Marian Regional Medical Center

2022 Community Health Implementation Strategy

Adopted November 2022

Dignity Health
Marian Regional Medical Center

Table of Contents

At-a-Glance Summary

Community Served	Marian Regional Medical Center and Arroyo Grande Community Hospital serve the communities of the City of Santa Maria (93454, 93455, and 93458), Orcutt (93455), Guadalupe (93434), Nipomo (93444), Arroyo Grande (93420), Grover Beach (93433), Oceano (93445), and Pismo Beach (93449).
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 • Access to primary health care, behavioral health, and dental health • Health promotion and prevention

Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including:
	• Educational attainment
	  ○ Expanded physician mentoring program for local high school students
	  ○ Health professions education
	• Access to primary health care, behavioral health, and dental health
	  ○ Multiple community health outreach programs providing free preventative screenings, support groups, and community health education
	  ○ Substance use navigation program and a street medicine program for unsheltered individuals
	• Health promotion and prevention
	  ○ Multiple community health outreach programs providing free preventative screenings, support groups, and community health education

Anticipated Impact	The strategies and programs described in this report will promote future opportunity in the healthcare field for high school and young adults residing in the community. The programs will bring medical professionals out of the hospital and into the community, where they will be able to encounter the most underserved populations that are least likely to access a traditional clinic or hospital, meeting the community where they are most comfortable. 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 organizations to execute the planned strategy/program such as: Marian Family Medicine Residency Program, SLO Noor free medical and dental clinics, MRMC/AGCH care coordination and social work departments, Alliance for Pharmaceutical Access (APA Inc.), Mission Hope Cancer Center, Hearst Cancer Resource Center, Pacific Central Coast Health Centers, MRMC Community Health Department, Herencia Indígena, Santa Maria Valley Fighting Back, Santa Barbara County Drug and Alcohol, Good Samaritan Shelter, San Luis County Drug and Alcohol, Transitions Mental Health, Community Counseling Center, Community Health Centers of the Central Coast and Tally Farms.

This document is publicly available online at the hospital's website. Written comments on this report can be submitted to Marian Regional Medical Center's Mission Integration Office at 1400 E. Church Street, Santa Maria, CA 93454 or by e-mail to CHNA-CCSAN@DignityHealth.org

Our Hospital and the Community Served

About the Hospital

Marian Regional Medical Center and Arroyo Grande Community Hospital are part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America.

Marian Regional Medical Center (MRMC) is located at 1400 East Church Street in Santa Maria, California, and is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Between 1940 and present day, MRMC has transformed into a state-of-the-art, 191-bed facility that is well positioned to serve a continuously growing patient population. MRMC is designated a STEMI Receiving Center in Santa Barbara County, and is designated a Level III Trauma Center by Santa Barbara County's Emergency Medical Services Agency. The facility has achieved prestigious designation as a Primary Stroke Center by the Joint Commission for advanced, comprehensive care for stroke patients. Our cancer care program is accredited as a Comprehensive Community Cancer Center by the American College of Surgeons' Commission on Cancer. The campus houses a comprehensive perinatology/ neonatology program, providing specialized care to the tiniest of patients. Marian Regional Medical Center is proud to announce that the hospital's inaugural class of Obstetrics and Gynecology (OB-GYN) Residency Program physicians graduated in June 2022.

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. 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. AGCH is home to an Acute Rehabilitation Center that 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.

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.

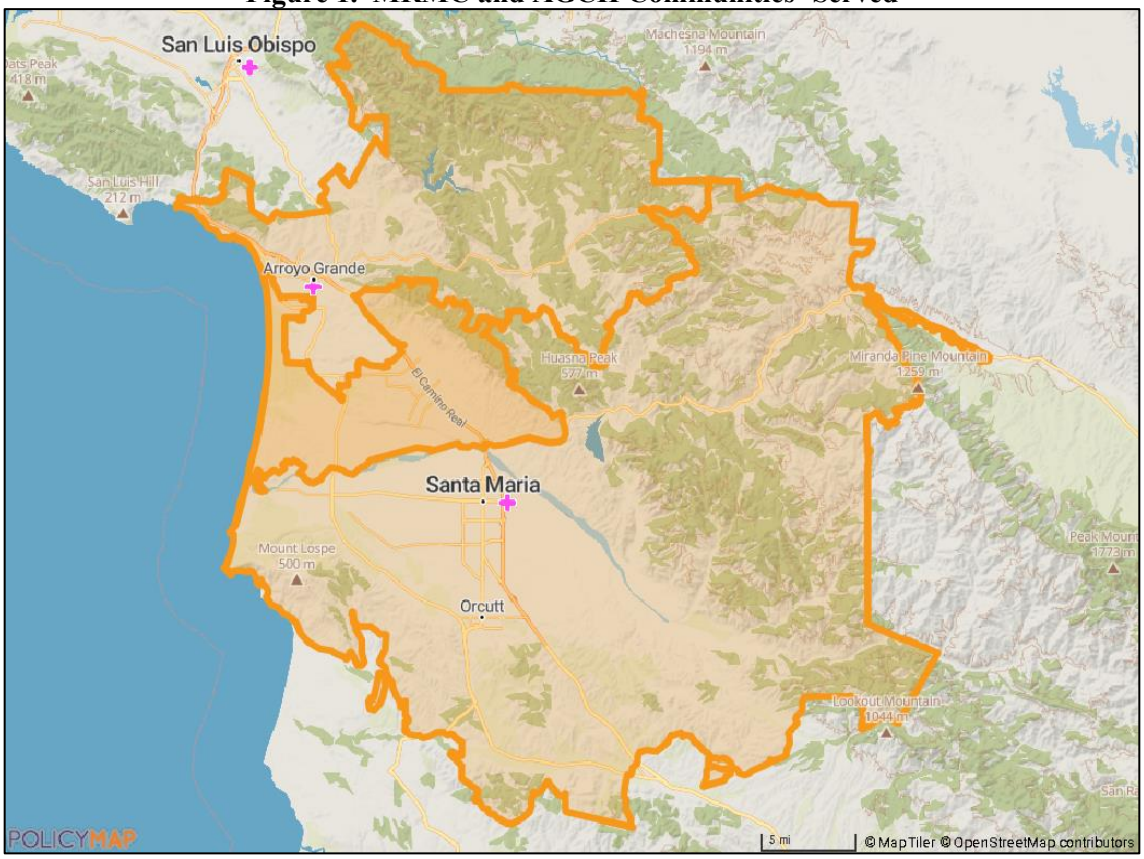
Financial Assistance for Medically Necessary Care

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 hospitals serve an aggregate community that encompasses all residents of northern Santa Barbara County and southern San Luis Obispo County, CA. The community served by the hospitals is home to over 231,000 individuals residing in Santa Maria, Guadalupe, Nipomo, Orcutt, Arroyo Grande, Grover Beach, Oceano, and Pismo Beach, CA. A summary description of the community is below, and additional details can be found in the CHNA report online. The geographic area of the communities served by FHMC are shown on the following Figure 1.

Figure 1. MRMC and AGCH Communities' Served



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). MRMC community is home to 150,072 residents, with the majority (73%) residing within Santa Maria City. The MRMC community is a culturally diverse area with the majority of residents (67.2%) considering

themselves Hispanic or Latino (a) origin. In the MRMC community, 26.6% of individuals over the age of five speak English less than "very well." Educational attainment for adults age 25 and older continues to be a challenge for the MRMC community. Overall, 31.1% of the MRMC community residents age 25 and over did not complete high school. Furthermore, over half (53.2%) of the adults (age 25 and over) residing in zip code 93458 (Santa Maria), and 44.3% of adults residing in 93434 (Guadalupe) have less than a high school education.[1]

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. 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.[2] The 2022 Point in Time Count for Santa Barbara County reported 457 persons experiencing homelessness in Santa Maria and 2 in Guadalupe. The homeless population in Santa Maria in 2022 is similar to the 2019 total of 464 and higher than the 2020 total of 382.

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).

The community served by AGCH is home to 81,148 residents, with nearly two-thirds (64.8%) considering themselves White, not Hispanic or Latino (a). The Hispanic or Latino (a) population of the AGCH community is approximately one-quarter (26.8%) of the total population. The AGCH community has a high school graduation rate of 91.0% for those aged 25 and older, and poverty rates below state and national levels. The 2022 Homeless Count and Survey Comprehensive Report for San Luis Obispo County documented 160 sheltered and unsheltered individuals experiencing homelessness in Pismo Beach, Arroyo Grande, and Grover Beach.

Community Assessment and Significant Needs

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 May 2022. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;

[1] U.S. Census Bureau (2022). *2016-2020 American Community Survey 5-Year Estimate.* https://data.census.gov/cedsci/table?q=ZCTA5%2093420%20Populations%20and%20People&g=860XX00US93420,93433,93434,93444,93445,93449,93454,93455,93458&tid=ACSST5Y2020.S0601

[2] National Center for Farmworker Health, 2022. *Agricultural Worker Estimates – 2017.* Retrieved from http://www.ncfh.org/number-of-ag-workers.html.

- 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 on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

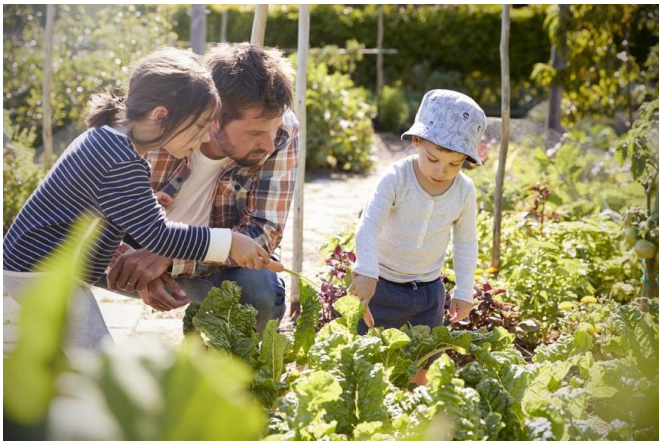
The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Educational attainment	Adults with a lower educational attainment level are more likely to encounter barriers in obtaining health care and negatively impacted by other social determinants of health.	•
Access to primary health care, behavioral health care, and oral health	Adults have barriers in accessing primary health care which also includes behavioral health and dental health.	•
Health promotion and prevention	Adults have barriers accessing preventive health screenings awareness, and education	•

2022 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others on 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 benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included social workers, care coordination, transitional care center, community benefit program coordinators, mission integration, cancer center, maternal health, health centers leadership, and the hospital executive leadership team.

Community input or contributions to this implementation strategy included meetings with the MRMC Family Residency Program, Community Benefit Committee of the Community Board, Santa Barbara County Health Equity Coalition, and community stakeholders.

The programs and initiatives described here began with a review of current programs already offered by the hospitals and the newly identified needs in the CHNA. Existing activities were reviewed for effectiveness, the need for continuation, or the need for enhancement. New programs were 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.

Community Health Strategic Objectives

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

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

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

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

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

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

Strategies and Program Activities by Health Need

Health Need: Educational Attainment					
Anticipated Impact (Goal)	Raise awareness and provide opportunities for local high school students to explore various careers in health care. Contribute the future supply of licensed health care providers by serving as a training site for health professions students. Improve community health efficacy by providing programs based on an individuals' spoken language and literacy level.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Community Health Improvement Grants 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 Need: Educational Attainment					
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.			•	•
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	Planned collaboration with San Luis Coastal School District, Lucia Mar School District, Allan Hancock College, Cuesta College, Central Coast Boys and Girls Club, United Way, Herencia Indígena, and Future Leaders of America Inc.				

Health Need: Access to Primary Health Care, Behavioral Health, and Dental Health					
Anticipated Impact (Goal)	Increase access to free medical care and community resources to provide early detection, prevention, and management of illness. Increase smooth transitions for discharged patients by providing access to "medical homes" and pharmaceutical patient assistance programs.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Community Health Improvement Grants Program	Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, medical prescriptions, and behavioral health care.		●	●	●
Street Medicine Program	In collaboration with the Marian Family Residency program, basic health and needs assessments are provided to unsheltered individuals in the MRMC community.		●		●
Chronic Disease Prevention and Self-Management Programs	Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program (DEEP) are offered to community members.		●		●
Diabetic Prevention and Self-Management Program (English and Spanish) & After-hour clinic	A new comprehensive, evidence-based, diabetes management program will be offered to the community. The after hour clinic program will include access to a registered dietician and a nurse specialized in diabetes management. These services will be added at a primary care site so the patient can experience multi-disciplinary, bi-lingual providers at one location.	●	●		●
Farming for Life	A new partnership with Tally Farms has been formalized to launch a program called Farming for Life. Farming for Life will provide free fresh produce for 12 weeks to diabetics enrolled in the program. Participants will undergo four bio/psycho/social evaluations during the twelve weeks.	●	●		●

Health Need: Access to Primary Health Care, Behavioral Health, and Dental Health					
Financial assistance programs to improve access	• Financial assistance programs are offered to medically underserved individuals to cover basic needs, hospital bills, transportation vouchers, and hotel vouchers. • The cancer center also provides financial assistance for basic needs (mortgage payment assistance, rent, gas cards) to community members affected by cancer.			•	•
Behavioral Wellness Support Groups	• Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). • Medically vulnerable population "MVP" for infants born with special medical needs, have a monthly support group. • Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. • Prenatal education programs are offered in Spanish and English to expectant mothers. • A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	•	•		•
Behavioral Wellness Center (Crisis Stabilization Unit)	The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.	•	•		
MRMC Medical Safe Haven Clinic for Human Trafficking	Provides a safe space where medical providers can offer a full spectrum of health services for victims and survivors of human trafficking.	•			
Community Health Navigator Program	The Community Health department will coordinate with the Transition Care Center to develop a "whole person" approach, for example, the MVP Program or DEEP participants, in helping those patients navigate access to medical, behavioral health, and basic needs services.	•	•		
Faith Community Nurse Program	• Further develop and expand the FCN program throughout the CA Central Coast market. • The FCN program will support the whole person including their spiritual, physical, mental and social well-being.		•	•	•

Health Need: Access to Primary Health Care, Behavioral Health, and Dental Health					
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening. • Provide financial support to medically underserved patients for transportation and genetic counseling.		•		•
Spanish & Mixteco Interpreter/Advocacy	Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. Provide Mixteco speaking individuals' advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	•	•	•	
Substance Use Navigation Program	Dedicated social workers assist patients presenting with Substance Use Disorder to link with appropriate resources. A naloxone distribution program is also part of the program.	•	•	•	
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	Planned collaboration with Marian Family Medicine Residency Program, SLO Noor free medical and dental clinics, MRMC/AGCH care coordination and social work departments, Alliance for Pharmaceutical Access (APA Inc.), Mission Hope Cancer Center, Hearst Cancer Resource Center, Pacific Central Coast Health Centers, MRMC Community Health Department, Herencia Indígena, Santa Maria Valley Fighting Back, Santa Barbara County Drug and Alcohol, Good Samaritan Shelter, San Luis County Drug and Alcohol, Transitions Mental Health, Community Counseling Center, Community Health Centers of the Central Coast and Tally Farms.				

Health Need: Health Promotion and Prevention					
Anticipated Impact (Goal)	Increase cancer, cardiovascular disease, diabetes, and stroke awareness, prevention, and management to the most vulnerable populations in the community, improving early detection and management.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Cancer Prevention and Screening Program	• Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. • Conduct community outreach surrounding cancer awareness, nutrition, and screening. • Provide financial support to medically underserved patients for transportation, genetic counseling.		•		•
Faith Community Nurse Program	• Further develop and expand the FCN program throughout the CA Central Coast market. • The FCN program will support the whole person including their spiritual, physical, mental and social well-being.		•	•	•
Behavioral Wellness Support Groups	• Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). • Medically vulnerable population "MVP" for infants born with special medical needs, have a monthly support group. • Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. • Prenatal education programs are offered in Spanish and English to expectant mothers. • A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	•	•		•

Health Need: Health Promotion and Prevention					
Diabetic Prevention and Self-Management Program (English and Spanish) & After-hour clinic	A new comprehensive, evidence-based, diabetes management program will be offered to the community. The after hour clinic program will include access to a registered dietician and a nurse specialized in diabetes management. These services will be added at a primary care site so the patient can experience multi-disciplinary, bi-lingual providers at one location.	●	●		●
Farming for Life	A new partnership with Tally Farms has been formalized to launch a program called Farming for Life. Farming for Life will provide free fresh produce for 12 weeks to diabetics enrolled in the program. Participants will undergo four bio/psycho/social evaluations during the twelve weeks.	●	●		●
Mixteco Pregnancy Education	Culturally appropriate education for Indigenous women to foster healthy pregnancy and maternal outcomes.		●		
Spanish & Mixteco Interpreter/Advocacy	Provide bilingual bicultural interpreter services to hospital departments for non-English speaking patients. Provide Mixteco speaking individuals' advocacy and navigation services for social/basic needs. The program supports in-patients, out-patients, and following hospital stay.	●	●	●	
Chronic Disease Prevention and Self-Management Programs	Promote to the community and provide Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program to community members. Conduct post workshop testing to determine efficacy of the program.		●		●
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	Planned collaboration with Marian Family Medicine Residency Program, SLO Noor free medical and dental clinics, MRMC/AGCH care coordination and social work departments, Alliance for Pharmaceutical Access (APA Inc.), Mission Hope Cancer Center, Hearst Cancer Resource Center, Pacific Central Coast Health Centers, MRMC Community Health Department, Latino Health Coalition, Santa Maria Valley Fighting Back, Santa Barbara County Drug and Alcohol, Good				

	Health Need: Health Promotion and Prevention
	Samaritan Shelter, and Tally Farms

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.

MRMC has launched multiple programs targeting the Mixteco community. MRMC provides Mixteco speaking individuals with culturally appropriate Mixteco interpreters both in the hospital and within the outpatient setting. The program also provides advocacy and navigation services for social/basic needs. Additionally, a culturally relevant program was developed that targets Mixteco women during pregnancy to provide education surrounding a healthy pregnancy and what to expect during delivery.

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 Street Medicine program conducts two outings to several homeless encampments in the community. The Street Medicine Program works in collaboration with the Homeless Health Initiative. The Homeless Health Initiative provides a social worker to address the transitional care needs of patients experiencing homelessness. The social workers have helped to identify numerous 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.

The MRMC Medically Vulnerable Pediatric (MVP) Program cares for high-risk medically fragile infants and children following their discharge from the hospital. The program provides support to families in their homes, providing essential resources and helping them navigate the health care system for their high-risk pediatric family members, to ensure they thrive. Many participating families reside in Santa Maria or Guadalupe and are monolingual in Spanish.

The Substance Use Navigation Program focuses on providing increased support through dedicated social workers to patients presenting with Substance Use Disorders. The primary goal of the provider is to provide assessment, intervention, and support while in hospital care, but also to link to appropriate resources with the flexibility to follow patients post-acutely as needed. Identified patients who are seen by providers after hours may also receive a follow up call from social work to coordinate care if/when appropriate. A naloxone distribution program was also launched through the support of this program.

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.