, MARIO, ESQ.
Attorney

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

McCABE, SISTER ELLEN, OSF
Religious Representative, Sisters of St. Francis

OFIEALI, IJEOMA, M.D., Secretary
Physician / Hospitalist

RAILSBACK, ROB
Insurance Agency Businessman / AGCH Foundation Board Chair

SNIDER, MARGAUX, M.D., Vice Chair
Physician / Emergency Services

STILWELL, JASON, Ph.D.
Retired City Manager, Santa Maria

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

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

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

SPRENGEL, JULIE (CommonSpirit Health Representative)
President, CommonSpirit Health, California Region

Marian Regional Medical Center

Community Benefit Committee Roster
FY 2025

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

Frost, Judy
Finance / Organizational Management

Tony Cowans
Manager Mission Integration Spiritual Care

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

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

Terry Fibich
Retired Fire Chief

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

Heidi Summers, MN RN
Market Director, Mission Integration
Central Coast Market, California

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

Patty Herrera, MS
Director, Community Health
CA Central Coast Market