Marian Regional Medical Center

2019 Community Health Implementation Strategy

Adopted October 2019

Santa Maria Campus

Arroyo Grande Campus

Dignity Health™
Marian Regional Medical Center

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At-a-Glance Summary

Community Served 	Marian Regional Medical Center serves the communities of the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434), Nipomo (93444), Arroyo Grande (93420), Grover Beach (93433), Oceano (93445), and Pismo Beach (93449) with two campus locations, Santa Maria and Arroyo Grande.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Educational attainment for adults in the community; • Access to primary health care, including behavioral health; • Aging, more mature population; and, • Chronic disease prevention and management.
Strategies and Programs to Address Needs 	The hospital intends to take several actions and to dedicate resources to these needs, including: • Educational attainment for adults in the community; o Addressed by targeted community grants program to encourage/support educational attainment in youth. • Access to primary health care, including behavioral health; o Improved outreach into the community by medical professionals targeting the most vulnerable population; o Project plan for behavioral health crisis stabilization center development. • Aging, more mature population; and, o Addressed by the community grants program; o Additional physician specializing in gerontology. • Chronic disease prevention and management o Bilingual community educational programming o Promotores de Salud o Improve community access to free screening programs
Anticipated Impact	These programs will bring medical professionals out of the hospital and clinics and into the community where they will be able to encounter the most underserved population that is least likely to access a traditional clinic or hospital. Programs will also allow the aging population to age well in place as long as possible. Educational programs will continue to provide community health education at low or no cost.
Planned Collaboration	Every program identified will engage multiple community non-governmental community organizations to execute the planned strategy/program.

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

Our Hospital and the Community Served

About Marian Regional Medical Center

Marian Regional Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health. Marian Regional Medical Center serves the community through two campuses, the Santa Maria Campus (MRMC-SM) and the Arroyo Grande Campus (MRMC-AG).

MRMC-SM 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-SM has transformed into a state-of-the-art, 191-bed facility, that is well positioned to serve a continuously growing patient population. MRMC-SM is designated a STEMI Receiving Center in Santa Barbara County, and is designated a Level III Trauma Center by Santa Barbara County's Emergency Medical Services Agency. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. Our cancer care program is accredited as a Comprehensive Community Cancer Center by the American College of Surgeons' Commission on Cancer, and is one of only three programs between Los Angeles and San Francisco to receive an Outstanding Achievement Award. The campus houses a comprehensive perinatology/ neonatology program, providing specialized care to the tiniest of patients.

Marian's Arroyo Grande campus is located at 345 South Halcyon Road in Arroyo Grande, California and is approximately 15 miles north of the Santa Maria campus. The Arroyo Grande Campus has been serving the health care needs of the Five Cities area since it became a member of Dignity Health in 2004. MRMC-AG is rated a top Joint Replacement Center by Blue Shield and among the top in the Nation for Joint Replacement, offering the latest in robotic and other technologically advanced orthopedic procedures. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. The Emergency Department is nationally recognized for superior patient satisfaction and the hospital provides the only comprehensive hospital-based Acute Rehabilitation Center on the Central Coast, offering a wide range of individualized therapies.

Our Mission

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

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

Financial Assistance for Medically Necessary Care

Marian Regional Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary and other materials are on the hospital's web site.

Description of the Community Served

The community served by Marian Regional Medical Center has a population of just over 225,000 individuals and are served through two campuses, the Santa Maria Campus (MRMC-SM) and the Marian Arroyo Grande Campus (MRMC-AG). Marian Regional Medical Center in Santa Maria serves the City of Santa Maria, Guadalupe, Nipomo, and Orcutt. The Marian Arroyo Grande campus, serves the community extending from the northern most boundary of the Santa Maria Campus service area and includes the communities of Arroyo Grande, Grover Beach, Nipomo, Oceano, and Pismo Beach. Nipomo demographic information was included in the MRMC-AG campus discussion to prevent duplication. A summary description for each community is below and additional details can be found in the CHNA report online.

Santa Maria Campus

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

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

Demographic information for the MRMC primary service area taken from © 2018 IBM Watson Health provides data on the following:

- Total Population: 176,499
- Hispanic or Latino: 61.6%
- Race: White 30.3%, Black/African American 1.2%, Asian, Pacific Islander 4.8%, Other 2.4%
- Median Income: $66,018
- Uninsured: 5.4%
- Unemployment: 4.3%
- No High School Diploma: 29.8%
- CNI Score: 4.2
- Medicaid Population*: 23.7%
  (* Does not include individuals' dually-eligible for Medicaid and Medicare)
- Other Area Hospitals: 0
- Medically Underserved Areas or Populations: Yes

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

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

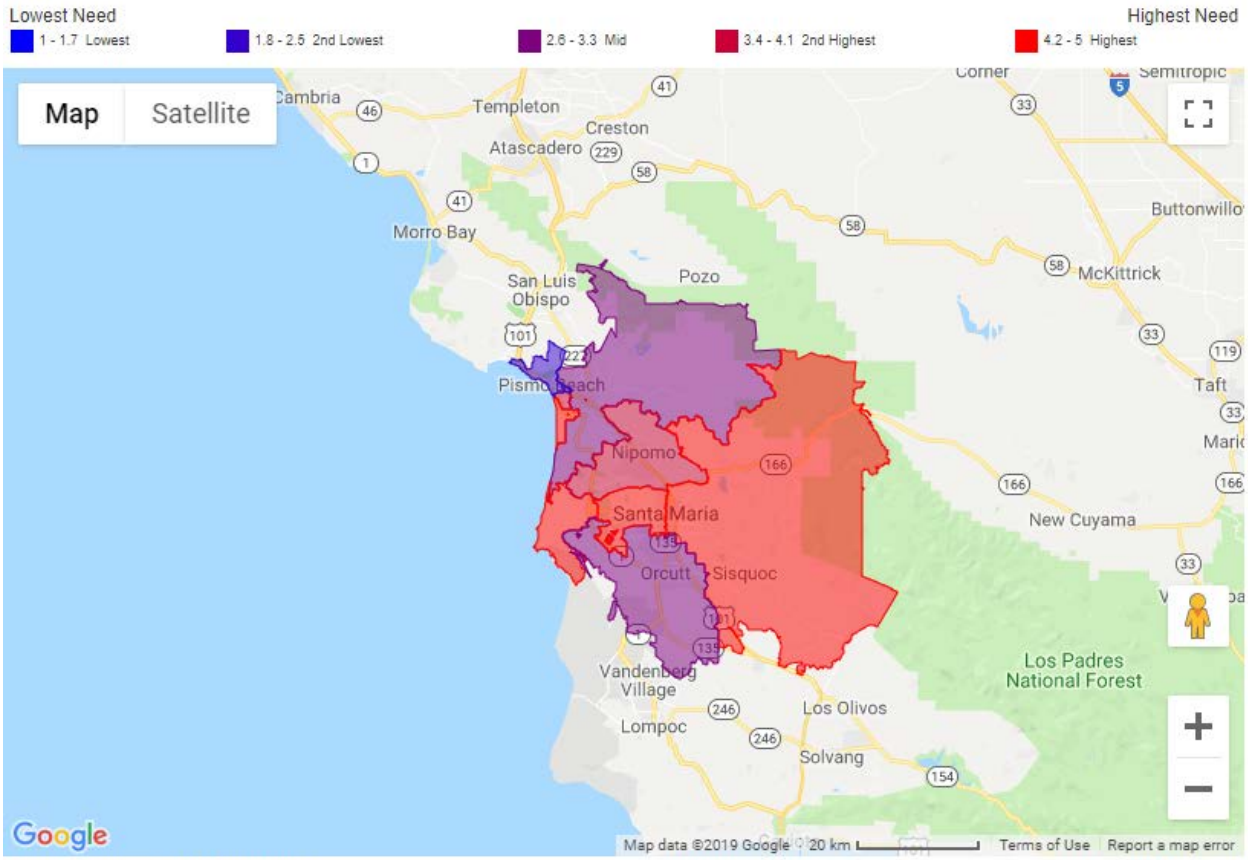
Demographic information for the MRMC-AG primary service area taken from © 2018 IBM Watson Health provides data on the following:

- Total Population: 72,455
- Hispanic or Latino: 29.4%
- Race: White 62.7%, Black/African American 0.6%, Asian, Pacific Islander 3.8%, Other 3.4%
- Median Income: $73,042
- Uninsured: 6.1%
- Unemployment: 3.3%
- No High School Diploma: 11.2%
- CNI Score: 3.5
- Medicaid Population*: 17.2%
  (*Does not include individuals' dually-eligible for Medicaid and Medicare)
- Other Area Hospitals: 0
- Medically Underserved Areas or Populations: Yes

Community Need Index

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

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



Mean(zipcode): 3.6 / Mean(person): 3.6 CNI Score Median: 3.6 CNI Score Mode: 4.2

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 health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in June 2019.

The CHNA contains several key elements, including:

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

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/central-coast/-/media/Service%20Areas/central-coast/PDFs/MRMC-SM-AG_CHNA_2019%20Final_06-07-19V4.ashx?la=en&hash=056C88232F1289B7C1351D490C8ED5A3E287B537 or upon request at the hospital's Community Health office.

Significant Health Needs

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

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

Significant Needs the Hospital Does Not Intend to Address

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

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community

health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

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

Creating the Implementation Strategy

Marian Regional Medical Center 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.

The development of this Community Health Implementation Strategy began with a review of current programs already offered by MRMC and the newly identified needs in the CHNA. Program planning for the next three years included input from members of the Community Benefit Committee, senior leadership, clinical experts, and program owners. External community organizations were also approached and discussions were held regarding collaborative efforts to address needs. Existing activities were reviewed for effectiveness, the need for continuation, or the need for enhancement. New programs have been developed and existing programs have been enhanced based upon feedback from internal and external stakeholders. Program development includes a plan for monitoring for performance and quality to find areas of improvement to facilitate their success.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need: Educational Attainment

Strategy or Program Name	Summary Description
Dignity Health Community Grants Program	Fund Accountable Care Communities (ACC) in FY2020 that support youth development programs encouraging higher education.
Formal Mixteco Interpreter Program	Providing bilingual, bicultural interpreter services to non-English speaking patients.
Anticipated Impact: Improve community capacity through advocacy, job training, and youth developmental programs, which in turn will improve community health efficacy.	
Planned Collaboration: Planned collaboration with Santa Maria Bonita and Orcutt School Districts, Herencia Indígena, MRMC Care Coordination, Social Work, ED, and Labor and Delivery departments.	

Health Need: Access to Primary Health Care, Including Behavioral Health

Strategy or Program Name	Summary Description
Dignity Health Community Grants Program	Fund ACC in FY2020 that provide access to health care, dental care, medical prescriptions, and behavioral health care.
Transitional Care Management (TCM)Program	The TCM program fosters external partnerships and community linkages to promote continuity of care.
Develop Behavioral Health Crisis Stabilization Center	Once the crisis stabilization center is open it will provide immediate outpatient services to assist patients to transition home or to the necessary next level of care.
Financial assistance programs	Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.
Family Practice Resident Outreach Program	The family medicine outreach program will provide residents at community events.
Promotores de Salud	The Promotores Community Health Outreach program utilizes a robust network of culturally competent community health workers that are members of their community, to further community health education in the community.
Emergency Department Expansion	Additional exam rooms are being added to the emergency departments at both campuses, facilitating quicker access to care. The new ED at MRMC-SM will include additional beds and a pediatric unit.

Health Need: Access to Primary Health Care, Including Behavioral Health

Street Medicine Outreach Program	A community health manager will attend a Street Medicine Training to better understand the necessary steps to develop a program.
Mental Health Crisis Intervention Program	Explore the ability to duplicate the current program in South Santa Barbara County to North County.

Anticipated Impact: Increase access to free and low cost medical care and resources to provide early detection, prevention, and management of illness. Increase smooth transitions for discharged patients by providing access to "medical homes" and pharmaceutical patient assistance programs. Develop the only behavioral health crisis stabilization center in Santa Barbara County.

Planned Collaboration: : Planned collaboration with SLO Noor free medical and dental clinics, MRMC/AGCH care coordination and social work departments, Alliance for Pharmaceutical Assess (APA Inc.), Mission Hope Cancer Center, and FHMC Community Health Department.

Health Need: Aging, More Mature Population

Strategy or Program Name	Summary Description
Dignity Health Community Grants Program	Fund Accountable Care Communities (ACC) in FY2020 that support adult based health care programs and/or a long term care solution for those seniors facing hospice.
Transitional Care Management (TCM)Program	The TCM program fosters external partnerships and community linkages to promote continuity of care.
Faith Community Nurse Program	Free program which approaches care as a "whole person" to address the spiritual, physical, mental and social health of the person in their faith community.
Financial assistance programs	Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.
Dignity Health Wellness programs	Free evidence based self-management disease workshops.

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

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

Health Need: Chronic Disease Prevention and Management

Strategy or Program Name	Summary Description
Dignity Health Wellness programs	Provide community education classes focused on evidence based self-management disease workshops.
Transitional Care Management Program	The CT program fosters external partnerships and community linkages to promote continuity of care.
Free Screening Mammogram clinics	Cancer Care program offers free screening mammograms to women who are uninsured or underinsured.
Street Medicine Outreach Program	A community health manager will attend a Street Medicine Training to better understand the necessary steps to develop a program.
Formal Mixteco Interpreter Program	Providing bilingual, bicultural interpreter services to non-English speaking patients.
Bilingual Support Groups	Free cancer, diabetes, stroke, and grief support groups will be offered.

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

Planned Collaboration: The hospital will partner with Community Clinics of the Central Coast, Pacific Central Coast Health Centers, and Santa Barbara Public Health Department, Mission Hope Cancer Center.

Program Digests

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

 **Cancer Prevention and Screenings**	
Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	Marian Cancer Care Program addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurse, social worker, certified cancer exercise trainer and registered dietician.
Community Benefit Category	A1-Community Health Improvement Services; A1-Health Care Support Services; A2 Community Based Clinical Services; E3-Financial and In-Kind Donations
Planned Actions for 2019 – 2021	
Program Goal / Anticipated Impact	The goal of the Marian Cancer program is to reduce cancer-related disparities in a largely rural and medically underserved population through the increase in participation of rehabilitation and psychosocial support services as well as cancer awareness and prevention activities, including screenings and genetic counseling.
Measurable Objective(s) with Indicator(s)	1. Increase the number of target population patient referrals (under/uninsured, medically underserved Latinos and seniors) to counseling and social support services by 5% annually (Year 1, 2, 3). 2. Increase the number of target population patients annually receiving screening services as follows: Colonoscopy-5%; Prostate-10%; Skin-10%; Lung-5%; Genetic Counseling-5% (Year 1, 2, 3) 3. Ensure at least 50 under/uninsured women annually identified as having missed an annual breast screening, return for a mammogram service (Year 1, 2, 3). 4. Increase the number of new patients from target population enrolled in the Cancer Rehabilitation Program by 5% annually. Ensure at least 80% of patients who complete the cancer rehabilitation are

Cancer Prevention and Screenings	
	continuing to exercise 4-weeks after program completion (Year 1, 2, 3). 5. Improve awareness among community youth about cancer prevention and screening for skin, lung and cervical cancers. Ensure 70% of youth reached are aware of risky behaviors link to cancer (Year 1, 2, 3). 6. Educate 20 local cosmetology and hair salon professionals about skin cancer screening and referral system (Year 1, 2, 3).
Intervention Actions for Achieving Goal	1. Maximize the use of both lay and nurse navigators to assess the psychosocial needs of each patient via the Distress Screening Tool, refer as needed to available psychosocial support services. 2. Provide cancer prevention and screening information through counseling and support services, outreach events, social media platforms, radio and print material. 3. Provide the necessary financial support and/or transport to medically underserved patients in need of assistance. 4. Continue to utilize the support of the lay patient navigator and dietitian to educate participants in medically underserved communities on healthy behaviors that can assist in cancer prevention, mitigating cancer symptoms and decrease the incidence of chronic illness. Encourage target population patients to seek further support through one-on-one nutrition counseling. 5. Coordinate with Marian Residency Program and Radiology Department to develop a breast cancer outreach strategy that removes identified barriers and provides access for under/uninsured women who have not returned for annual mammogram screenings.
Planned Collaboration	Community Health Centers of the Central Coast, SLO Noor Free Clinic, Community Action Partnership of San Luis Obispo County, Santa Barbara and San Luis Obispo County Health Department, Catholic Charities, The Cecilia Fund, Okerblom Clinic, Area Agency on Aging, Teddy Bear Foundation, Wisdom Center, Community Partners in Caring, local Latino barber shops and beauty parlors, local Latino markets and laundry mats, Employment Development Department (EDD) Santa Maria, *El Show de La Revista OKEY* Magazine, *La Buena* Radio, local ranches/ wineries, California Farm Labor Contractors, St John's Newman Church, St Joseph's Church, St Mary's Church, Sunny Country Radio, Every Woman Counts (EWC) program, Jack Helping Hand, Alan Hancock Community College, Lucia Mar Unified School District, Bonipak Produce and New Tech High School.

Cardiovascular Disease and Stroke

Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ☒ Aging, More Mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	The cardiovascular disease and stroke program at MRMC will provide risk assessments and education to community members to improve their health self-efficacy and facilitate medical follow-up for any identified risk factors.
Community Benefit Category	A1-Community Health Education-Lectures; A2- Community Based Clinical Services;

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase cardio/stroke screening by 5% at target population health fair events (Year 1, 2, 3). 2. 80% of the participants deemed at-risk and identified with no primary care provider, and/or become aware for the first time they have an elevated blood pressure reading will self-report at 3 months appropriate lifestyle changes (Year 1, 2, 3). 3. Increase number of participants in the Healthier Living and the Diabetes Empowerment Education Program (DEEP) by 5% annually (Year 1, 2, 3). 4. Provide 4 FAST Friday events for target populations (Spanish and elderly) (Year 1, 2, 3). 5. Present Explaining Stroke 101 class twice annually, increasing 50% Year 1, 33% Year 2, 25% Year 3 to an elderly population.
Intervention Actions for Achieving Goal	1. All screened participants will be referred to all Dignity Health Wellness Programs. 2. At-risk individuals will be provided appropriate education, referrals, and follow-up and will be placed on a 3 month follow up call list. 3. At –risk individuals will self-report lifestyle modification at their 3 month follow up call. 4. Maximize usage of current referral pipelines to increase enrollment in the Healthier Living and DEEP workshops.
Planned Collaboration	Dignity Health Hospital Departments: Cardiovascular, Stroke and Community Education. Local partners will be invited to community health fair events.

Care Transitions

Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	The Care Transitions (CT) program provides consistent telephonic patient follow-up and education thereby decreasing the number of participant admissions to the hospital focusing on COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure. The CT program fosters external partnerships and community linkages to promote continuity of care.
Community Benefit Category	A3-Health Care Support Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	The CT program provides consistent telephonic patient follow-up and education to better help participants manage their COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure. Program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage.
Measurable Objective(s) with Indicator(s)	1. 95% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis (Year 1, 2, 3) 2. 95% of participants enrolled in the program will self-report that they keep follow-up appointments with their physician(s) on an ongoing basis (Year 1, 2, 3). . 3. Utilizing available communication tools (Octavia) send at least 50% of patients not enrolled in the CT program to community education for ongoing support (Year 1, 2, and 3). 4. 70% of CT participants referred to community education will complete at least one program, increasing 5% annually, and 5% will register for ongoing programs, increasing to 10% by year 3 (Year 1, 2, 3). 5. Assess participants' for social determinant needs and refer to community programs including social support, health literacy, and food and housing security.
Intervention Actions for Achieving Goal	1. Patients referred to Care Transitions (CT) from hospital discharge will be called to enroll into the program and nurse will identify any problems or symptoms they may have and intervene with education and medication reconciliation.

Care Transitions	
	2. CT will utilize Medical Social Worker support by phone or home visit to assist with patient barriers to success with their plan of care. 3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their meds. 4. Identify patients who are having difficulty with physician follow up and assist in locating MD and getting appointments. 5. Provide information to patients and their caregivers on home safety, Family Caregiver Program, community based palliative care program, medication and disease information specific to their needs and identify those needing support.
Planned Collaboration	Planned collaboration with Dignity Heath's Home Health, Care Coordination, Care Transitions, Social Work, Family Service Agencies, and Meals on Wheels, SB Foodbank, APA Inc., and Area on Aging Agency.

Diabetes Prevention and Self-Management

Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	Provide a comprehensive evidence-based diabetes management program for the American Diabetes Association recognized program, providing education with registered dietitian and nurse specializing in diabetes management. The program will improve behavior and self-management practices of diabetic patients; enhance and improve the access and delivery of effective preventive health care services
Community Benefit Category	A1-Community Health Improvement Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	The program will improve behavior and self-management practices of diabetic participants; enhance and improve the access and delivery of effective preventive health care services
Measurable Objective(s) with Indicator(s)	1. Increase pre-diabetes education visits offered thru Diabetes Empowerment Education Program (DEEP) classes, diabetes support groups and, physician referrals by 3% annually (Year 1, 2, 3). 2. Increase Diabetes Support group attendance by 2.5% annually (Year 1, 2, 3). 3. All participants' will self-report progress on blood sugar monitoring, weight maintenance, and medication management (Year 1, 2, 3).
Intervention Actions for Achieving Goal	1. Participate in four Community Health events for seniors/underserved populations, providing diabetes education, prevention information and programs available through center. 2. Identify pre-diabetes population in need of individual education and counseling as well as classes available on management of diabetes available from DEEP classes, community outreach, diabetes support groups, physician referrals, Octavia and, recent hospitalizations. 3. Invite and educate community about English and Spanish Diabetes Support groups available at community events, physician offices / clinics, and lab clinics. 4. Identify diabetes individuals in need of individual nutritional and/or diabetes nursing education from DEEP classes, community outreach, diabetes support groups, physician referrals and, recent hospitalizations.
Planned Collaboration	Internal Dignity Health Departments, Alliance of Pharmaceutical Access, Pacific Central Coast Health Centers, CHCCC.

Dignity Health Community Grants Program

Significant Health Needs Addressed	☒ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospitals health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.
Community Benefit Category	E2-Cash and In-Kind Contributions

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in MRMCs service area to "Accountable Care Community" who serve areas aligning with MRMC's CHNA.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year (Year 1, 2, 3). 2. Build richer ACC that are focused on multiple significant health needs (Year 1, 2, 3). 3. 100% of funded ACC will update local community benefit committees on their project (Year 1, 2, 3). 4. 100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained (Year 1, 2, 3).
Intervention Actions for Achieving Goal	1. 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 ACC to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACC will present at Community Benefit Committee meetings.
Planned Collaboration	SLO Noor Foundation, Community Counseling Center, Transitions Mental Health Association, and other community organization addressing the community health needs.

Pacific Central Coast Health Centers

Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	The Pacific Central Coast Health Centers (PHC) ensures access to quality primary health care for the residents of Santa Barbara County and San Luis Obispo County. PHC will address health disparities for all individuals regardless of age and socioeconomic status.
Community Benefit Category	C3-Hospital Outpatient Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Increase healthcare access by providing free health screenings and appropriate health care community referrals.
Measurable Objective(s) with Indicator(s)	1. PHC will refer all patients that present with a diagnosis of Diabetes or Obesity with a BMI greater than 28 to the following programs: CDSMP Self-Management Program DEEP (Diabetes Empowerment Education Program Healthy for Life Wellness Program (HLW) (Year 1, 2, 3) 2. Increase blood pressure screenings and random glucose testing by 5 % annually at all Community Outreach Events that PHC participates (Year 1, 2, 3). 3. Participate in ten Community Outreach Events annually (Year 1, 2, 3). 4. Increase free flu shots by 5% for each flu season (Year 1, 2, 3). 5. Provide free sports physicals and health screenings for local high schools students (Year 1, 2, 3). 6. PHC will attend the annual Homeless Outreach event, targeted to homeless vets, and provide health screenings and resource referrals. 7. Explore a Walk with the Doc Program for success in provider- patient relationships and improved healthy lifestyles within our communities. Identify three program champions for each community (Year 1, 2, 3). Hold one event and evaluate.
Intervention Actions for Achieving Goal	1. Utilize data from Electronic Health Care System (Cerner) to identify poorly controlled diabetic patients to ensure proper referral is made. Explore opportunities within Cerner to capture referrals made to Community Resources. This information will allow us to partner with Marian Regional Medical Center and other outside non-profits to provide education.

Pacific Central Coast Health Centers	
	2. Utilize data from Cerner to create a workflow to identify patients with a >BMI of 28 and ensure proper referrals are provided. 3. Continue partnership with outside non-profit organizations to provide diabetic education workshop. 4. Partner with local community organizations to identify flu vaccine outreach opportunities 5. Work with Community Partners to establish an Annual Homeless Outreach Event. 6. Work with Community Partners to determine opportunity and resources available for Mental Health and Substance Abuse issues in our community. 7. Collaborate with Physician Leadership to develop a sustainable Walk with the Doc Program. 8. PHC will continue to work with Community Partners to collaborate on Mental Health Services and Outreach.
Planned Collaboration	Dignity Health Community Education Center, Dignity Health Diabetic Center, Local School Districts, Special Olympics, Scouts of America, SB County Mental Health Services, SLO Behavioral Health Services, Community Homeless Shelters, Veterans Administration, Salvation Army and Community Health Clinics

Perinatal Mood and Anxiety Disorders

Significant Health Needs Addressed	❑ Educational Attainment ☒ Access to Healthcare, including Behavioral Health ❑ Aging, More mature Population ❑ Chronic Disease Prevention and Management, including Cancer
Program Description	Improve screening and treatment for Perinatal Mood and Anxiety Disorder (PMAD) by engaging pediatricians, obstetricians, mother's primary care providers, community-based organizations, and other key stakeholders in health care to address the link between maternal and child health
Community Benefit Category	A1-Community Health; A2-Community-Based Clinical Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Educate new mothers that postpartum depression as a common part of postpartum recovery to lessen the stigma associated with seeking care.
Measurable Objective(s) with Indicator(s)	1. Provide 150 pregnant and postpartum Spanish and Mixteco moms with PMAD education to reduce the stigma of mental health annually (Year 1, 2, 3). 2. Increase attendance by 5% annually in monthly Spanish support groups (Year 1, 2, 3). 3. Connect at least 40 mothers annually to the appropriate community resources (Year 1, 2, 3).
Intervention Actions for Achieving Goal	1. Spanish and Mixteco speaking postpartum moms will be contacted and invited to participate in Cambio de Vida con un Bebé; our culturally sensitive program about postpartum depression. 2. Following completion of Cambio de Vida con un Bebé, the attendees will be invited to participate in monthly support groups. 3. Provide education to Spanish moms on the use of 211.
Planned Collaboration	Santa Barbara County Public Health Dept.; SBC Promotores Coalition; Behavioral Wellness, PMAD Stakeholders Group

Hospital Board and Committee Rosters

Marian Regional Medical Center
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Community Educator/Administrator, Ret.

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Dentist

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Superintendent, Orcutt Union School District

Michael Bouquet
Businessman
Business Manager, Toyota of Santa Maria

Julie Coleman
Philanthropist / Chair, Arroyo Grande
Community Hospital Foundation Board

Raynee Daley, EdD
Retired Educator, School District Superintendent

Sister Pius Fahlstrom, OSF
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Sisters of St. Francis

Kevin Ferguson, MD (Secretary)
Physician / Pathologist

Terry Fibich
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Attorney / Community Leader
Frederick Law Firm

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Senior Vice President, Operations
Dignity Health

Kenneth R. Dalebout
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Dignity Health Central Coast

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Health Services Operations

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Vice President, Mission Integration

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

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

Marian Regional Medical Center
Community Benefit Committee FY2019

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Physician Advisor
Case Management & Utilization Review

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Hospital Community Board Member

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Senior Regional Director, Cancer Services

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

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Anne Rigali
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Elizabeth Snyder, MHA
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Superintendent Orcutt School District

Patty Herrera MS
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