



Marian Medical Center

A member of CHW



Marian Medical Center

Community Benefit Report 2011
Community Benefit Plan 2012

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EXECUTIVE SUMMARY

Marian Medical Center, a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis, became a member of Catholic Healthcare West (CHW) in 1997 and has a 25-acre campus with a fully integrated healthcare delivery system. Marian Medical Center is 167-bed, general acute care hospital located on two campuses. Services include emergency, general medical-surgical, cardiac surgery, ICU/CCU, NICU, obstetric and pediatric services. Marian also has a 99-bed Extended Care Center, homecare/hospice and infusion service, and two primary care clinics. The Marian West campus houses 35 acute care beds, and outpatient services, which includes a free-standing imaging center and ambulatory surgery center. Marian Medical Center has a staff of 1,448 and professional relationships with 248 active medical staff members and another 28 with consulting or courtesy privileges.

In response to the rapidly growing population of the Santa Maria Valley, Marian Medical Center has embarked on building a new hospital. Central to the new hospital project will be a new Patient Tower. This state-of-the-art, four-story tower will include a 188-bed acute care facility with private rooms and baths, providing room-in capability for loved ones visiting patients. It also will include an expanded emergency department, further increasing the ability of Marian to provide life-saving care when patients need it most. Finally, the new hospital will provide specialized care for patients and families including an expanded Neonatal Intensive Care Unit for babies needing special care.

Major community benefit activities for FY2011 focused on improving access to health care. **North Santa Maria and Guadalupe clinics** provide access to health care for the underserved and disadvantaged for primary and specialty medical care to reduce health disparities. Each clinic is located in a primarily Hispanic, low-income area. The Santa Maria Clinic includes Obstetrics & Gynecological Care, and the “New Life Program” for crisis pregnancies, which works in conjunction with the Marian Clinics offering adoption referrals, counseling, clothing for mother and baby and prenatal care for teens that become pregnant.

Health education is viewed as a priority to address prevention of disease, to empower community members to assume responsibility for their health and increase their ability to make wise choices. Marian offers two specific chronic illness related programs. The Stanford University’s School of Medicine evidenced-based chronic disease self-management program, Healthy Living: Your Life Take Care consists of six 2 ½ hour sessions. This workshop empowers participants in the development of their own action plan for healthy living. In addition, Marian’s Healthy for Life Lecture Series is an interactive program providing nutrition education and a physical activity component. Both programs are offered in English and Spanish.

Marian continues to provide **Maternal Outreach Meetings** such as Sibling Big Brother and Sister, Breastfeeding, Baby-Safe Infant CPR, and our newest addition, Home with Baby meetings for postpartum support. All our classes are led by experienced perinatal nurse educators with the objective of teaching new parents safe and healthy parenting techniques. Each class is taught in English and Spanish.

The **Congestive Heart Failure Program (CHF)** continues to bridge the medical and educational needs of patients living with heart failure through a collaborative effort between the acute care hospital, Home Health, Community Clinics, public health and the physicians' offices at Marian. This program continues to prove successful in minimizing readmission of patients and helps decrease the severity of the illness for most program participants.

The **Osteoporosis Program** provides resources for the promotion of bone health among residents in the Santa Maria Valley, offers educational support services teaching osteoporosis prevention, early intervention and treatment options. This program also provides fracture management support to discharged hospital patients to encourage bone health through calcium and Vitamin D, exercise, and appropriate medical follow-up including DXA and medication.

Marian Cancer Care Services will have a new home located in **Mission Hope Cancer Center** (which is affiliated with UCLA Jonsson Cancer Center). This will be the first integrated facility for cancer care in the region. Upon its opening in late 2011, the center will be home to medical and radiation oncology, selective oncologic subspecialists and surgeons, as well as a pain management center. It will also house a UCLA clinical research network where patients will have access to a multitude of clinical trials without the need for travel. Cancer support services at Mission Hope includes nurse navigators among which will be a dedicated breast cancer nurse navigator whose program has been in existence since 2007. Navigators are the community "411" information points for cancer care and can answer many questions regarding cancer screening, treatment, follow-up and resources available to patient and family members touched by a cancer diagnosis.

The total dollars quantified for Community Benefits for these and numerous other community benefit programs in FY2011 are \$16,291,496, which excludes Medicare. Including the expenses incurred for the unreimbursed costs of Medicare, the total Community Benefit expense for Marian Medical Center was \$24,466,896.

MISSION STATEMENT

A. Marian Medical Center Mission Statement (CHW Mission Statement)

Catholic Healthcare West and Marian Medical Center 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.

ORGANIZATIONAL COMMITMENT

A. Hospital's organizational commitment

1. Marian's organizational commitment to the community benefit process begins with our Strategic and Operating Plan which focuses on enhancing the Community Benefit Planning process through improved quality of data and accountability of results. Marian is also committed to implementing education strategies to reduce the risk of diabetes and childhood obesity. Our commitment to identify opportunities and implement changes through collaboration with CHW Central Coast entities continues to improve operational efficiency and performance.

- Marian's commitment to the CHW community grants program offers other not-for-profit community-based organizations an opportunity to support the community at large. Marian's Community Grants Committee works together to screen applications, giving consideration and priority to organizations and programs that are most consistent with Marian's existing outreach programs.
- While Marian does not have active participation with the CHW Community Investment program we are stepping up the promotion of this program offering to community partners who may be eligible.
- A subcommittee of Hospital and Community Board members participates in quarterly Community Benefit Team meetings. Board members contribute community expertise while monitoring programs to ensure continuing program focus.
- Each year the hospital community board reviews community outreach statistics to determine which projects, particularly those that focus on the unmet health-related needs of the economically disadvantaged and underserved, will be funded in the coming year.
- Program leaders are accountable for meeting their program's community benefit goals and reporting on the outcomes of their program to the Community Benefit Team on a quarterly basis.
- Other community based organizations, through Marian's Healthier Communities Council, are actively involved in Marian's community benefit programs, collaborating to maintain a focus on health-related community needs, and are involved in partnering to provide services in the Santa Maria Valley.

B. There are many examples of non-quantifiable benefits related to the community contribution of the hospital. Working collaboratively with community partners, the hospital provided leadership and advocacy, assisted with local capacity building, and

participated in community wide health planning. The following are some non-quantifiable services:

1. The Partners for the Environment Committee adopts a local Santa Maria park and meets once a month to clean the Joe White Park.
2. Marian also plays a key role collaborating on the Communities of Excellence in Nutrition, Physical Activity and Obesity Prevention (CX3) project. The Santa Barbara County Public Health Department project took an in-depth look at two Santa Maria neighborhoods to measure the nutrition environment and identify opportunities for improvement. CX3 project staff collected and analyzed local data to gain a realistic picture of the overall quality of the nutrition environment in these two Santa Maria neighborhoods two years ago. The low-income neighborhoods are out-of-balance from a nutrition and health perspective. A second evaluation will take place in the near future. The ultimate goal of this on-going project is to demonstrate that neighborhood, city and county government actions and policies can play a vital role in reshaping and improving the overall health of these two most challenged neighborhoods, while also addressing the childhood obesity epidemic.
3. Marian generated 879,480 pounds of solid waste increasing our poundage by 7,980 pounds when compared to FY 09/10 [871,500]. This increase was minimal, considering the construction and remodeling project presently underway. Marian Medical center medical waste program has decreased their pounds of medical waste by 1,309.79 pounds, when compared to FY 09/10 [30,361.81]. Additionally 29,052.02 pounds of medical waste have been diverted from the land fill. Our on-going paper and cardboard recycling, has generated a total of 1,101,821.1 pounds, all of these being diverted from the landfill. The use of micro fiber mopping system has continued to help reduce water consumption, while helping to provide a safer environment for the patient to recuperate. Despite our efforts, an internal goal to achieve a 2.5% reduction in solid waste was not met.
4. The People for Non-Violence committee is a community partnership that seeks to alleviate or curb violence in the community by sponsoring an annual Peace Week celebration. Participants in this partnership span the Santa Maria, Orcutt and Guadalupe communities. Peace Week activities included: an opening ceremony with a free community luncheon, a special celebration focusing on cultural diversity, a tree planting on "Respect for Creation Day," and a reflection service featuring various philosophies and religions. The People for Non-Violence also assess local crime rates by reviewing police statistics.
5. Marian Medical Center is one of only a few hospitals in the nation to have a cogeneration plant that operates on methane gas. The 2000 square foot facility uses waste methane gas to produce as much as one megawatt of electricity. The cogeneration process significantly reduces methane emissions in the environment and offsets the use of non-renewable resources such as coal, natural gas and oil. In addition, the plant will save the hospital between \$300,000 and \$500,000 in energy costs each year.
6. Meals on Wheels (MOW) serve meals to the economically disadvantaged people of the Santa Maria Valley who are in need of special life-sustaining medical diets and who wish to continue living an independent lifestyle. This program has been established to ensure diabetic people don't go without a meal two days in a row and

serve medical diet meals to others as well. This community collaborative now serves eighty-five customers daily.

COMMUNITY

A. Definition of Community (geographic and demographic)

1. Since March 1999, Marian Medical Center has been the only hospital providing services to the Santa Maria. Marian Medical Center, located in northern Santa Barbara County, has the Santa Maria Valley as its largest service area. The four largest communities in Marian's primary service area are the City of Santa Maria, the City of Guadalupe, the unincorporated portion of North County that includes Orcutt, Sisquoc and Tepesquet with Nipomo, an unincorporated community of approximately 13,000 people in southern San Luis Obispo County. Recently Santa Maria became the largest populated city in the county surpassing the city of Santa Barbara and is still growing. The US Census Bureau estimates the population of Santa Maria in the County of Santa Barbara to be approximately 85,528. The northern part of the County has a high percentage of Latinos, with 67% of Santa Maria city residents identified as Latino, compared to 34% of Santa Barbara city residents. Over twelve percent (12.9%) of adults living in Santa Barbara County are over the age of 65 with Santa Maria at 9.8%.
2. A description of the community in this service area from the most recent community health needs assessment is provided below to assist in better understanding the community setting:

Economic Indicators

- 43% of indigenous Mexicans reported average annual household incomes below \$10,000 per year.
- Children and families on Medi-Cal in 2009-10 grew at a rate of 6-7%, higher than initial estimates and most likely due to increased economic hardship.
- The Central Coast population is aging which affects the local revenue base and signals an increasing need for senior health services, including long term care.
- Hispanic and Oaxaca income is most likely overestimated because, while the official income is based on total household income, there are sometimes three or four laborer families living together in one house. If income earned by each separate family were calculated, their average income would most likely be significantly lower.

Housing status

- Poverty, lack of health insurance, substandard housing and high levels of stress and anxiety, which may be associated with alcohol abuse, child abuse and domestic violence are factors affecting their health and well-being:
- Poor housing conditions including the presence of mold and cockroach droppings are associated with asthma in young children

Santa Maria

Language/Culture: According to the assessment, among people in Santa Maria 59 % spoke a language other than English at home; of those 92% spoke Spanish and 8% spoke some other language while 58% reported that they did not speak English "very well." Many Oaxaca immigrants speak enough Spanish to give the impression of understanding, but lack sufficient competency for more complex situations such as obtaining social or legal services. There is also unfamiliarity with Western medicine

and such concepts as preventive and prenatal care. They often have different cultural belief systems and rely on indigenous healers, *curanderos*, and folk and herbal remedies for care.

- Many patients depend on family and friends as non-certified medical interpreters raising an issue of privacy.
- Health promotion and disease prevention programs need to take into consideration cultural differences and sensitivity in how to encourage clients to take part in screenings or engage in behavior change.
- Providers are not aware that the levels of comprehension might be low and outreach may be further hampered by racism that may exist among non-indigenous eligibility workers.

Education: Sixty-five percent of people 25 years and over had at least graduated from high school and 13% had a bachelor's degree or higher. Thirty-six percent were dropouts; they were not enrolled in school and had not graduated from high school.

Income: The median income of households in Santa Maria city was \$48,819. Twenty-seven percent of the households received Social Security. The average income from Social Security was \$14,471. Seventeen percent of people live in poverty. Twenty-two percent of related children under the age of 18 were living below the poverty level, compared with 7 percent of people 65 years old and over.

Ethnicity: Approximately 58% identified as White; 1.9% African-American; 4.7% Asian; 1.8%; 1.8% American Indian & Alaskan and 5.4% as Mixed Race. Sixty-seven percent of Santa Maria city residents identified as Latino which means that they could be included in other categories listed above.

Guadalupe

Language: Seventy-four percent of Guadalupe residents spoke a language other than English at home. Of those, 98 percent spoke Spanish and 2 percent spoke some other language; 62 percent reported that they did not speak English "very well."

Education: Forty-four percent of people 25 years of age and over had at least graduated from high school and 4 percent had a bachelor's degree or higher. Fifty-six percent were dropouts; they were not enrolled in school and had not graduated from high school.

Income: The median household income in Guadalupe was \$41,126. Eighty-four percent of the households received earnings and 10% received retirement income other than social security. 34% of households received social security. Seventeen percent of people were living in poverty. Twenty percent of related children under 18 were living below the poverty level compared with 14 percent of people 65 years old and over.

Population: Guadalupe has a total of 6,500 residents. The median age was 31.5 years. Thirty-three percent of the population was under 18 years and 10 percent was 65 years and older.

Ethnicity: Eighty-six percent of the people are Hispanic and eleven percent of the people are White non-Hispanic.

Orcutt

Language: Thirteen percent spoke a language other than English at home. Of those speaking a language other than English at home, 60 percent spoke Spanish and 40% spoke some other language. 36% reported that they did not speak English "very well."

Education: 92 percent of people 25 years and over had at least graduated from high school and 27 percent had a bachelor's degree or higher. Nine percent were dropouts; they were not enrolled in school and had not graduated from high school.

Income: The median income of households in Orcutt was \$67,263. Seventy-six percent of the households received earnings and 27 percent received retirement income other than Social Security. The average income from Social Security was \$15,944. Five percent of people in Orcutt live in poverty. Four percent of related children under 18 were living below the poverty level, compared with 5 percent of people 65 years old and over.

Population: Orcutt has a total population of 28,000. The median age is 42.9 years. Twenty-six percent of the population is under the age of 18 years and 18 percent is 65 years and older.

Ethnicity: Twenty percent of the people in Orcutt are Hispanic. Seventy-three percent of the people in Orcutt are White non-Hispanic.

Although Marian contracts with over 25 insurers that provide healthcare insurance to this community, an alarming percent of residents in the Santa Maria Valley have little or no health insurance. Community Health Centers of the Central Coast have one dental and five health clinics in Santa Maria, one in Nipomo, and one in Guadalupe. Marian Community Clinic has two clinics; one in Guadalupe and one in Santa Maria. The Santa Barbara County Public Health Department has three community clinics including a Women's Health Center and a community clinic in Santa Maria and a small clinic with limited hours in New Cuyama.

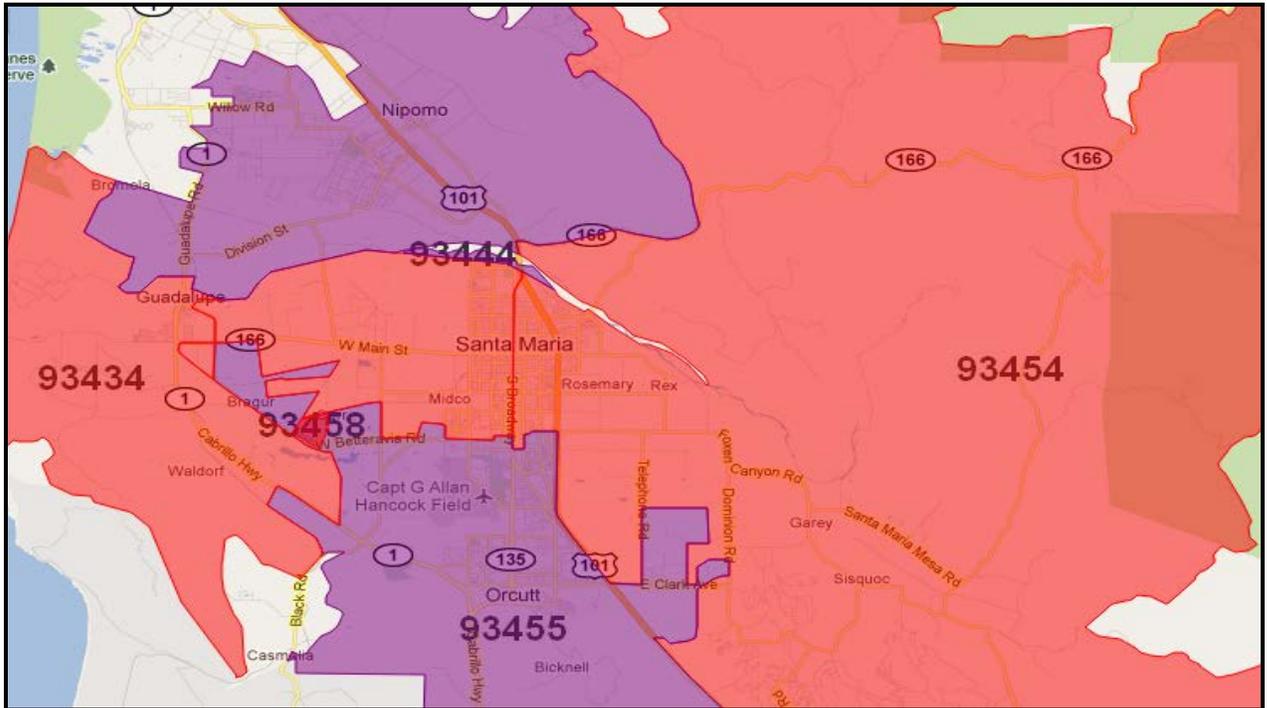
3. Guadalupe, a small community in the Santa Maria Valley, has been federally designated as a Medically Underserved Area (MUA).

Community Need Index

Zip Code	State	County	CNI Score	Income Ranking	Education Ranking	Cultural Ranking	Insurance Ranking	Housing Ranking	HH Poverty 65+	Fam Poverty w kids	Fam Poverty F Hd	Prct 25+ wo HS dip	Prct NWhite Hisp	Pop 5+ Ltd Eng	Prct Unemployed	Percent Uninsured	Prct Renting	Total 2009 Pop
93434	CA	Santa Barbara County	5	5	5	5	5	5	21%	27%	43%	56%	92%	29%	9%	26%	44%	7,034
93444	CA	San Luis Obispo County	3.2	2	3	5	3	3	6%	8%	25%	20%	39%	7%	6%	11%	22%	18,151
93454	CA	Santa Barbara County	4.2	3	4	5	4	5	6%	17%	35%	24%	59%	8%	6%	21%	41%	33,073
93455	CA	Santa Barbara County	2.6	2	2	4	3	2	6%	7%	18%	13%	32%	3%	6%	11%	17%	40,804
93458	CA	Santa Barbara County	5	5	5	5	5	5	10%	26%	50%	55%	87%	31%	11%	25%	49%	51,351

Attachment A

Marian Medical Center



Lowest Need ■ 1 - 1.7 **Lowest** ■ 1.8 - 2.5 **2nd Lowest** ■ 2.6 - 3.3 **Mid** ■ 3.4 - 4.1 **2nd Highest** ■ 4.2 - 5 **Highest**

	Zip Code	CNI Score	Population	City	County	State
■	93454	4.2	33073	Santa Maria	Santa Barbara	California
■	93455	2.6	40804	Santa Maria	Santa Barbara	California
■	93458	5	51351	Santa Maria	Santa Barbara	California
■	93434	5	7034	Guadalupe	Santa Barbara	California
■	93444	3.2	18151	San Luis Obispo	Santa Barbara	California

Attachment B

COMMUNITY BENEFIT PLANNING PROCESS

A. Community Needs Assessment Process

Marian Medical Center conducted its needs and assets assessment for FY 2011/2012 for our primary service area by utilizing secondary data from various other agencies such as: **Santa Barbara County Public Health Department Community Health Status Report April 2011; California Cancer Facts & Figures 2010, Cancer Facts and Figures for Hispanics/Latinos 2009-2011;** and the **Community Need Index (CNI) 2009**. CHW CNI uses socio-demographic data to provide an “at a glance” view of those living with disproportionate unmet health care needs (DUHN) in a given geographic area.

Marian Service Area	Zip Code Location	CNI Score FY09	2009 Estimated Population
93454	Santa Maria	5	84,424
93458	Santa Maria	5	
93455	Orcutt	2.6	40,804
93434	Guadalupe	5	7,034
93444	Nipomo	3.2	18,151
	Total	4	150,413

These published reports and statistics are the foundation for the Community Benefit Report and reflect needs of the underserved community, children, seniors, homeless and the migrant community who work and/or live in the Santa Maria Valley. Analyzing the data from these published reports for FY 2010/2011, we find commonalities that reflect identified health and socio-economic needs by specific population.

Access to (Primary) Healthcare Services

- In 2009, 19.3% of County residents had no health insurance for all or part of the year. Latinos were much more likely than Whites to be uninsured, with 22.9% of Latinos ages 0-64 lacking health insurance at the time of the survey compared to 5.6% of Whites in this age group.
- Many Santa Maria Valley Latinos do not have pharmaceutical access to fill their prescriptions.
- Nearly 5.8% of the Santa Barbara County population received Medi-Cal benefits in 2009. Thirty-nine percent of those receiving Medically Indigent Adults (MIA) services in Santa Barbara County live in Santa Maria.
- Many indigenous from Mexico do not seek follow-up care following a health fair or other outreach events because fee-based services are often prohibitive and access is limited.
- Health disparities or differences in the quality of health were evident among people with lower incomes and Latinos. These groups experienced more health problems and were less likely to have health insurance.
- Lower income seniors and elderly Latino reported lower perceived health status, and less use of preventive screenings and primary care than the general senior population.
- The waiting list for Latino families seeking mental health services for adults and/or children is one year.
- Thirty-nine percent of 11th grade girls and 26% of 11th grade boys in the state report having felt so sad or hopeless that they stopped doing some of their usual activities indicating a risk of depression. Children who do not receive mental health services are more likely to commit suicide.

- Unduplicated elder abuse reports increased by approximately 10% in Santa Barbara County.
- In 2009, California eliminated or suspended funding for a number of critical children’s health care programs, including Children’s Dental Disease Prevention Program, the Immunization Program, the Adolescent Family Life Program, county Maternal and Child Health grants, county Early and Periodic Screening, Diagnosis and Treatment programs developed with Mental Health Services Act (Proposition 63) funds, and Community clinic programs. The children served by these programs are now more vulnerable to major health issues, which will result in unaffordable costs for families and the state.
- Oral and dental health continues to be a key health concern in Santa Barbara County particularly among lower-income children. Tooth decay is the single most common chronic disease of childhood: five times more common than asthma and seven times more common than hay fever. An estimated 874,000 school days are lost annually in California due to dental problems.

Disease Management

- Obesity poses the greatest threat to the health and lives of the largest number of county residents. Obesity-related illness such as heart disease (leading cause of death), stroke (second leading cause of death), hypertension, diabetes and various cancers contributed to hundreds of deaths, and thousands of years of life lost to premature death.
- The three leading causes of death for individuals over the age 65 include major cardiovascular diseases (40% of all deaths), cancer (22 %) and stroke (7%). These three causes of death account for 69% of all deaths among older adults. Falls are the leading cause of injury death for seniors.
- 10.4% of area residents over one year old were diagnosed with asthma in 2009.
- Scientific evidence suggests that about one-third of cancer deaths are due to nutrition and physical activity factors, including excess weight. Social, economic and cultural factors strongly influence individual choices and attitudes about diet and physical activity.
- The risk of developing cancer varies considerably by race/ethnicity. The reasons for these differences are not well understood. It is likely that they result from a combination of dietary, lifestyle, socioeconomic, environmental, and genetic factors.

		New Cases		Deaths	
		California	Santa Barbara County	California	Santa Barbara County
Male	Prostate	20,010(Hispanic 15,285)	225	3,035	45
	Lung	7,825/ (Hispanic 4,463)	170	6,985	155
	Colon & Rectum	7,200 (Hispanic 5,874)	145	2,585	55
Female	Breast	22,385 (Hispanic 16,791)	260	4,195	55
	Lung	6,855 (Hispanic 3,575)	170	6,150	155
	Colon Rectum	6,950 (Hispanic 5,037)	145	2,490	55
	Uterus & Cervix	5,585 (Hispanic 3,421)	70	1,220	15

- Hispanic women have the highest risk of developing cervical cancer; but preventive health screenings for major diseases such as breast and cervical cancer are not always utilized by the target populations.

- Prostate cancer is the most common cancer among men in almost all racial/ethnic groups in California. In 2010, 15,285 new cases were diagnosed in Hispanic men.

Health Promotion/Disease Prevention

- In 2009, 51.5% of children age 2-11 consumed the recommended five or more daily servings of fruits and vegetables while only 16.9% of teens age 12-17 consumed the recommended serving levels. Low consumption of fruits and vegetables, excessive consumption of high calorie foods contribute to obesity and related health problems among youth and adults. Soda or other sugary drinks as well as fast food consumption (28.6% and 83.5%) adds to the alarming obesity rates in Santa Barbara County. The consequences of this obesity epidemic to children's well-being are GRAVE. Today's children will be the first generation to be less healthy and live shorter lives than their parents.
- Lower than recommended levels of physical activity also contribute to obesity-related health problems. The percentage of local children who were active for at least one hour every day was 38.7% with 11.7% of children being completely sedentary. Only 23.2% of teens reported engaging in vigorous activity three or more days per week compared to 35.3% of teens statewide in 2007.
- Santa Barbara County has three times as many fast food restaurants as supermarkets and produce vendors. The county has the 11th highest rate of food insecurity in the state, indicating that many local families are having difficulty providing sufficient food for all family members.
- California made no notable progress in pressuring federal policymakers to ensure that at least 50% of all food advertising to children on broadcast and cable television programming is devoted to healthy food products; ensuring the development of strong uniform nutrition standards that easily identify healthy, nutritious foods; and collaborating with media companies to ensure proper use of those nutrition standards as a way to evaluate the food and beverage ads that media companies air on their channels and networks.

Maternal Health

- The percentage of pregnant women who do not receive early prenatal care has been increasing since 2005; in 2005-2008 only 65.1% of Latinas began prenatal care during their first trimester.
- Births to teens have declined since 2007 although the local teen birth rate is higher than the statewide average. Births to teens were most common in the northern part of the County, with the highest teen birth rates in the cities of Guadalupe and Santa Maria.
- Maternal depression has adverse affects on children's development; consequently screenings for maternal depression at well-child clinics and other locations visited by women is needed

Findings from the Community Need Index and secondary data as identified above reflect a significant downward trend for those community members' standard of living in the northwest area of Santa Maria and the whole of Guadalupe.

B. Community Assets

An inventory of community assets is described below and is categorized by the hospital community benefit priority areas identified by Marian Medical Center. In addition to the specific hospital programs described on pages 23-30 the following assets have been identified.

Access to Primary Healthcare Services

- The Santa Barbara Public Health Department (SBCPHD) and Marian's Community Clinic (August 27, 2008) have been designated as Federally-Qualified Community Health Centers which will support the ability to meet local health needs.
- The Santa Barbara County Public Health Department's Cancer Detection Program identified State restrictions on reimbursement for digital mammography as a barrier for lower-income women, leading to a change in State law allowing reimbursement for this service.
- In an effort to reduce unnecessary emergency room visits that can include long waiting room times, many CenCal primary care providers in Santa Barbara County have extended their office hours to 6pm to see patients.
- In an effort to reduce health disparities, Marian Community Clinics operate in northwest Santa Maria and Guadalupe providing access to health care for the underserved and disadvantaged for primary and specialty medical care to reduce health disparities.
- Marian funded through grants an on-call interpreter to provide services for Labor and Delivery and Emergency Department patients. Disparities in accessing health and social services for Oaxaca has been addressed by providing a part-time community advocate in the hospital where these community members can get support filling out applications for rental property, food stamps, Food Bank distribution sites and health insurance forms for their children serving over 200 people since July 2010.

Disease Management

- Over 200 community based patients living with heart failure throughout the Central Coast Service Area service area are currently enrolled in our telephonic care management program. We received a grant from the Center for Technology and Aging at the end of last year to add remote patient monitoring technology to this program. Partnering with Philips Medical Systems, Marian acquired 50 home tele-station monitors for use in educating community-based patients throughout the service area living with heart failure and in the monitoring and reporting of critical vital signs such as blood pressure, pulse oximetry and weight. 35 telestations have been deployed to date. Patient satisfaction, improvement in self care capacity and functional status are being assessed upon enrollment to the program and at discharge. Marian has also been selected to participate in the second phase of this project aimed at developing a return on investment model for this technology.
- Marian Medical Center, the SBCPHD and Community Health Centers of the Central Coast work collaboratively to provide English and Spanish evidence-based chronic disease self-management workshops which were developed by the Stanford University School of Medicine. Healthy for Life Nutrition Lecture Series is also offered at no cost to all community members.
- Marian's Cancer Care Services provides services for disease management as described in the Program Digests on page 28-29. Marian also has an Osteoporosis program that provides heel scans, community education, as well patient contact to follow up after

fracture, education materials is sent to patient and patients' primary care physician is notified.

Health Promotion/Disease Prevention

- “Promotora de Salud” is a coalition to promote the expansion and integration of promotores in all aspects of the community’s health and well-being. This coalition is supported financially in part by CHW’s central coast service area and the SBC Food Bank. The Coalitions vision is to facilitate use of a thriving group of Promotores that have ability to enhance the community’s overall health and well-being. Promotora de Salud successfully trained over 50 promotora in Santa Barbara County during the past fiscal year. Marian has used promotora to promote health education programs at health fairs and throughout Santa Maria.
- A bilingual health education television program, Healthy for Life/Una Vida Saludable is produced monthly and broadcast daily in Spanish and English on multiple TV stations by the Santa Barbara Public Health Department.
- The Tobacco Prevention Program developed a board approved policy that prohibits smoking at County parks and beaches as well as a ban on licensing of new tobacco retailers within 1,000 feet of schools.
- In Santa Maria the Santa Maria Bonita School district and the Guadalupe School District received a First Five planning grant to promote inter-agency cooperation among those that support children and families, such as education, health and social services. This plan will support implementation of services in a community setting which is proven to be effective in increasing children’s access to health care providers while improving parent involvement in their community and their children’s education. Marian has been an integral part of the planning process and will continue to support efforts during the implementation.
- The SBCPHD works with other community members and organizations to promote healthy behaviors ensure quality and accessible health services, prevent epidemics and protect against environmental hazards.
- AB 667 clarifies existing law so that any person including dental assistants and non-health care personnel, with a prescription and protocol of a licensed dentist or physician may apply topical fluoride varnish in public health and school-based settings.

Maternal Health

Partnering with the SBCPHD Women’s Health Center, Marian provides monthly Mixteco birthright classes and tours. Marian produced a DVD for use with Mixteco families in Labor and Delivery and registration to help them become familiar with processes encountered during their hospital stay. Marian now has a neonatal intensive care unit.

C. Developing the Hospital's Community Benefit Report and Plan

1. The community benefit planning process considers the fiscal year 2011 program outcomes serving as a springboard for the continuation of most current programs. There are a number of checks and balances set to ensure CHW values are integrated into programs and services: (a) strategic planning has impact on factors of involvement for specific program implementation; (b) the Community Benefits Committee reviews outreach programs on a quarterly basis comparing goals to objective measures and outcomes of each program and ensuring commitment to the strategic plan; (c) two Hospital and Foundation board members participate and provide strategic influence to the Community Benefit Committee while the Hospital Board reviews community

- outreach programs through monthly board meetings and; (d) finally the community needs and assets assessment process provides a data analysis that directors and coordinators can use for program improvement and continuation of their respective programs.
2. Factors considered in planning for outreach programs include analysis of the high utilization rate of the hospital's emergency room by those uninsured or underinsured and the severity of their health problems. In the last five years, Marian has seen an increase in the number of uninsured residents and residents covered by Medi-Cal which resulted in a greater than 400% increase in charity care expense and greater than a 300% increase in Medi-Cal expense. This trend is driven by a variety of factors, including an increased demand for healthcare services to treat chronic conditions - conditions that if treated through primary care services in the community would likely not result in a hospitalization or need for emergency care. To effectively impact the increase in charity care and Medi-Cal expense, Marian has established a plan to address these issues internally while providing quality healthcare service to this population.
 - a. Partner with physicians and share ambulatory care sensitive condition admission/readmission data;
 - b. Collaborate on improved healthcare education and referral plan addressing those patients within our control;
 - c. Collaborate with Marian clinics to take referrals from the ER;
 - d. Identify physician/Staff champion within service area to promote disease management initiative;
 - e. Identify the availability of community partners that will collaborate with us in providing disease prevention education programs that target cost-effective prevention.

As identified in the Community Need Index, two key target areas identified in Santa Maria; the northwest corner of Santa Maria: the New Love community as well as Guadalupe. These two areas are in need of improved access to healthcare and services for the underinsured and uninsured. Uninsured Latinos in the Santa Maria Valley do not have adequate access to clinical support or health education for chronic illnesses. Many Latinos are not aware that free and low-cost programs and health education classes even exist. The U.S. Department of Health and Human Services Center for Disease Control and Prevention states, "The failure to effectively manage chronic conditions due to poor quality, uncoordinated care and/or insufficient access to care can result in heavier use of emergency room services and hospital services, poorer overall health and greater mortality." While these topics of social and health disparities will guide our process for community benefit planning, Marian will also focus on building community capacity by strengthening our partnerships among community based organizations.

2. The following are identified health issues that can be addressed with program enhancement and/or services. All of these suggestions specifically address the vulnerable population as described in the definition of community.

Access to (Primary Health) care Services

- Health care costs can be successfully contained by collaborating with other local agencies to provide programming and services, but most important containment could be cost effective with further investigation of a similar program the CHW

Sacramento Service Area has established; a Community Health Referral Network. This program connects uninsured and underinsured patients treated in emergency departments for non-urgent/emergent care to permanent health care homes in the community. Goals are to increase access to care for those that need it most, reduce avoidable admissions and reliance on emergency departments by maximizing community health resources, improve the health status of the underserved, and lower health care costs. The Network shows remarkable program outcomes for the first three months of implementation.

- To improve healthcare education and to help patients without a medical home, the ER could enhance collaboration with the Marian clinics, the SBC PHD and CHCCC for patient referrals which would be both cost effective for Marian and good stewardship. An unprecedented number of uninsured and underinsured patients are turning to the emergency department for basic care because of lack a primary care provider and/or are unable to navigate a dramatically altered health care landscape. Poor communication and collaboration among Santa Maria clinics and minimal patient outreach further exacerbates barriers to care. The Community Health Referral Network mentioned above or further investigation of an Emergency Room discharge planner can shift the paradigm to connect patients to community services.
- The Santa Maria Bonita School District Collaborative partnership, after analyzing their assessment data, suggests that late evening hours and Sunday hours in the Clinics would be conducive to better meeting the needs of members of the most vulnerable target population.
- Care Management will need to be engaged to better address the needs of the Oaxacan population. A very small percent of this population understands their medical condition, what services were provided to them and why, and what they need to do to improve their condition (particularly newly arriving immigrants – women).

Disease Management

- Identifying a physician/staff champion for Marian's chronic disease self-management program will help strengthen the program. Home Health will assume a new role for hospitalized patients with chronic disease, serving as care transition coordinators for these fragile populations. Physicians and case management could develop a seamless process for referrals to this evidence-based program. It would also be beneficial to recruit and train promotoras within this service area to promote disease management initiative.
- The Asthma Coalition and the American Lung Association had for many years facilitated a community partnership to offer a kids camp for children. Preliminary meetings have taken place for Marian to continue this program for children in the summer of 2012.
- Marian has had an ADA recognized Diabetes Self-Management Program for 8 years providing Diabetes counseling by a Registered Dietician and Certified Diabetes Educator RN to patients in Santa Maria. Marian will work with the other CHW Central Coast Hospitals this year to develop strategies and objective measures for enhanced Diabetes programs in tandem with the community clinics, with a focus to improve behavior and self management practices of diabetic patients, and enhance and improve access to and delivery of effective preventive health care services.

Health Promotion/Disease Prevention

- Marian will offer more screenings for breast and cervical cancer screenings for Latino low income woman and prostate screenings for Latino low income men.
- Marian is a stakeholder in the Promotoras de Salud program in Santa Barbara County attending monthly collaborative meetings to support the development of goals, objective measures and strategies. Marian will consider ways to continue to support this collaboration, and in particular, the need for the promotora coordinator position. Further support will ensure ongoing recruitment, basic and on-going training of promotora, and the effective coordination of all promotoras in Santa Barbara County.
- The gap in service due to the elimination of the Adult and Aging Network will be in part picked up by the local Area Agency on Aging. Educating of seniors, the importance of fall prevention, active aging, preventive health screenings, elder abuse, mental health issues, and legislative activity/advocacy in the State of California are all important services for seniors. Marian does provide some screenings: memory screening, blood pressure checks, CarFit testing and chronic disease related lectures.

Maternal Child

The highest teen birth rates are in the cities of Guadalupe and Santa Maria. It is suggested that perhaps further investigation is needed on the how, what, where and why of this increase perhaps at least offering teen prenatal classes to ensure healthy babies.

Education

The Santa Maria Bonita School District and the Guadalupe School District both received a First Five implementation grant to promote inter-agency cooperation among those that support children and families, such as education, health and social services. While the amount of funding was reduced, it does allow for development of a strong infrastructure, to develop goals for the year to effectively plan for implementation and to develop an individualized organizational capacity plan. This implementation is focused on children 0-5 but inclusive of all family members. Implementation in Santa Maria focuses on the Robert Bruce and Fairlawn schools.

Other

- With a growing community need to address the **mental health** issues of the northern Santa Barbara County, Marian's Strategic and Operating Plan has identified a collaborative effort with the Department of Alcohol, Drug and Mental Health Services of Santa Barbara County to implement the Santa Maria CARES (Crisis and Residential Emergency Services) program for improving mental health services for patients in the north county. Marian continues to work with Santa Maria Bonita School District with referrals for mental health services. Marian has collaborated with other community advocacy agencies in an effort to provide support to young at-risk Latina girls between the ages of 8-12 years of age. Dove soap offers a self-esteem program for young girls. Marian, utilizing the Dove website, provided two summer workshops which encourages in the workshop to build a positive relationship with beauty equipping them with critical media literacy skills and self-esteem education to help youth and young teens to reach their full potential.
- To assist in the critical status of children's **oral health** care, Marian provides support to Community Action Commission's Head Start program's annual children screenings. The least of this activity is to support this consistent major unmet need

in Santa Barbara County by recruiting support of dentists and dental hygienists for CAC’s children’s health fairs. Health Linkages (SBCEO-HL) have collaborated to bring two SBCEO-HL staff to the hospital facility for Health Coverage Enrollment Assistants two days each week at a time conducive for the Spanish-speaking community members. Health Linkages also provides the application of dental varnish to children attending all state-preschools; but budget constraints have reduced staffing and supplies. Marian could support this project through the purchase of fluoride varnish to support Health Linkages efforts in applying fluoride varnish for children at all state preschools.

- With the acknowledged **healthcare professional shortage**, particularly nurses, Marian has developed a projected priority recruitment list for health care workers including pharmacists, imaging technologists, clinical lab scientists, physical therapists, and respiratory therapists, Marian continues to identify and develop a projected priority recruitment list for healthcare workers. Partnering with Allan Hancock College, Cuesta College, and Cal State Dominguez Hills, Marian contributes money annually to provide for instructors and other program support. These agreements allow the hospital to provide clinical training experiences for students in a variety of health science fields of study, thereby providing the hospital with improved recruitment capacity. Physician recruitment continues for specialties such as ob/gyn, neurology, cardiology, family practice, internal medicine, general surgery, pediatrics and hospitalists.

3. Housing and education are both ranked at 5 which is the highest need in both the 93434 zip code for Guadalupe and 93458 identified as the northwest side of Santa Maria. The chart below will further describe these zip codes:

	Percent 25+ without High School diploma	Family Poverty Female Head of Household	Percent Non-White Hispanic	Percent Poverty with kids	Percent uninsured	Percent Renting
Guadalupe 93434	56	43	92	27	26	44
Santa Maria 93458	55	50	87	26	25	49

These key indicators show some alarming statistics. Limited resources and the focus on access to care and disease management do not presently allow us to move in direction to support these needs.

D. Planning for the Uninsured/Underinsured Patient Population

1. The provision of Charity Care for those in need is a high priority for Catholic Healthcare West. Marian follows the CHW Charity Care/Financial Assistance Policy and Procedures (attachment A).
2. Marian Medical Center trains and educates all staff regarding the Patient Payment Assistance Policy. The PFS/HIM Manager ensures that staff is qualified to determine when it is appropriate to give payment assistance information and applications to patients.
3. Marian Medical Center keeps the public informed about the hospital’s Financial Assistance/Charity Care policy by providing signage and two types of informative brochures. Patient Financial Services and Admitting/Registration staff are provided training and scripting information about payment assistance and the various programs

that may be linked to services they need during the patients registration process. Letters are sent to all self-pay patients informing them of the program. Nursing units and lobby areas have brochures and information accessible to patients as well. A Financial Counselor is available to work with patients and to link them to various financial assistance programs including government funded insurance programs for which they may be eligible.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are major initiatives and key community based programs operated or substantially supported by Marian Medical Center in 2010/11. Based on our findings in our assessment data statistics, related data in the Community Need Index and hospital utilization data, Marian has selected six key programs that provide significant efforts and resources guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs:** Seeks to accommodate the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention:** Addresses the underlying causes of a persistent health problem.
- **Seamless Continuum of Care:** Emphasizes evidence-based approaches by establishing operational linkages (i.e., coordination and redesign of care modalities) between clinical services and community health improvement activities.
- **Build Community Capacity:** Targets charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance:** Engages diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Marian has focused on seven key programs for FY2011. For FY2012 Marian will select five key programs organized by the Priority Focus Areas. Survey data statistics, data in the Community Need Index and hospital utilization data indicate three Priority Focus Areas for the FY2012.

Below are the major initiative and key community based programs operated or substantially supported by Marian Medical Center in 2011. Programs intended to be operating in 2012 are noted by *. Programs were developed in response to the current Community Health Needs Assessment and are guided by the five core values.

Priority Area 1: Access to Primary Healthcare Services

- Charity Care for uninsured/underinsured and low income residents*
- Clinical experience for medical professional students*
- Operation of Marian's Guadalupe and Bunny Clinics*
- Alliance for Pharmaceutical Access*
- Transportation vouchers for discharged patients*
- Oaxacan Advocacy*

Priority Area 2: Health Promotion / Disease Prevention

- Healthy for Life Nutrition Lecture Workshop*
- Maternal Outreach*
- Community Blood Pressure Checks*
- Kid Friendly Farmers Market*
- Kohl's nutrition education grant*
- Grief and Stroke Support Groups*
- Stroke / Glucose/ Memory Screenings*

Priority Area 3: Disease Management

Conversion of Marian Medical Center to a “Tobacco Free Campus”
Congestive Heart Failure Program – Long term improvement program*
Diabetes Prevention and Management – Long term improvement program*
Marian Cancer Care Services*
Osteoporosis Program*
Home/Care/Hospice Services*
Healthy Living: Your Life Take Care*
Outpatient Palliative Care*

	referrals (Healthy Living Your Life Take Care) of existing and new patients in the FY12/13.
Baseline	FY 2011 total clinic visits – 20,733
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Implement the CPSP (Comprehensive Perinatal Services Program) that both the clinics and perinatal services could benefit from. 2. Identify dietitian to work with clinic patients. 3. Identify staff to help expand the community outreach and involvement. 4. Explore expansion in Santa Maria and San Luis Obispo Counties and provide an alternative model for physicians new to the community. 5. Update the clinic brochure for promotion. 6. Evaluate opportunities to further expand hours of service.
Community Benefit Category	C-3 Hospital Outpatient Services

Diabetes Prevention and Management	
Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Child
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	
	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	Provide a comprehensive evidence-based diabetes management 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.
FY 2012	
Goal FY 2012	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education.
2012 Objective Measures/ Indicator of Success	Participants in the facility/service area evidence-based chronic disease self management program(s) will avoid admissions to the hospital or emergency department for the six months following their participation in the program.
Baseline	
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Identify and engage a physician program champion. 2. Identify registered dietician or CDE RN specializing in diabetes management to facilitate program. 3. Engage home health, and Emergency Department case management for patient enrollment. 4. Refer uninsured/underinsured patients to Alliance for Pharmaceutical Access for prescriptions. 5. Develop a mechanism to these enrolled follow-up and track patients and for the six months following their participation in the program. (i.e. telephonic support). 6. Identify culturally and linguistically appropriate messaging for this population of diabetic patients. 7. Provide in-service to hospital staff regarding Diabetes Prevention and Management Program. 8. Enroll program participants in CDSMP and Healthy for Life programs. 9. Support in-patient awareness of chronic disease education through case management. 10. Investigate availability of software that can track indicators to follow patients.
Results for FY 2012	
Hospital Contribution/ Program Expense	
Community Benefit Category	A1c – Community Health Education – Individual Health Education for uninsured/under insured

Community Health Education	
Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Disease Management <input checked="" type="checkbox"/> Maternal Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	Provide health education to the Santa Maria Valley community addressing current needs as identified through the needs and assets assessment. Collaborate with other community based organizations to support education of the community to increase health awareness.
FY 2011	
Goal FY 2011	Increase attendance of chronic disease related education to those with disproportionate unmet health related needs in the Santa Maria Valley by establishing a continuum of care with case management, emergency department and other hospital programs to reduce emergency room use.
2011 Objective Measure/Indicator of Success	Reduce use of Emergency Room and readmission for chronic disease related illness by increasing CDSMP attendance Spanish by 50% and English by 30% and increase HFL attendance Spanish / English by 20%
Baseline	181 broader and 597 underserved provided chronic conditions and nutrition education; 539 people screened; 29 Spanish speaking encounters and 86 English speaking encounters for CDSMP; 458 Spanish encounters, 75 English encounters for HFL Nutrition Workshops
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Engage leaders (CEO, physicians/staff champion to promote disease management initiatives. Collaborate on an improved healthcare education and referral plan addressing those patients within our control. Set up “booster training” for master trainers and leaders twice each year to build skills on core elements of CDSMP program For CDSMP, standardize telephone follow up surveys for participants. Use satisfaction questionnaire upon completion of a workshop to improve the program. Establish a continuum of care for uninsured Emergency Room discharged patients diagnosed with a chronic condition. Establish a baseline measurement for referrals from case management, physician and clinic. Use evidence-based intervention strategies to address the identified disproportionate unmet health-related need.
Results FY 2011	<ol style="list-style-type: none"> Marian’s self management program for chronic disease; Healthy Living: Your Life Take Care increased attendance by 204% (English decreased 39%) (Spanish increased 686%) Healthy for Life Nutrition Workshops increased in attendance by 180%. Community Health Education focused on nutrition education for children through partnerships with the B&G Club and the YMCA. This activity includes Yoga and Zumba classes for adults increasing those served by 333% (English – 164% increase) (Spanish – 184% increase). While #1 and #2 above both have telephonic follow up that can provide measurable results to reflect hospital readmissions and behavior modification leaders/educators have not been successfully in completion for this outcome. CDSMP Spanish leaders attended the first scheduled quarterly meeting reviewing the “Fidelity Checklist” with 100% attendance. Leaders are asking for additional “booster training” HFL Educators attended the first quarterly meeting providing them with updates of curriculum and further instruction on conducting follow-up support There has not been a continuum of care established for referrals to the CDSMP/HFL programs by those discharged ER patients/clinic patients nor MMC’s other community based programs.
Hospital’s Contribution / Program Expense	\$31,339 was the total for this program expense. This does not include the staff time for 1.5 FTE’s
FY 2012	
Goal 2012	Increase attendance of chronic disease / nutrition related education to those with disproportionate unmet health related needs in the Santa Maria Valley.
2012 Objective Measure / Indicator of Success	<ol style="list-style-type: none"> Increased English HFL and CDSMP attendance by 20% Increase physical activity/exercise attendance by 30% Train 3 promotoras to teach HFL and Zumba workshops Utilize Healthy Start and SMBSA advocates for promotion of Self-Esteem workshop for at risk girls; increasing workshops by 50% As identified by the needs assessment, Internal Environmental Policy/External Environmental Policy change regarding nutrition.
Baseline	<u>Healthy Living: Your Life Take Care</u> –235 total served (199 Spanish/34 English) <u>HFL</u> – 1110(243 English/867 Spanish); <u>Yoga</u> 629 Spanish; <u>Zumba</u> 124 Spanish; Kids <u>Farmer’s Market</u> – 132 poor and vulnerable; <u>YMCA</u> 630 children/adults; <u>Dove’s Self-Esteem Workshop</u> 41 at risk Spanish girls and mothers.

Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Need strategies for Mixteco education and teen pregnancy 2. Need strategy for Osteoporosis and how it may relate to fall prevention (need) 3. Working with the Santa Barbara Public Health Department, Food Bank of Santa Barbara County and key stakeholders at Marian Medical Center, utilize Marian's strategic plan and California's Obesity Prevention Plan to effect local policy change. 4. Establish a continuum of care between clinics, case management, emergency department and other hospital programs to support increase in HFL and CDSMP workshop attendance. 5. Work with Community Partners in Care and Corporate Office to provide better support to CDSMP leaders.
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops) A1a

FY 2012	
Goal 2012	Restructure AGCH and Coastal Care Center under one <u>American College of Surgeons: Commission on Cancer</u> accreditation program. New service area will continue services and incorporate into one with the Marian Cancer Care Services' Program Digest. Improve health and well-being of Marian's primary and secondary service area by providing health education, cancer screenings, educational seminars, support services to the poor and vulnerable community, to provide earlier detection of cancer in an effort to reduce preventable cancer-related deaths.
Objective Measure/ Indicator of Success	<ol style="list-style-type: none"> 1. Increase number of participants attending screenings by 3% to facilitate early detection. Focus on prevalent types of cancer (skin, prostate, breast, cervix) by offering three cancer screenings, targeting poor, vulnerable and Hispanic community. Provide follow-up care and/or referrals. Work closely with Community Education Department and advertise to local farms, wineries, and churches. Increase by 3% number of patients receiving nutritional counseling. 2. Increase by 3% educational development for cancer patients and caregivers through informative presentations, and support group. Results from the Community Focus Groups identifying mammograms and colonoscopies as focal areas. Educational presentations and/or forums will facilitate this education. 3. Increase by 10% underserved and underinsured community members participating in cancer-related events.–Develop a cultural competency for staff to better understand surrounding preventions, early detection and treatment of cancer for this target population.
Baseline	FY10/11 total is: 19,676: Support Groups: 561; Educational/Lectures: 1,090 (12,550 received educational articles in the newsletter); Self-Help: 1,807; Spanish Group: 132; Information & Referral: 15,357 and Spanish Calls: 729
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Utilize promotoras to promote cancer screenings to the poor and vulnerable Hispanic community and expand to Senior Centers. 2. Identifying newly diagnosed patients and expands outreach utilizing promotoras for one-on-one nutritional counseling which will be needed during cancer patients' treatment. 3. Target poor and vulnerable community to provide cancer education expanding outreach to senior citizen communities and senior centers which service Hispanic community. 4. Utilize Cancer Care Newsletter and weekly newspaper column as a tool to educate underserved community. 5. Establish relationship between dedicated cancer center staff and promotoras to promote a raised awareness of health, and cancer related educational issues by working with local farms and wineries. 6. Promotora can support Spanish speaking clients through recurring phone calls, follow-up, regularly distributed cancer-related material and available resources through Marian Cancer Care Services.
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops; Support Groups, Self-help; Information and Referral) A1a, A1d, A1e, A3e, E1b

Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Continue to offer the CHF Program to all inpatient's with a diagnosis of heart failure. 2. Provide hospital inpatients evidence based education regarding heart failure. 3. Implement Philips telemonitoring pilot program for 50 patients within the CHW of the Central Coast service area. 4. Implement telephonic assessments in Philips software for remaining participants. 5. Continue to collaborate with CHW facilities as well as partners in the community (Community Health Clinic, Public Health Departments) to refer patients to the CHF Program. 6. Track reports for both telemonitor and telephonic participants for outcomes using SHP solutions tool as well as hospital MIDAS reports. 7. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers. 8. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center. 9. Utilize American Heart Association and American College of Cardiology resources and guidelines to continue education regarding heart failure as well as referrals to community based programs. 10. Evaluate participant response the telemonitor and telephonic programs using exit surveys.
Community Benefit Category	Health Care Support Services A3e

COMMUNITY BENEFIT AND ECONOMIC VALUE

A. Classified Summary of Quantifiable Community Benefit Costs is calculated using cost accounting methodology.

Marian Medical Center
For period 7/1/2011 through 6/30/2011

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Poor						
Traditional Charity Care	5,088	2,062,138	0	2,062,138	1.0	0.9
Unpaid Cost of Medicaid	45,631	49,529,745	42,842,604	6,687,141	3.2	2.8
MIA	884	1,372,241	756,196	616,045	0.3	0.3
Community Services						
Cash and In-Kind Contributions	5,339	1,031,430	0	1,031,430	0.5	0.4
Community Benefit Operations	0	167,129	0	167,129	0.1	0.1
Community Building Activities	331	8,608	0	8,608	0.0	0.0
Community Health Improvement Services	34,016	1,303,835	110	1,303,725	0.6	0.6
Subsidized Health Services	29,374	3,128,980	0	3,128,980	1.5	1.3
Totals for Community Services	69,060	5,639,982	110	5,639,872	2.7	2.4
Totals for Poor	120,663	58,604,106	43,598,910	15,005,196	7.1	6.4
Benefits for Broader Community						
Community Services						
Community Benefit Operations	0	54,112	0	54,112	0.0	0.0
Community Building Activities	0	3,855	0	3,855	0.0	0.0
Community Health Improvement Services	9,963	414,006	0	414,006	0.2	0.2
Health Professions Education	180	805,172	0	805,172	0.4	0.3
Research	0	8,155	0	8,155	0.0	0.0
Totals for Community Services	10,143	1,285,300	0	1,285,300	0.6	0.5
Totals for Broader Community	10,143	1,285,300	0	1,285,300	0.6	0.5
Totals - Community Benefit	130,806	59,889,406	43,598,910	16,290,496	7.7	6.9
Unpaid Cost of Medicare	48,657	62,463,663	54,288,263	8,175,400	3.9	3.5
Totals with Medicare	179,463	122,353,069	97,887,173	24,465,896	11.6	10.4



Sue Andersen, Chief Financial Officer
Central Coast Service Area, Catholic Healthcare West

B. Telling the Story

As a member of Catholic Healthcare West, Marian Medical Center is committed to serving the health needs of our community with particular attention to the needs of the economically disadvantaged members of our community. Serving the community is a high priority for Marian Medical Center. Each year a report of progress is posted to the Marian Medical Center website. This report is available to our local community, provides information on the uncompensated care and programs for the benefit of the community. It includes costs for persons who are poor and cost associated with Medi-Cal and other government program beneficiaries and costs for services our hospital subsidizes because they are not offered anywhere else in the community. Other community benefit expenses may also include clinic services, health promotion and disease prevention programs, grants and donations of cash or services to other non-profit organizations addressing the identified needs of the community.

Consensus building and community benefit work continues to take place with the help of strong partners in the Santa Maria Valley community. Sharing resources helps all community based organizations become better acquainted with services available in the Santa Maria Valley in an effort to better serve their clients.

Please find the following attachments at the end of this report: Summary of Patient Financial Assistance Policy (attachment C), Hospital Community Board Membership Roster (attachment D), Community Benefit Team Roster (attachment D)

CATHOLIC HEALTHCARE WEST
SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY
(June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Financial Assistance:

- Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the CHW facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need for financial assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the determination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the CHW facility.

CHW's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as *income* for these purposes.

Communication of the Financial Assistance Program to Patients and the Public:

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- CHW system management has developed policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements: Implementing this policy, CHW management and CHW facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.



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VP, Mission Services

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