

2025 Community Health Implementation Strategy and Plan

Adopted October 2025






**Marian Regional Medical Center
Arroyo Grande Community Hospital**



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At-a-Glance Summary

<p>Community Served</p> 	<p>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). The service area covers portions of both Santa Barbara and San Luis Obispo Counties in California.</p>
<p>Significant Community Health Needs Being Addressed</p> 	<p>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).</p> <p>Needs the Hospital intends to address with strategies and programs are:</p> <ul style="list-style-type: none"> • Priority 1: Culturally sensitive and accepting healthcare • Priority 2: Readily available healthcare and navigation assistance in patients' spoken language • Priority 3: Unmet Vital Conditions • Priority 4: Access to Improved Behavioral Health including substance use disorder treatment and navigation of services
<p>Strategies and Programs to Address Needs</p> 	<p>The Hospital intends to take several actions and to dedicate resources to these needs, including:</p> <p><i>Priority 1:</i></p> <ul style="list-style-type: none"> • Colibrí Project: Cultural Awareness Training • Schwartz Rounds • Peer to Peer Support • Healthcare Humility Series <p><i>Priority 2:</i></p> <ul style="list-style-type: none"> • Heritage Language Identifier Tool • Dignity Health Interpreter Certification Program • Mixteco Interpreters <p><i>Priority 3:</i></p> <ul style="list-style-type: none"> • Community Health Improvement Grant Program • Financial assistance programs <p><i>Priority 4:</i></p> <ul style="list-style-type: none"> • Behavioral Wellness Support Groups • Behavioral Wellness Center (Crisis Stabilization Unit) • Community Health Improvement Grant Program • Substance Use Navigation Program

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the “Strategies and Program Activities by Health Need” section of the document.

This document is publicly available online at the Hospital's website. Written comments on this strategy and plan can be submitted to the hospital Manager of Community Health at 1400 E. Church Street, Santa Maria, CA 93454 or by e-mail to CHNA-CCSAN@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

Marian Regional Medical Center is a member of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America. Marian Regional Medical Center (“the Hospital”) is located at 1400 East Church Street in Santa Maria, Santa Barbara County, California. The Hospital also operates a second facility 17 miles to the north under the same hospital license, Arroyo Grande Community Hospital. Arroyo Grande Community Hospital is located at 345 South Halcyon Road in Arroyo Grande, San Luis Obispo County, California.

Marian Regional Medical Center is a state-of-the-art, 191-bed medical center located in Santa Maria, California. The modern facility is home to a broad array of services including a Level II trauma center, a Level III neonatal intensive care unit, a nationally recognized cardiac care center, and the Central Coast’s only Comprehensive Community Cancer Program as recognized by the Commission on Cancer.

Arroyo Grande Community Hospital is a 67-bed hospital offering health care services to Central Coast residents. The Hospital operates the busiest Emergency Department in South San Luis Obispo County and houses the only Acute Rehabilitation Center in San Luis Obispo County offering a wide range of individualized therapies. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients.

Both facilities have been recognized for quality and patient safety and have received an “A” grade in hospital safety from the Leapfrog Group.

Our Mission

The Hospital’s dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

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

The Hospital serves approximately 234,000 individuals from the urban and rural areas of northern Santa Barbara County and southern San Luis Obispo County, California. According to the U.S. Census, the overall community served by both facilities of the Hospital is home to 234,668 residents. A summary description of the community is below, and additional details can be found in the CHNA report online.

The community served by the Hospital primarily resides within the incorporated areas of Orcutt, Santa Maria, Guadalupe, Nipomo, Arroyo Grande, Grover Beach, Oceano, and Pismo Beach. The community served by the Hospital includes the following zip codes and are shown on Figure 1:

Santa Barbara County

- 93434 (Guadalupe)
- 93454 (Santa Maria)
- 93455 (Santa Maria and Orcutt)
- 93458 (Santa Maria)

San Luis Obispo County

- 93420 (Arroyo Grande)
- 93433 (Grover Beach)
- 93444 (Nipomo)
- 93445 (Oceano)
- 93449 (Pismo Beach)



Figure 1. Communities Served by the Hospital

According to the American Community Survey (2019-2023, 5-year Estimates), the overall community served by both facilities of the Hospital is home to 234,668 residents. The community is ethnically diverse with over half (56%) of the residents identifying as Hispanic or Latino(a) origin, and approximately one-third (36%) consider themselves White alone, not Hispanic or Latino(a). The remaining community members either identify as Asian (4%), two or more races (3%), or members of the Black community (1%). Nearly half (113,771) of the community served by the Hospital are members of Medi-Cal.

The Hospital serves the City of Santa Maria which has approximately 110,000 residents, of which 79.3% of the population identify themselves as Hispanic or Latino(a). Comparing Santa Maria to all U.S. cities with populations over 100,000, it has the 8th highest proportion of Hispanic or Latino(a) residents.

The Hospital supports two distinct communities: approximately two-thirds of the community reside in Santa Barbara County (153,637 individuals) and commonly utilizes Marian Regional Medical Center, and one-third of the community resides in southern San Luis Obispo County (81,031 individuals), and frequents Arroyo Grande Community Hospital.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

- Description of the community assessed consistent with the hospital's service area;
- Description of the assessment process and methods;
- Data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

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 or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Culturally sensitive and accepting healthcare trusted by the community.	Provide health care services that acknowledge the patient's culture and traditions to enhance trust among provider and patient.	•

Significant Health Need	Description	Intend to Address?
Readily available healthcare and navigation assistance in patients' spoken language.	Provide interpretation services, forms and literature in the patient's preferred language.	•
Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare.	Barriers to basic needs can affect an individual's health in all aspects: body, mind, and spirit.	•
Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.	Developing low barrier criteria to behavioral health and substance abuse disorder treatments to the most neediest.	•

2025 Implementation Strategy and Plan

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, including resources for and anticipated impacts of these activities.

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 Implementation Strategy

The Hospital is dedicated to improving community health and delivering community benefits with the engagement of its staff, clinicians and board, and in collaboration with community partners.

Hospital and health system participants included in creating this implementation strategy and/or will help in the delivering of the 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 implementation strategy included members from the Community Benefit Committee, senior leadership, clinical experts and program owners

met to evaluate the existing programs and develop new programs. Collaboration with community partners also led to improved program design, best practices, and effective intervention.

The programs and initiatives described here were selected on the basis of the current 2025 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 Central Coast Community Benefit Committee, Dignity Health California Region Central Coast Hospitals Leadership Team and their Community Board, and the national CommonSpirit Health community health system office (Dignity Health) receive regular program updates.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. 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.



- **Core Strategy 1:** Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2:** Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3:** Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio¹ to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen “vital conditions” or provide “urgent services,” both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?

These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?

These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

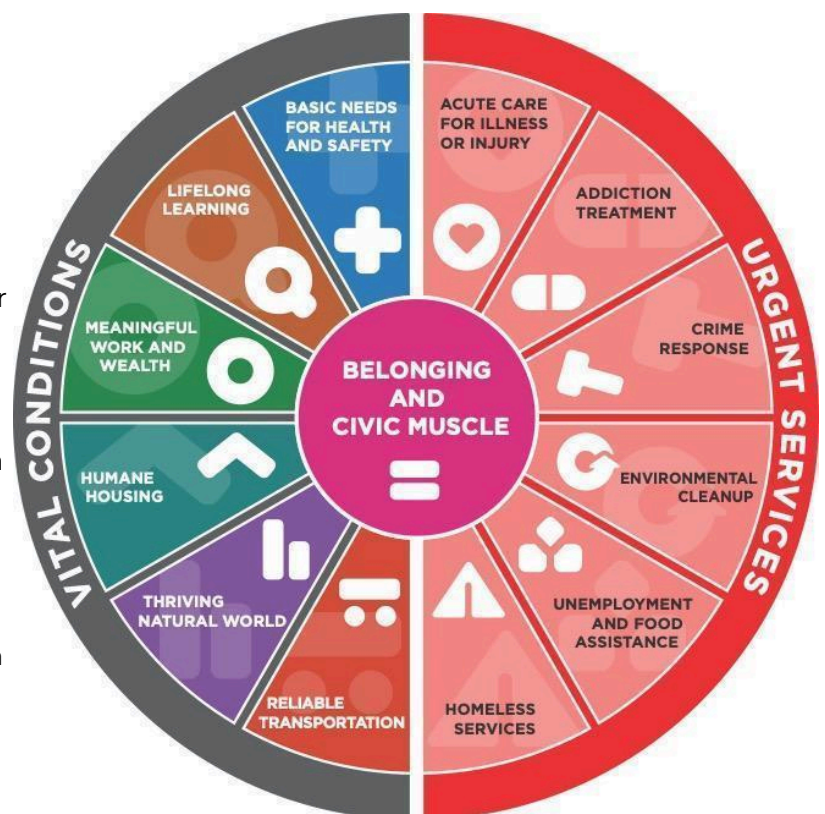
What is Belonging and Civic Muscle?

This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan

The hospital’s planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.



¹ The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit <https://rippel.org/vital-conditions/> to learn more.

Strategies and Program Activities by Health Need

Health Need No. 1:	Culturally sensitive and accepting health care trusted by the community.				
Population(s) of Focus:	MRMC Most Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Colibrí Project: Cultural Awareness Training	Training will equip clinicians with: <ul style="list-style-type: none"> • Cultural knowledge and tools to be utilized when caring for our non-English speaking population; • Increase patient-provider trust; and, • Decrease moral distress in caregiver staff that occurs when medically necessary options are declined. 		•	•	VC: Lifelong Learning and Meaningful Work and Wealth US: Acute Care for Illness or Injury = Belonging & Civic Muscle
Schwartz Rounds	Schwartz Rounds provides a regular open forum to discuss the psychosocial and emotional aspects of working in healthcare and will provide an opportunity for caregivers to: <ul style="list-style-type: none"> • Appreciate the roles and contributions of colleagues from different disciplines; • Decrease feelings of stress and isolation, • Increase insight into the social and emotional aspects of patient care, and • Increase feelings of compassion. 		•	•	VC: Lifelong Learning and Meaningful Work and Wealth US: Acute Care for Illness or Injury = Belonging & Civic Muscle

Health Need No. 1:	Culturally sensitive and accepting health care trusted by the community.				
Peer to Peer Support	A peer to peer support program for staff to decrease anxiety, depression, stress, and burnout.		•	•	VC: Lifelong Learning and Meaningful Work and Wealth = Belonging & Civic Muscle
Healthcare Humility Series	A series to increase awareness and cultural humility about the different subpopulations that exist in the community.			•	VC: Lifelong Learning = Belonging & Civic Muscle
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Herencia Indígena, Marian Residency Program, MPMC Mission, hospital administration, and other hospital departments.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To improve patient trust, health outcomes and healthcare experiences by sharing cultural, historical and language differences when serving the community.	<ul style="list-style-type: none"> 80% of the Colibrí Project training attendees will be able to identify 2 cultural norms on their post survey Schwartz Round self-assessments indicate growth or improvement 	<ul style="list-style-type: none"> Pre & post test results; Self-reflective evaluation; and, Tracking of participation in Peer to Peer Support

Health Need No. 2:	Readily available health care and navigation assistance in patients' spoken language.				
Population(s) of Focus:	MRMC Most Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Heritage Language Identifier Tool	A map that can be used to pinpoint the area where the patient is from to match them with the correct interpreter.			●	VC: Basic Needs for Health and Safety US: Acute Care for Illness or Injury = Belonging & Civic Muscle
Dignity Health Interpreter Certification Program	Program that certifies bilingual staff who pass a written and oral exam to provide interpreter services to patients with limited English proficiency.			●	VC: Basic Needs for Health and Safety US: Acute Care for Illness or Injury = Belonging & Civic Muscle

Health Need No. 2:	Readily available health care and navigation assistance in patients' spoken language.				
Mixteco Interpreters	Herencia Indígena provides Mixteco interpreters both in the hospital and within the outpatient setting. The program also provides advocacy and navigation services for social/basic needs.	•		•	VC: Basic Needs for Health and Safety US: Acute Care for Illness or Injury = Belonging & Civic Muscle
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Hospital Administration, all hospital departments, and Pacific Central Coast Health Centers				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To improve patient communication between healthcare team and patient to enhance health outcomes and healthcare experiences.	<ul style="list-style-type: none"> 40% hospital patient interfacing staff will report that they use the language Identifier tool as a resource. The number of staff that are certified to provide interpreter services will increase by 25% from baseline. 	<ul style="list-style-type: none"> Tracking of hospital departments and staff using the language identifier tool Interpreter certification tracking

Health Need No. 3:	Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare.				
Population(s) of Focus:	MRMC Most Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Community Health Improvement Grant Program	Fund projects whose goal is to meet the vital condition(s) of: <ul style="list-style-type: none"> • Basic needs, • Housing, • Transportation, and • Childcare. 	•		•	VC: Basic Needs for Health and Safety, Humane Housing, and Reliable Transportation US: Homeless Services, Unemployment and Food Assistance, and Addiction Treatment
Financial Assistance Programs	<ul style="list-style-type: none"> • Financial assistance programs are offered to medically underserved individuals to cover basic needs, hospital bills, transportation vouchers, and hotel vouchers. • The Mission Hope Cancer Center Basic Needs program provides financial assistance for basic needs (mortgage payment assistance, rent, gas cards) to community members affected by cancer. 	•		•	VC: Basic Needs for Health and Safety, Humane Housing, and Reliable Transportation US: Homeless Services

Health Need No. 3:	Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare.
Planned Resources:	The hospital will provide financial assistance, registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.
Planned Collaborators:	Not for profit community partners, hospital care coordination team, transition care center, Mission Hope, Hearst Cancer Resource Center and Pacific Central Coast Health Centers.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To help address the unmet vital conditions among the most marginalized community members.	<ul style="list-style-type: none"> Community Grant awardee reporting metrics Provide assistance to the most vulnerable community members as the need presents 	<ul style="list-style-type: none"> List of annual Community Grant awardees and projects Community benefit reporting

Health Need No. 4:	Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.				
Population(s) of Focus:	MRMC Most Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	Strategy 2: Evidence- informed	Strategy 3: Community capacity	Vital Condition (VC) or Urgent Service (US)
Behavioral Wellness Support Groups	Community support groups that provide mental health support to families and individuals that are impacted by: <ul style="list-style-type: none"> • Perinatal mood and anxiety disorder (PMAD), • Diabetes, and • Other chronic illnesses. 	•	•	•	VC: Basic Needs for Health and Safety, and Lifelong Learning US: Acute Care for Illness or Injury =Belonging & Civic Muscle,
Behavioral Wellness Center (Crisis Stabilization Unit)	The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.		•	•	VC: Basic Needs for Health & Safety US: Acute Care for Illness or Injury
Community Health Improvement Grant Program	Fund projects whose goals are: <ul style="list-style-type: none"> • To improve behavioral health; • Offer substance use disorder treatment; and • Navigation services. 	•	•	•	US: Acute Care for Illness or Injury, Addiction Treatment, and Homeless Services

Health Need No. 4:	Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.				
Substance Use Navigation Program	A dedicated social worker assists patients presenting with Substance Use Disorder (SUD) to link with appropriate resources.	•	•	•	US: Acute Care for Illness or Injury, Addiction Treatment, and Homeless Services
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Hospital care coordination team, transition care center, behavioral wellness team, community health department, community homeless service providers, community substance use providers, and community mental health providers				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve access to behavioral health, substance use disorder treatments, and implementation of navigation services.	<ul style="list-style-type: none"> • Increase attendance by 5% at support groups • Improve self efficacy score by 5% between pre- and post assessments for Behavioral Wellness Support 	<ul style="list-style-type: none"> • Support groups attendance logs • List of 2026 Community Grant awardees • Behavioral Wellness Support Groups pre- and post test results

Program Highlights

Since 1940, MRMC has been living the Franciscan mission daily by providing excellent healthcare for the patients in our community, especially the poor and disenfranchised. The following paragraphs are a few examples of MRMC's commitment to improving community health, especially for the vulnerable, while advancing social justice for all.

Another program that aims to meet the unmet healthcare needs within Mixteco indigenous communities is Building Health Bridges: Empowerment through Collaboration. Supported by grant funding from Dignity Health, the Sisters of St. Francis have delivered vital healthcare services to uninsured indigenous communities in southern Mexico and in 2022, they established a health clinic in Palenque. The new program will collaborate with the MRMC Residency Program to bolster existing medical missions and clinic services and support the creation of a women's health education program designed with people speaking the Ch'ol and Tzeltal languages most common to the area. Then in Santa Maria, the MRMC Residency Program will leverage insights and inspiration gained from rural indigenous villages to collaborate with Herencia Indígena, the LA County Department of Public Health's doula training program, and the Santa Maria Valley Doula Collective.

The MRMC Community Health Department and Marian Family Residency Program continue to expand their Street Medicine Program to the AGCH Community. The Street Medicine Program provides very basic health and basic needs assessments to unsheltered individuals in the MRMC and AGCH community.

The Substance Use Navigation Program focuses on providing increased support to patients presenting with Substance Use Disorders through a dedicated social worker. The primary goal of the provider is to provide assessment, intervention, and support following hospital discharge, but also to link to appropriate resources with the flexibility to follow patients post-acutely as needed.

MRMC and AGCH also engage in a variety of essential community building activities as a means to further the mission of advocacy, partnership, and collaboration. Activities include executive, system leadership and staff involvement in community boards such as Santa Maria Boys and Girls Club, Area Agency on Aging, YMCA of Santa Maria Valley, Community Partners in Care, 1st Five Advisory Board, Live Well Santa Barbara County, Active Aging Committee, CALM, Santa Barbara County Education Office's Promotoras Coalition, Children & Family Resource Services, Family Service Agency, Santa Barbara County Human Trafficking Task Force, and The Salvation Army.

