



**Arroyo Grande  
Community Hospital.**  
A Dignity Health Member



**Arroyo Grande Community Hospital**  
**Community Benefit Report 2012**  
**Community Benefit Implementation Plan 2013**



A message from Ken Dalebout, Administrator/CEO, and Jacqueline Fredrick, Board Chair  
Arroyo Grande Community Hospital

At Arroyo Grande Community Hospital we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and our how we live out our Mission. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals, such as Arroyo Grande Community Hospital.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$5,229,722 million in charity care, community benefits, and unreimbursed patient care.

At Arroyo Grande Community Hospital we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy the Arroyo Grande Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 18, 2012 meeting.

Kenneth Dalebout  
Administrator/CEO  
Arroyo Grande Community Hospital  
Hospital

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Hospital Board Chair  
Arroyo Grande Community

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# EXECUTIVE SUMMARY

Since 1961 Arroyo Grande Community Hospital (AGCH) has been servicing the community's health care needs and became a member of Dignity Health, formerly Catholic Healthcare West (CHW)<sup>1</sup> in 2004. This 67-bed state-of-the-art facility provides a full range of services, including medical-surgical, acute and emergency care. AGCH has been recognized with a "Blue Distinction" award for their Knee and Hip Replacement Services by Blue Cross and Blue Shield and continues to be nationally ranked in the top 15% of all U.S. hospitals for Joint Replacement surgical services. In June 2011, AGCH opened its new 14-bed Acute Rehabilitation Center that serves patients who suffer functional loss from illnesses such as stroke, neurological and brain injury, spinal cord injury or other impairments requiring rehabilitation. Arroyo Grande Community Hospital has the second busiest Emergency Department in the County, treating an average of 1600 patients each month, and consistently excels in patient satisfaction ratings. With an affiliation of approximately 109 active physicians, surgeons and other medical professionals and 382 employees, AGCH continues to be highly regarded for excellent healthcare.

Major Community Benefit activities for FY2012 has focused on improving **access to healthcare**, along with other community needs, by assisting in financial counseling and connecting patients to either federal or state insurance programs. A goal of this focus is also to increase the **cultural awareness** of staff by providing information in both English and Spanish, since a major portion of our community is a growing Hispanic population. Currently, admitting personnel provide information about the Healthy Families insurance programs in both English and Spanish. Additionally, in-house assistance is provided to assist patients through the enrollment process for insurance using the contracted services of Integrated Health Management Services. Admitting personnel also provide bi-lingual payment assistance brochures in the Emergency waiting room and hospital admitting room.

With the acknowledged need to support the development of qualified healthcare professionals, Arroyo Grande Community Hospital continues to identify and develop a projected priority recruitment plan for healthcare workers. Partnering with Cuesta College, AGCH contributes money annually to provide for instructors and other program support. These arrangements 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. AGCH, as a means to foster professional development and improve patient care, continues to expand hospital programs, including case management, post acute care coordinators and medical directorships to coordinate and monitor patient transitions across the continuum of care settings. AGCH will continue its ongoing program of supporting the recruitment of primary care physicians to the area and promote expansion of existing community health care services, focusing on the needs of the poor.

**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. AGCH offers two specific courses to help empower the community with

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<sup>1</sup> For more information about the name change, please visit [www.dignityhealth.org](http://www.dignityhealth.org)

the ability to manage their personal health: ***Healthy for Life Nutrition Lecture Series*** consists of four 1 ½ hour workshops. This interactive program provides nutrition education and a physical activity component and makes a correlation between nutrition, physical activity, body mass and physical wellness. Stanford University's School of Medicine evidence-based Chronic Disease Self-Management Program; ***Healthier 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. Both programs are offered in English and Spanish and are held in designated locations in the community for easier access for community participation. These locations include schools, churches or other community rooms that are made available by collaborative partners. Health lectures for disease prevention focused on topics of diabetes, heart health and hypertension for the broader community. The hospital provides support to the underserved with a variety of bilingual health fairs. Through partnerships with other community agencies, these health fairs provide opportunity for screenings and other health related services for the poor.

The **Congestive Heart Failure Program (CHF)** continues to bridge medical and educational needs of patients living with heart failure through a collaborative effort between the acute care hospital, Home Health, and the physicians' offices at AGCH. This program successfully minimizes readmission of patients and helps decrease the severity of the illness for most program participants. The CHF program has been enhanced with the use of patient telemonitors. Telemonitors can build a network of distance health service delivery based on reliable, easy-to-use, integrated technology that supports equitable access for patients and efficiency for clinicians. Patients show improved quality of care and clinical outcomes to include early detection, intervention and reductions in avoidable hospitalization. Telemonitoring also improves physician engagement and patient satisfaction while improving patient compliance with medications, diet, weight-monitoring and symptom management.

The **cancer awareness and support program** offers extensive informative educational outreach efforts about the many types of cancer to the community, including but not limited to skin, prostate, lung, breast, and colon, particularly to those identified as poor, vulnerable, and underinsured. Outreach consists of on-site screenings at health fairs and promotional events, mailers and newsletters and other informative tools to reach the poor and broader community on how to prevent cancer, treatment options if necessary and other resources available to the community. Support services at Coastal Cancer Care Center include a dedicated breast cancer nurse navigator whose program has been in existence since 2008. 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.

**Outreach to the underserved** included providing meals for the homeless at the local People's Kitchen and partnering with Catholic Charities to provide monthly box lunches to the poor at a Food Bank distribution center located at St. Patrick's Catholic Church. Local senior citizens were provided a healthy lunch or snack at health lectures at AGCH.

The total dollars quantified for Community Benefits for these and numerous other community benefit programs in FY2012 are \$5,229,722 which excludes Medicare. Including the expenses incurred for the unreimbursed costs of Medicare, the total expense for Arroyo Grande Community Hospital was \$14,471,392.

## **MISSION STATEMENT**

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

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

## **ORGANIZATIONAL COMMITMENT**

### **A. Hospital's Organizational Commitment**

1. Arroyo Grande Community Hospital's (AGCH'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. AGCH 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 Dignity Health Central Coast entities continues to improve operational efficiency and performance.
  - AGCH's commitment to the Dignity Health community grants program offers other not-for-profit community-based organizations an opportunity to support the community at large. AGCH's Community Benefit Committee annually reviews and awards non-profit organizations community grants.
  - AGCH and sister hospital, French Medical Center, have joined together to support the San Luis Obispo County Trust Fund with their application to the Dignity Health Community Investment Fund. This has enabled them to develop new low income housing for county residents in the communities of Paso Robles, Atascadero and Nipomo. AGCH continues to encourage eligible non-profit organizations to apply for Dignity Health Community Investment Funding.
  - A subcommittee of Hospital and Community Board members and staff participates in quarterly Community Benefit Team meetings and contributes their expertise in monitoring community programs to ensure success (roster of participants is in the appendix).
  - Each year the hospital community board reviews community outreach statistics and determines which programs will be funded in the coming year, choosing programs that focus on the unmet health-related needs of the poor and underserved.
  - Program coordinators 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.

- Community based organizations regularly collaborate with AGCH to plan and facilitate local community health fairs and assist with AGCH’s outreach programs while providing valuable support in maintaining a focus on community needs. These organizations are active partners in providing health services to the community.
- 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. Two AGCH employees (a pharmacist and a nurse) walked for an hour at Relay For Life 10:00-11:00 pm in Paso Robles on Saturday, June 23<sup>rd</sup> to benefit the American Cancer Society.
  2. AGCH Transformational Care team worked with the Emergency Department to decrease the time from door to admit to doctor to discharge, and with the Inpatient Direct Care team to improve patient education, perception of care, home discharge needs and discharge time and improved identification of palliative care patients.
  3. Eighty-three employees contributed personal funds to the employee assistance fund, up from 32, to assist employees through difficult circumstances such as death, tragedy, accident, or illness.
  4. An AGCH hospital employee has donated his time to benefit the homeless as a cook in the “People’s Kitchen,” chair a fundraising committee to raise funds for the “Special Olympics,” pick up litter on the roadside through volunteering in the “Adopt-A-Highway” program, and supports AGCH as a member of ‘Circle of Friends’ and the ‘Friendship Fund Group.’
  5. The Environmental Team at AGCH regularly uses non-toxic paints on maintenance projects, and regularly promotes reducing waste through a recycling program.
  6. Meals on Wheels (MOW) serve meals to the economically disadvantaged people of the AGCH service area 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 with AGCH and Food Bank Coalition now serves eighty-five customers daily.

## COMMUNITY

- A. Definition of community— Dignity Health hospitals define the community as the geographic area served by the hospital, considered its primary service area. This is based on a percentage of hospital discharges and is also used in various other departments of the system and hospital, including strategy and planning. Arroyo Grande Community Hospital (AGCH) defines its community as located equidistant between San Luis Obispo and Santa Maria. It’s service area is entirely within San Luis Obispo County. The largest cities in its service area are Arroyo Grande, Grover Beach, Nipomo, Oceano and Pismo Beach.
1. The poverty rate in the AGCH service area is less than it is statewide, but about one in every five female heads of household living with children are living in poverty. In Nipomo that number is about 1 in 4 (24%), and in Arroyo Grande, it is 19.3%.

- B. A description of the community in this service area from the most recent community health needs assessment (see Appendix 1) is provided below to assist in better understanding the community setting:

**Language**

The number of Spanish-speaking households in some communities in the AGCH service area is relatively high. In Nipomo, one in every four households speaks Spanish at home. In Oceano, nearly one-third of all households speak Spanish at home. This can become a barrier for access to healthcare and result in more serious conditions if their issues go untreated. Telephone translation services offered at some facilities also are not necessarily of high quality, as has been reported, and some educational materials do not reflect the comprehension levels of most Spanish-speaking patients, resulting in the non-use or discarding of materials.

**Economic Indicators**

1. Key industries in the county include tourism, education, agriculture and government. Health services and other public services account for the largest concentration of jobs in the area. Because of the national recession and California's huge struggling economy, the County's economy remains stagnant.
2. Hispanic income in the service area is most likely over estimated. There are often three or four laborer families living together in one household. If calculated by each family separately, their average income would most likely be significantly lower.
3. The percentage of the county's population that is living at or below the Federal poverty level is 13.6%. Poverty increases the risk of many conditions, including poor nutrition, low birth weight, children's cognitive and developmental delays, unaffordable and inaccessible health care, decreased mental well-being, poor academic achievement, unemployment and inadequate housing.
4. Death rates for people below the poverty level are much higher than those above it. Low socioeconomic status is also associated with higher risks of infectious diseases accidents and homicides.

**Housing**

1. San Luis Obispo County is one of the least affordable housing markets in the nation. 57.4% of local households are able to afford a median-priced home.
2. There is a significant need for more affordable housing in Latino dominated areas and other low-income communities in the county. The cities of Nipomo and Oceano exhibit the highest percentages of "overcrowded" housing units in the county.
3. There is a large population of homeless, mostly men, living on the streets, in creeks, in the sand dunes and campgrounds. Their numbers are estimated by churches and other community service agencies to be approximately 3,774 homeless people.

**Uninsured Population**

A lack of health insurance can mean an inability to afford healthcare and create unnecessary barriers for prevention of disease. People who do not have health insurance or cash prefer to have food on their table instead of going to see the doctor. Access to health insurance has been indicated as one of the most common issues facing the community.

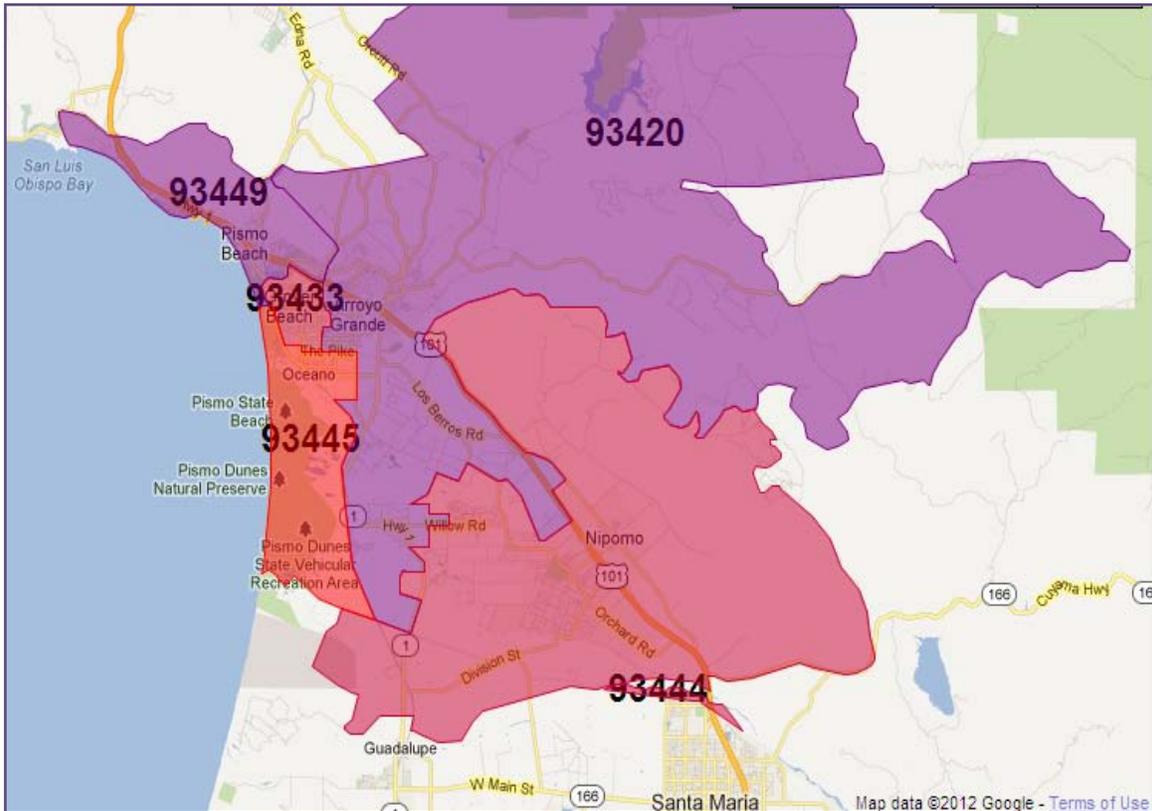
1. 13.3% of children 0-17 are eligible for Medi-Cal, however,
2. Only 2.1% of SLO County residents are eligible for Medi-Cal.

**Education:**

1. Eighty-six percent of the AGCH service area has at least graduated high school with a diploma and 28.6% have a bachelor's degree or higher.
  2. Over thirteen percent have less than a 9<sup>th</sup> grade education or no high school diploma. This will affect their ability to have qualified vocational skills, which could have negative outcomes regarding housing, access to healthcare, health insurance, employment, and may, for example, increase their risk of alcohol and drug use.
- C. The demographics of the Arroyo Grande Community Hospital's service area is more clearly defined below as identified in the 2010 Census data and which is reported on the Schedule H 990.
- Population: 75,494
  - Diversity: Caucasian – 67% | Hispanic – 26.4% | Asian, Pacific Islander – 3.0% | African American – 0.7% | Other – 2.9%
  - Average Household Income: \$76,494 (43.7% rank \$50,000 and under; 56.3% rank over \$50,000)
  - Uninsured: 15.1%
  - Unemployment: 4.1%
  - No HS Diploma: 14.0%
  - Renters: 29.4%
  - CNI Score: 3.4
  - Medicaid Patients: 8.5%
  - Other Area Hospitals: 2

Although Arroyo Grande contracts with over 25 insurers that provide healthcare insurance to this community, a large percentage of residents in the Five Cities area have little or no health insurance. We rely heavily on our partners, Integrated Health Management Services (IHMS), to assist these patients with health coverage, including government and non government programs. Community Health Centers of the Central Coast have five community health clinics: three in Arroyo Grande, one in Nipomo, and one in Oceano. Arroyo Grande Community Hospital is not considered a Medically Underserved Area (MUA).

# Arroyo Grande Community Hospital



Lowest Need

1 - 1.7 Lowest

1.8 - 2.5 2nd Lower

2.6 - 3.3 Mid

3.4 - 4.1 2nd Higher

4.2 - 5 Highest

Highest Need

<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
93420	3	28603	Arroyo Grande	San Luis Obispo	California
93433	3.6	12844	Grover Beach	San Luis Obispo	California
93444	3.4	18894	Nipomo	San Luis Obispo	California
93445	4.8	7441	Oceano	San Luis Obispo	California
93449	3	8440	Pismo Beach	San Luis Obispo	California

**CNI SCORE MEDIAN: 3.4**

# COMMUNITY BENEFIT PLANNING PROCESS

## A. Community Health Needs Assessment Process

The Affordable Care Act issued a new law that affects the community health needs assessment. The requirement is that every not-for-profit hospital must conduct a health needs assessment in accordance with the following criteria:

- at least once every three years – 1<sup>st</sup> must be completed by end of tax year beginning after March 23, 2012,
- include input from persons who represent the broad interests of the community, and
- include input from persons having public health knowledge or expertise. We must also make the assessment widely available to the public and adopt a written implementation strategy to address identified community needs.

AGCH's community health needs assessment was completed during the current tax year, and will be made publicly available by January 2013. AGCH's Implementation Strategy Report will be posted no later than March 23, 2013.

In the areas that overlap, each central coast hospital's report identified findings and recommendations based on that particular service area. The Community Health Needs Assessment (CHNA) report for each hospital provides a more in depth explanation for Next Steps. The next step in completing this process is to set up a working committee meeting to brainstorm strategies for implementation of the top identified priorities. While implementations strategies will be reflected in the FY2013/2014 Community Benefit Plan and Report, AGCH will utilize some of this primary research, supported by secondary data which indicates the prevalence of several medical conditions occurring in the community.

There are a number of barriers to healthcare that while they may appear disparate, have the same outcome: hindering vulnerable populations from obtaining care. The qualitative and secondary data findings indicate that the rates of uninsured and underinsured in the area are major barriers to care. Around 15% of AGCH service area residents reported being uninsured.

A summary of community needs is provided below. The section tells the story by comparing and contrasting primary data with the secondary data gathered from publicly available reports.

- a. People are utilizing **Emergency Department** services inappropriately because of an inability to afford primary care, they are tired of waiting to get a clinic appointment or their schedules do not permit them to get to the clinic during its hours of operation. People put off seeking care until their conditions are so serious they have no choice but to go to the emergency room.
- b. Preventing **obesity** and reducing the prevalence of overweight and obesity is an area of community need, as obesity is associated with increased incidence of multiple serious health conditions. A majority of the AGCH service area's adults are overweight or obese and more than one-third of children in the area are overweight or obese. The primary research shows that residents in the AGCH service area have poor dietary and exercise habits which may contribute to the relatively high rates of

overweight and obesity. Diet and exercise are linked to diabetes and other serious illnesses. Residents frequently consume fast food, soda, and sugary drinks. Teenagers, in particular, reported drinking large quantities of soda and sugary drinks, while at the same time consuming few fruits and vegetables. The American Academy of Pediatrics recommends that parents limit children's soda consumption and underscores soda's link to the childhood obesity epidemic.

- c. Study participants are concerned about the number of people who have **diabetes** in the community. Secondary data show that people who have diabetes in the AGCH service area are not receiving treatment that adheres to guidelines established by the American Diabetes Association. The number of diabetes patients reporting that a provider had never checked their feet for sores or ordered an HgA1C test has been increasing. Some of the increase appearing in the secondary findings may be artificial, as some patients may not know which specific blood tests are being performed, or they may forget the names of the tests. But the fact that up to about one-half (depending on the indicator) of AGCH service area adults with diabetes are not being monitored according to established guidelines should be cause for concern if the hospital hopes to achieve its diabetes-related goals.
- d. There are not enough **mental healthcare** providers resulting in people being referred out of the area. To address the community needs, we might explore alternative approaches, such as consultations with mental health patients by telephone or video-teleconferencing.
- e. **Language** is a barrier to care in the AGCH area, especially if interpreting service providers are not available or there are not bilingual medical staff available in community-based primary care settings. In Nipomo, for example, over 20% of households speak Spanish as their primary language, while in Oceano, over 30% are speak Spanish as their primary language at home. Increase the number of interpreters on staff and broaden translation offerings to meet appropriate literacy level are recommended. Many patients depend on family and friends as non-certified medical interpreters raising an issue of privacy.
- f. The primary research findings also indicate that some community-based providers are not **culturally sensitive** and some educational programs are not culturally appropriate. Some residents, particularly immigrants, do not trust modern medicine or healthcare providers and avoid seeking healthcare services as a result. Cultural beliefs can lead to the use of culturally-based, non-medical remedies that people employ hoping to avoid the cost of a clinic appointment.
- g. While addressing poor diet and exercise habits is important to improving the health of residents in the AGCH service area, participants also identified **oral health** as an area of need, and oral health has been shown to impact overall health. Low-income residents have inadequate access to affordable dental care. Many children have never been to a dentist and more than one-third of adults have no dental insurance.
- h. Transportation is a major barrier to care in the AGCH service area and is one of the biggest complaints some key informants hear from people who live in the community. First, the cost of **transportation** can be prohibitive and, for those who do not own vehicles, options are few. Bus schedules are inconvenient and the number of available routes has been shrinking, so taking the bus to and from a medical appointment can take a full day. In addition, some people cannot afford bus fare.

- Others cannot afford to take a full day off to go to a medical appointment when they are having trouble putting food on the table. Instead, they may choose to forgo care.
- i. Though there are five Community Health Centers (CHC) and four Community Action Partnership of San Luis Obispo (CAPSLO) service programs in the AGCH service area, residents suggest that there is a lack of **awareness of existing programs and services** provided in the AGCH service area, with English speakers more aware of programs than the Latino population. Rebuilding trust and providing more education about what is available to these residents is critical if health services and health-related goals are to be met.
  - j. Utilization of **maternal and teenage healthcare** services indicates the AGCH service area has a lower rate of women receiving late prenatal care than both SLO County and the State of California. However, access to quality, safe child care is a major issue facing the community. Sex education and a lack of communication between parents and teens on the subject of sexuality is a key issue facing the community. In the Latino community specifically, this is exacerbated by the fact that parents are working long hours just to pay rent and that this strains their relationships with their children who spend “a lot of time alone”.
- B. An inventory of community assets can be described below and are categorized by the hospital community benefit priority areas of Arroyo Grande Community Hospital:
- a. Access to Primary Healthcare Services
    - i. Community Health Centers of the Central Coast have five community health clinics: three in Arroyo Grande, one in Nipomo, and one in Oceano.
    - ii. Community Action Partnership of San Luis Obispo County has four service programs in AGCH service area. These programs include: Health Clinic & Direct Services, Head Start, and Migrant Head Start. CAPSLO locations include: one in Arroyo Grande, one in Grover Beach, one in Oceano and one in Nipomo.
    - iii. The San Luis Obispo County Public Health Department has several services it offers from its San Luis Obispo location, and one satellite location in Grover Beach.
  - b. Health Promotion/Disease Prevention
  - c. Lucia Mar Unified School District, local churches, Santa Barbara Coalition in Support of Promotora de Salud
  - d. Disease Management
    - i. Alliance for Pharmaceutical Access; Arroyo Grande Community Hospital’s CHF and Diabetes Education Programs

### C. Developing the Community Benefit Report and Plan

1. The community benefit planning process considers the fiscal year 2012 program outcomes serving as a springboard for the continuation of most current programs. There are a number of checks and balances set to ensure Dignity Health values are integrated into programs and services: (a) strategic planning has impact on factors of involvement for specific program implementation; (b) the Community Benefit 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) 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, AGCH has seen an increase in the number of uninsured residents and residents covered by Medi-Cal. 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, AGCH 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 CHC 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 areas with disproportionate unmet health needs are Grover Beach and Oceano. These areas are in need of improved access to healthcare and services for the underinsured and uninsured. Uninsured Latinos in the AGCH service area 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 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, AGCH will also focus on building community capacity by strengthening our partnerships among community based organizations.

A number of community needs exist in the service area of Dignity Health's three Central Coast hospitals. Marian Regional Medical Center, Arroyo Grande Community Hospital, and French Medical Center may realize efficiencies by working together to address the following common unmet community needs as we work together in FY2013/2014.:

- Access to Care
- Emergency Department Utilization
- Cultural Awareness
- Preventive Care
- Clinical Conditions
- Nutrition and Physical Exercise
- Awareness of Existing Services
- Mental Health
- Oral Health
- Transportation

By working together to identify, adopt, and develop programs to address these common areas of need, each of the hospitals may save valuable resources. However, it is important to be mindful of the population that each hospital serves and tailor programs to meet the needs of each hospital's unique population. This may mean modifying programs to suit cultural and/or language differences.

3. The recommendations above are not ranked. A next step is for AGCH, along with Marian Regional Medical Center, French Hospital Medical Center, community partners, and others to determine which issues to address first. There are resources available that may assist AGCH's strategic planning committee in determining which needs to address first and how best to allocate resources. Implementation strategies, identified target areas and populations, how the major needs were prioritized, a description of what AGCH will do to address Community Health Needs and the subsequent Action Plan will be completed and part of Arroyo Grande Community Hospital's CHNA and Implementation Strategies Report by March 23, 2013. The governing body of the organization must adopt the implementation strategy for each facility in the same taxable year that each facility's CHNA report is widely publicized. Implementation strategy documents must be filed with IRS Form 990 beginning with Taxable Year starting after March 23, 2012.

D. Planning for the Uninsured/Underinsured Patient Population

1. The provision of Charity Care for those in need is a high priority for Dignity Health. AGCH follows Dignity Health Charity Care/Financial Assistance Policy and Procedures (Attachment A).
2. AGCH 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. AGCH 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.

## PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are major initiatives and key community based programs operated or substantially supported by AGCH in 2011/12. Based on our findings in our assessment data statistics, related data in the Community Need Index and hospital utilization data, AGCH 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.

AGCH has focused on five key programs for FY2013. For FY2013 AGCH will implement/enhance 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 FY2013.

Below are the major initiative and key community based programs operated or substantially supported by Arroyo Grande Community Hospital in 2012. Programs intended to be operating in 2013 are noted by \*. Programs were developed in response to the current Community Health Needs Assessment and are guided by the five core principles.

### Priority Area 1: Access to Primary Healthcare Services

- Charity Care for uninsured/underinsured and low income residents\*
- Clinical experience for medical professional students\*
- Alliance for Pharmaceutical Access for medication\*
- Transportation vouchers for discharged patients\*
- Physicians Orders for Life Sustaining Treatment (POLST) lectures\*

Priority Area 2: Health Promotion / Disease Prevention

- Healthy for Life Nutrition Program\*
- Community health fairs with health screenings
- Flu shots for farm workers and seniors\*
- Breast Cancer Screening event\*
- Food for homeless, poor and seniors at health lectures\*
- Promotoras de Salud education program\*

Priority Area 3: Disease Management

- Congestive Heart Failure Program – Long term improvement program\*
- Diabetes Prevention and Management – Long term improvement program\*
- Cancer Support Group\*
- English / Spanish --Healthy Living: Your Life Take Care (Chronic Disease Self Management classes)\*

## PROGRAM DIGESTS

<b>Community Health Education</b>	
<b>Hospital Community Benefit Priority Area</b>	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Disease Management
<b>Program Emphasis</b>	<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 type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
<b>Program Description</b>	Provide south San Luis Obispo county with health-related programming that will empower community members to become proactive and assume responsibility for their health and to educate people to prevent and manage chronic disease conditions.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Provide health-related opportunities to prevent or manage chronic disease.
<b>2012 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Increase English and Spanish HFL and CDSMP attendance by 10%</li> <li>2. Train at least 4 promotoras to teach HFL workshops to increase attendance by 20%, and help recruit participants at health fairs in AGCH service area.</li> <li>3. Partner with Lucia Mar Unified School District (LMUSD) and other community based organizations to increase attendance at HFL/CDSMP lectures</li> <li>4. Gather community health needs data through screenings at health fairs.</li> <li>5. Partner with community based organizations to serve food to the homeless and underserved.</li> </ol>
<b>Baseline</b>	99 chronic disease self management participants, 449 underserved participants received health education, 583 broader seniors participated in health related classes
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Provide 4 Chronic Disease Self Management class series in 2/English and 2/Spanish.</li> <li>2. Provide 10 Healthy for Life nutrition lecture programs for poor families.</li> <li>3. Provide bi-monthly senior health lectures.</li> <li>4. Provide and participate in 3 comprehensive health fairs that offer cholesterol and BP screenings.</li> <li>5. Train Promotoras to assist with health lectures in the community and health fairs.</li> </ol>
<b>Result FY 2012</b>	<ol style="list-style-type: none"> <li>1. Healthy Living: Your Life Take Care, the chronic disease self-management program decreased attendance 19% over last year. The Central Coast Service area has had a reduction in Spanish and English leaders for this program.</li> <li>2. Healthy for Life Nutrition education increased by 16% overall with a significant increase in nutrition education to children</li> <li>3. 298 people were served through health fairs providing blood pressure checks and cholesterol screenings. 260 people were served through health fair promotion which AGCH promoted nutrition education and workshops featuring HFL and CDSMP classes.</li> <li>4. Seven promotoras from San Luis Obispo County graduated from the Santa Barbara County Coalition –Promotora y promotoras training. AGCH recruited these seven graduates to, assist at health fairs for health promotion. Six promotoras attended HFL curriculum training and will be certified as instructors August 2012.</li> <li>5. 2,160 homeless people served food at St. Patrick’s Catholic Church and through People’s Kitchen.</li> </ol>
<b>Hospital’s Contribution / Program Expense</b>	\$44,403 (staff hours); \$8302 (program activity); \$4943 (health promotion and screenings); \$16,255 (People’s Kitchen, Salvation Army and St. Patrick’s Lunch meal) Total: \$73,903

<b>FY 2013</b>	
<b>Goal 2013</b>	Increase attendance of chronic disease / nutrition education and physical activity to those with disproportionate unmet health related needs in the Arroyo Grande Community Hospital service area.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Increase English HFL and CDSMP attendance by 20%</li> <li>2. Train 2 promotoras as Zumba Instructors to teach in communities identified as poor and impoverished.</li> <li>3. Using three and six month follow up calls to engage 20% of these attendees to take HFL, CDSMP, and/or Zumba classes.</li> <li>4. Report through telephonic follow up 50% of respondents report an increase in knowledge, improvement in attitude and change in behavior.</li> </ol>
<b>Baseline</b>	<p><u>HFL</u>: 639 total served (463 children, 176 Spanish speaking participants)  <u>Healthy Living: Your Life Take Care</u>: 79 total served  <u>Senior Health Lectures</u>: 122 total served  <u>Homeless</u>: 2160 homeless people served healthy lunches at People's Kitchen and St. Patrick's Catholic Church.</p>
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Network, promote and establish a continuum of care with AGCH department managers, nurses, case managers and social workers to increase attendance at HFL/CDSMP/Senior and Zumba classes.</li> <li>2. Recruit participants for HFL and CDSMP at 3 Community-based Health Fairs.</li> <li>3. Collaborate with Lucia Mar Unified School District to offer health education to parents and students.</li> <li>4. Inform physician's offices, and local senior residential communities about our CDSMP and Senior Health lecture offerings.</li> </ol>
<b>Community Benefit Category</b>	Community Health Improvement Services (Lectures/Workshops) A1a

<b>Congestive Heart Failure</b>	
<b>Hospital Community Benefit Priority Area</b>	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Disease Management
<b>Program Emphasis</b>	<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 type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment Vulnerable Population</b>	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
<b>Program Description</b>	<p>The Congestive Heart Failure (CHF) program provides education to patients diagnosed with CHF during the hospital stay who additionally have a doctor's order for the program in their discharge instructions. Patients enrolled in the program are provided consistent telephonic patient follow-up and education thereby decreasing the number of readmissions to the hospital. This program also serves cardiac patients through education, risk assessment and referrals</p>
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Avoid hospital and emergency department admissions for 6 months among 60% of participants enrolled in CHF Program.
<b>2012 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Enhance the telephone based monitoring program by implementing Philips Tele-monitoring devices to prevent hospital readmissions within 6 months of enrolling in the CHF Program</li> <li>2. Identify all patients at high risk for readmission within 6 months of hospital discharge using the Probability of Repeated Readmission tool in Philips software for both telemonitor and telephonic patients.</li> <li>3. Measure quality of life changes for all participants enrolled in the CHF Program by the completion of program (6 months)</li> </ol>
<b>Baseline</b>	Current number of CHF participants at each facility.
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Continue to offer the CHF Program to all in-patients with a diagnosis of heart failure. who have a doctors order</li> <li>2. Provide hospital inpatients evidence based education regarding heart failure.</li> <li>3. Implement Philips telemonitoring pilot program for 50 patients within the Dignity Health of the Central Coast service area.</li> <li>4. Implement telephonic assessments in Philips software for remaining participants.</li> <li>5. Continue to collaborate with Dignity Health facilities as well as partners in the community (Community Health Clinic, Public Health Departments) to refer patients to the CHF Program.</li> <li>6. Track reports for both telemonitor and telephonic participants for outcomes using SHP solutions tool as well as hospital MIDAS reports.</li> <li>7. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers.</li> <li>8. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center.</li> <li>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.</li> <li>10. Evaluate participant response the telemonitor and telephonic programs using exit surveys.</li> </ol>

<b>Result FY 2012</b>	<b># of Participants</b>	<b># of Participants Admitted to the Hospital or ED within six months of the intervention</b>	<b>% of Participants Admitted to the Hospital or ED within six months of intervention</b>
	Q1/2012	106	3
	Q2/2012	97	3
	Q3/2012	129	2
	Q4/2012	124	4
<b>Hospital's Contribution / Program Expense</b>	\$4,407 plus \$59,257		
<b>FY 2013</b>			
<b>Goal 2013</b>	Avoid hospital and emergency department admissions for 3 months among 80% of participants enrolled in the CHF Program		
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Identify all patients with a CHF diagnosis at high risk for readmission</li> <li>2. Maintain the telephone based monitoring and Philips Home Monitoring Programs to prevent readmissions within 3 months of enrolling</li> <li>3. Measure program satisfaction with a Satisfaction survey</li> </ol>		
<b>Baseline</b>	Current number of CHF participants at each facility.		
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Continue to offer the CHF Program to all inpatients with a diagnosis of heart failure.</li> <li>2. Provide hospital inpatients evidence based education regarding heart failure.</li> <li>3. Implement Philips telemonitoring pilot program for 50 patients of the Central Coast service areas.</li> <li>4. Implement telephonic assessments in Philips software for remaining participants.</li> <li>5. Continue to collaborate with CHW facilities as well as partners in the community (Community Health Clinics, Public Health Departments) to refer patients to the CHF Program.</li> <li>6. Track reports for both telemonitor and telephonic participants for outcomes using SHP solutions tool as well as hospital MIDAS reports</li> <li>7. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers.</li> <li>8. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center.</li> <li>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.</li> <li>10. Evaluate participant response to the telemonitor and telephonic program.</li> </ol>		
<b>Community Benefit Category</b>	Health Care Support Services A3e		

<b>Cancer Awareness</b>	
<b>Hospital Community Benefit Priority Area</b>	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Disease Management
<b>Program Emphasis</b>	<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 type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment Vulnerable Population</b>	<input type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
<b>Program Description</b>	AGCH and Coastal Cancer Center will partner to provide education, support groups, screenings and health information to encourage prevention, early detection and disease and disability management for cancer patients. The Coastal Cancer Center provides resources for patients and their families in the AGCH service area and referrals to the Hearst Cancer Resource Center and Marian Cancer Resource Center and other community partners.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Restructure AGCH and Coastal Care Center under one American College of Surgeons: Commission on Cancer 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 AGCH 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.
<b>2012 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Offer cancer screenings to facilitate early detection which address prevalent types of cancer (skin and prostate) focusing on the poor, vulnerable and Hispanic community and supply follow-up care and/or referrals.</li> <li>2. Offer cancer educational forum and health fairs for patients and caregivers through presentations and materials.</li> <li>3. Nurse Navigator to increase the number of patients seen by 10%.</li> </ol>
<b>Baseline</b>	Served 768 through screenings, lectures and support groups FY 2010-2011. Served 157 walk-ins, calls, patient meetings and referrals.
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Target poor and vulnerable and Hispanic community to provide cancer screenings expanding to Senior Centers.</li> <li>2. Target poor and vulnerable community to provide cancer education expanding outreach to Senior Communities and Centers which service Hispanic community. Also utilize Cancer Care Newsletter as a tool to educate underserved community.</li> <li>3. New program conducted by staff distinguishing local farms and wineries on cancer education, prevention, early screenings, mammograms, diagnosis and available resources through AGCH Coastal Care Center and Marian Cancer Care Services.</li> </ol>
<b>Result FY 2012</b>	<ol style="list-style-type: none"> <li>1. Skin Cancer Screening-49 participants (4% decrease from FY 10/11) 47% needing follow-up (20% broader and 80% poor)</li> <li>2. Community Education Programs-426 participants; Annual Report distributed to the community and physicians on Lung Cancer</li> <li>3. Increase in patients by 77%</li> <li>4. New Life Support Group-25 participants</li> </ol>
<b>Hospital's Contribution / Program Expense</b>	\$121,521



<b>FY 2013</b>	
<b>Goal 2013</b>	Improve health and well-being of AGCH 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.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Increase the number of participants seeing the nurse navigator by 10%.</li> <li>2. Educate high schools with the awareness and focus on skin cancer, prevention and tanning beds.</li> <li>3. Provide 10% increase in skin and establish breast cancer screenings to facilitate early detection focusing on the poor vulnerable and Hispanic community. Provide follow-up care and/or referrals.</li> <li>4. Identify the number of people for cancer prevention or screenings.</li> </ol>
<b>Baseline</b>	Served 419 through screenings, lectures and support groups FY 2011-2012. Served 1160 walk-ins, calls, patient meetings and referrals.
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Provide inservice to Internal Medicine, Family and Primary Physicians and healthcare personnel treating new or returning patients to refer to the Nurse Navigator.</li> <li>2. Work with the high school district's Physical Education and Health Education Departments in our service area (public and private) in presenting cancer awareness education regarding skin cancer and danger of tanning beds. Nurse Navigator to be available to speak to classes individually. Provide education through annual report on skin cancer and melanoma.</li> <li>3. Work with promotoras in targeting DUHN community to provide cancer screenings, expanding to senior centers and focus marketing on Hispanic communities.</li> <li>4. Work with promotoras in tracking, providing inservice and taking questionnaires out into the community.</li> </ol>
<b>Community Benefit Category</b>	Community Health Improvement Services (Lectures/Workshops; Support Groups, Self-help; Information and Referral) A1a, A1d, A1e, A3e

<b>Diabetes Prevention and Management</b>	
<b>Hospital Community Benefit Priority Area</b>	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Disease Management
<b>Program Emphasis</b>	<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 type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment Vulnerable Population</b>	<input type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
<b>Program Description</b>	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.
<b>FY 2012</b>	
<b>Goal 2012</b>	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.
<b>2012 Objective Measure/Indicator of Success</b>	Participants in the facility/service area evidence-based CDM program(s) will avoid admissions to the hospital or emergency department for the six months following their participation in the program.
<b>Baseline</b>	
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Identify and engage a physician program champion</li> <li>2. Identify registered dietician or CDE RN specializing in diabetes management to facilitate program</li> <li>3. Engage home health, and Emergency Department case management for patient enrollment</li> <li>4. Refer uninsured/underinsured patients to Alliance for Pharmaceutical Access for prescriptions</li> <li>5. Develop a mechanism to follow-up and track these enrolled patients and for the six months following their participation in the program. (i.e. telephonic support)</li> <li>6. Identify culturally and linguistically appropriate messaging for this population of diabetic patients.</li> <li>7. Provide in-service to hospital staff regarding Diabetes Prevention and Management Program.</li> <li>8. Enroll program participants in CDSMP and Healthy for Life programs.</li> <li>9. Support in-patient awareness of chronic disease education through case management.</li> <li>10. Investigate availability of software that can track indicators to follow patients.</li> </ol>
<b>Result FY 2012</b>	<ol style="list-style-type: none"> <li>1. 22 participants in the program with none readmitted to the hospital or emergency department within six months of intervention</li> <li>2. 47 received education related to diabetes management</li> <li>3. Participants enrolled in the Diabetes Management Program were referred by a primary care physician/clinic. Participants were insured or referred to Business Office to set up a payment plan.</li> <li>4. Zero participants from this program were enrolled in the CDSMP or HFL programs for FY 2012</li> </ol>
<b>Hospital's Contribution / Program Expense</b>	\$445.63

<b>FY 2013</b>	
<b>Goal 2013</b>	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.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Identifying 20 high risk patients for glycemic control issues that frequent the ER (focusing on uninsured patients) using monthly Meditech reports and determine the best process for following these patients after ER visit.</li> <li>2. Identify culturally appropriate messaging for Spanish diabetic patients, (use of medical interpreter, flyers and brochures that are culturally sensitive for education)</li> <li>3. Establish diabetes support for English and Spanish.</li> </ol>
<b>Baseline</b>	22 participants enrolled in program
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Collaborate with CHF coordinator to develop a system for identifying CHF patients with diabetes and referral to the nutrition department and diabetic educator.</li> <li>2. Update Meditech to include a checkbox for uninsured (not just self-pay).</li> <li>3. Identify resources and tools needed to meet these patient needs and develop a plan for providing care.</li> <li>4. Track number of uninsured re-admittance to the ER for glycemic control issues.</li> <li>5. Engage home health and Emergency Department case management for patient enrollment.</li> <li>6. Track results such as: MD filling out glucose goals, re-admittance or ER visit for glycemic control issues.</li> <li>7. Diabetes Association best Practice guidelines and educational tools will be used.</li> </ol>
<b>Community Benefit Category</b>	A1c – Community Health Education – Individual Health Education for uninsured/under insured

# Community Benefit and Economic Value

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

**Complete Summary - Classified Including Non Community Benefit (Medicare)**  
 For period from 7/1/2011 through 6/30/2012

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<b>Benefits for Poor</b>						
Financial Assistance	1,203	544,651	0	544,651	0.9	0.8
Medicaid	8,702	7,615,358	3,817,061	3,798,297	6.2	5.8
Means-Tested Programs	416	683,701	388,421	295,280	0.5	0.5
<b>Community Services</b>						
Community Benefit Operations	0	49,368	0	49,368	0.1	0.1
Community Building Activities	27	1,255	0	1,255	0.0	0.0
Community Health Improvement Services	6,881	163,140	0	163,140	0.3	0.3
Financial and In-Kind Contributions	2,175	50,192	0	50,192	0.1	0.1
<b>Totals for Community Services</b>	<b>9,083</b>	<b>263,955</b>	<b>0</b>	<b>263,955</b>	<b>0.4</b>	<b>0.4</b>
<b>Totals for Poor</b>	<b>19,404</b>	<b>9,107,665</b>	<b>4,205,482</b>	<b>4,902,183</b>	<b>7.9</b>	<b>7.5</b>
<b>Benefits for Broader Community</b>						
<b>Community Services</b>						
Community Benefit Operations	0	15,075	0	15,075	0.0	0.0
Community Health Improvement Services	1,399	123,878	0	123,878	0.2	0.2
Health Professions Education	0	188,586	0	188,586	0.3	0.3
<b>Totals for Community Services</b>	<b>1,399</b>	<b>327,539</b>	<b>0</b>	<b>327,539</b>	<b>0.5</b>	<b>0.5</b>
<b>Totals for Broader Community</b>	<b>1,399</b>	<b>327,539</b>	<b>0</b>	<b>327,539</b>	<b>0.5</b>	<b>0.5</b>
<b>Totals - Community Benefit</b>	<b>20,803</b>	<b>9,435,204</b>	<b>4,205,482</b>	<b>5,229,722</b>	<b>8.5</b>	<b>8.0</b>
<b>Unpaid Cost of Medicare</b>	<b>20,851</b>	<b>27,334,716</b>	<b>18,093,046</b>	<b>9,241,670</b>	<b>15.0</b>	<b>14.2</b>
<b>Totals with Medicare</b>	<b>41,654</b>	<b>36,769,920</b>	<b>22,298,528</b>	<b>14,471,392</b>	<b>23.5</b>	<b>22.3</b>

 Sue Andersen Chief Financial Officer Central Coast Service Area	9/27/12 Date
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## B. Telling the Story

As a member of Dignity Health, Arroyo Grande Community Hospital 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 Arroyo Grande Community Hospital. Each year a report of progress is posted to the Arroyo Grande Community Hospital 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 AGCH service area. Sharing resources helps all community based organizations become better acquainted with services available in the Arroyo Grande Community Hospital service area in an effort to better serve their clients.

Please find the following attachments at the end of this report: Dignity Health's Reporting Sheet for Community Need Index (attachment A); Summary of Patient Financial Assistance Policy (attachment B), Hospital Community Board Membership Roster (attachment C), Community Benefit Team Roster (attachment D)

## COMMUNITY NEEDS INDEX

Zip Code	City	2011 Population	2011 CNI	2010 CNI	% Households in poverty, Head of Household 65+	% families w/kids < 18 in poverty	% families single mother w/kids < 18 in poverty	Income Quintile	% age > 5 w/no English	% pop. minority	Cultural Quintile	% pop. > 25 w/no High School diploma	Education Quintile	% population in labor force unemployed	% population - No health insurance	Insurance Quintile	% Households renting	Housing Quintile	Income Barrier	Cultural Barrier	Education Barrier	Insurance Barrier	Housing Barrier
93420	Arroyo Grande	28,603	3	3	5.4%	6.8%	18.7%	2	1.3%	19.0%	4	10.6%	2	5.6%	14.3%	3	28.7%	4	20.5%	19.0%	10.6%	15.3%	28.7%
93433	Grover Beach	12,844	3.6	3.6	9.3%	10.5%	19.7%	2	4.8%	33.9%	4	15.6%	3	7.2%	19.0%	4	50.6%	5	23.7%	34.2%	15.6%	20.3%	50.6%
93444	Nipomo	18,894	3.4	3.2	5.9%	7.7%	24.3%	2	6.7%	40.4%	5	18.7%	4	7.8%	11.4%	3	24.2%	3	26.1%	40.9%	18.7%	13.2%	24.2%
93445	Oceano Pismo	7,441	4.8	4.6	3.4%	18.5%	40.6%	4	14.0%	59.5%	5	30.3%	5	12.7%	22.0%	5	48.6%	5	44.2%	60.6%	30.3%	24.8%	48.6%
93449	Beach	8,440	3	3	5.6%	9.0%	16.7%	2	1.3%	15.6%	3	7.0%	1	6.8%	18.8%	4	38.6%	5	19.6%	15.6%	7.0%	20.0%	38.6%

Attachment A

**DIGNITY HEALTH**  
**SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY**  
(June 2012)

**Policy Overview:**

Dignity Health is committed to providing payment 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, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment 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 Payment Assistance:

- Eligibility for payment 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 payment 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 Dignity Health 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 payment assistance and a determination of financial need occur prior to rendering of services. The need for payment 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 payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment 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 termination 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 Dignity Health 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 Dignity Health 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 Dignity Health facility.

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

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

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health 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 Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment 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:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health 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:

IN IMPLEMENTING THIS POLICY, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.

## Hospital Community Board Roster 2011-2012

Sister Janet Corcoran, OSF  
**Sister of St. Francis**

Terry Fibich  
Jacqueline Frederick  
**Secretary/Co-Chair**

Nathan Alvarado  
**General Manager**  
Wachovia Securities

Rebecca Alarcio  
**Director of Public Affairs**  
Allan Hancock College

John Hayashi  
**Hayashi Y & Sons**  
Community Member

Ernest Jones, M.D.  
**Physician**

Scott Robertson, M.D.  
**Past Chief of Staff**

Steve Flood, DDS  
**Dentist**

Sister Barbara Staats, OSF  
**Sister of St. Francis**

Ken Dalebout  
**Administrator/CEO**

Jacqueline Frederick  
**Attorney at Law**  
HCB-Chair

Dan Cashier  
**Foundation Board Chair**

Larry Foreman, D.O.  
VPMA  
**AGCH**

Jonathan Fow, M.D.  
**Chief of Staff**

**Arroyo Grande Support Staff**  
Sue Andersen  
**Service Area CFO**

Chuck Cova  
**Service Area President**

Villa Infanto, RN  
**VP, Patient Care Services**

Tauny Sexton, RN  
**Director, Quality Services**

Montisa Phelan Lopez  
**Director of Foundation and  
Mission Services**

## **Community Benefit Committee 2011-2012**

Villa Infanto, RN  
Vice President, Patient Care Services

Susan Cedars  
Vice President, Human Resources

Sandy Underwood  
Senior Community Education Coordinator

Ami Padilla  
Director, Education Services and Community Benefit  
Central Coast Service Area

Matthew Kronberg, BCC  
Chaplain, Mission Services

Katherine Guthrie, RN  
Regional Director Cancer Care Services

Christina Squires  
Education Coordinator

Joan McKenna  
Case Management Director/Social Worker

Joel Pace  
Community Benefits Coordinator/Educator

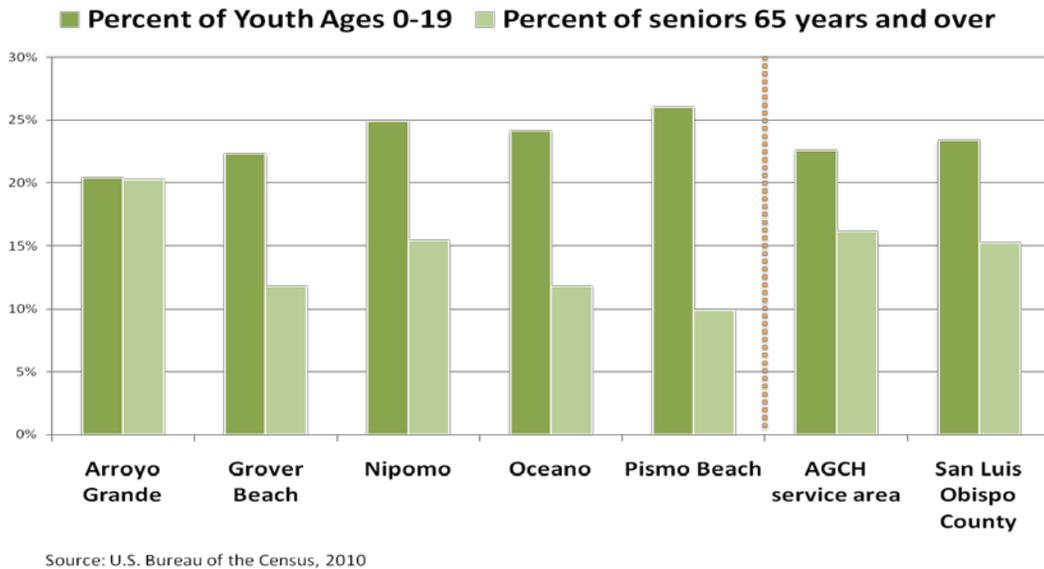
APPENDIX 1

## Demographics

Population		
	2000	2010
93420 Arroyo Grande	24,482	28,413
93433 Grover Beach	13,099	13,162
93444 Nipomo	15,391	19,244
93445 Oceano	7,422	7,173
93449 Pismo Beach	8,562	7,657
<b>AGH service area</b>	<b>68,956</b>	<b>75,649</b>
<b>San Luis Obispo County</b>	<b>246,681</b>	<b>269,637</b>
<b>California</b>	<b>33,871,648</b>	<b>37,253,956</b>

Source: U.S. Bureau of the Census, 2000, 2010

## Youth and Seniors

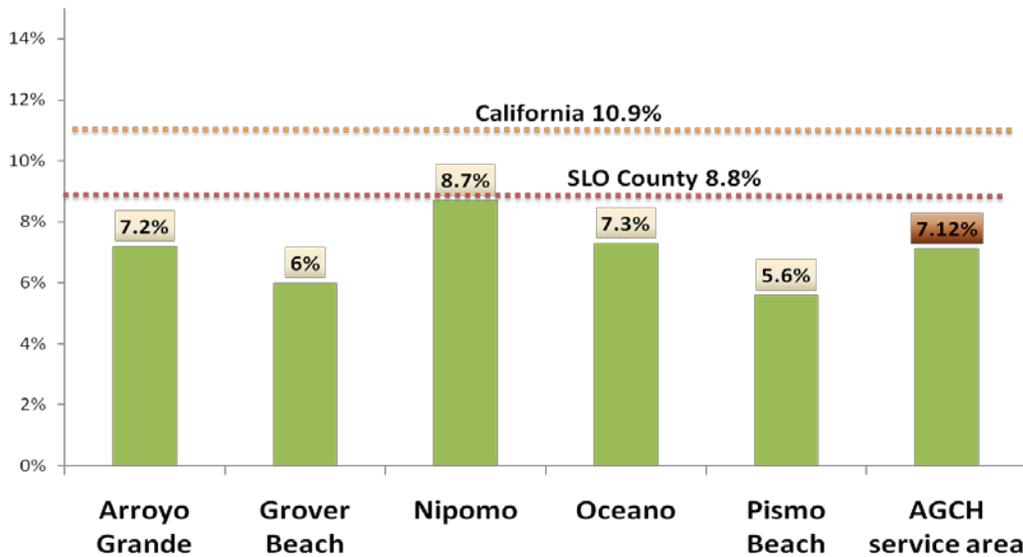


## Median Household Income

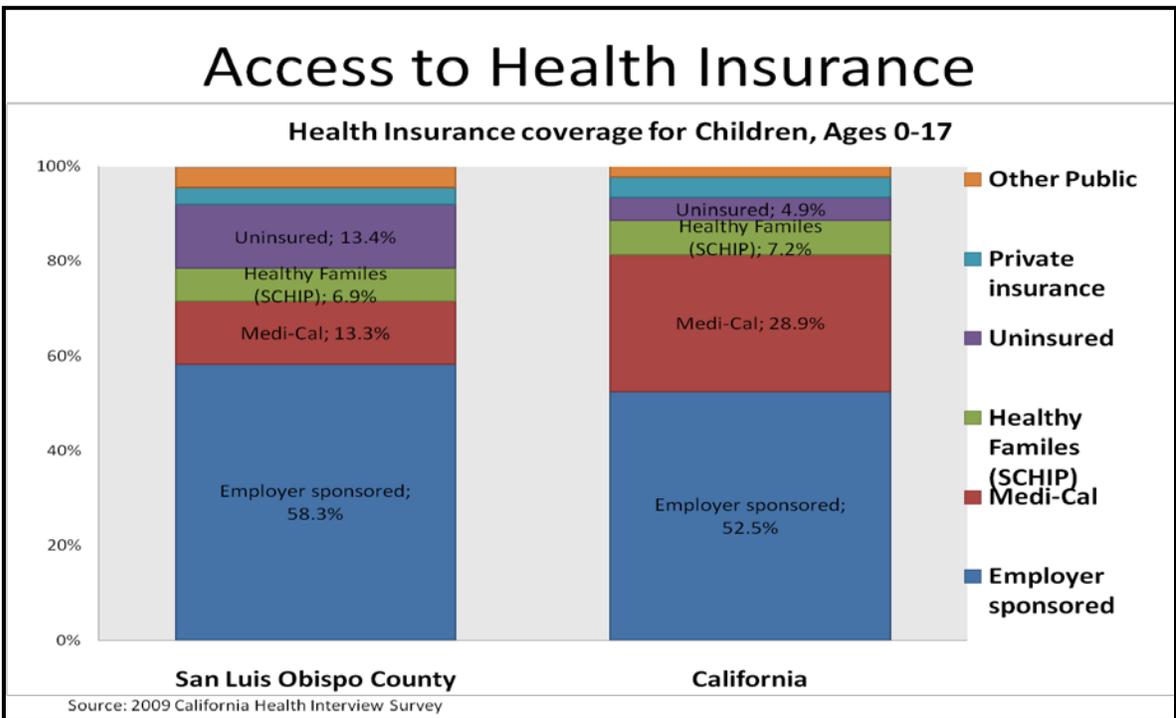
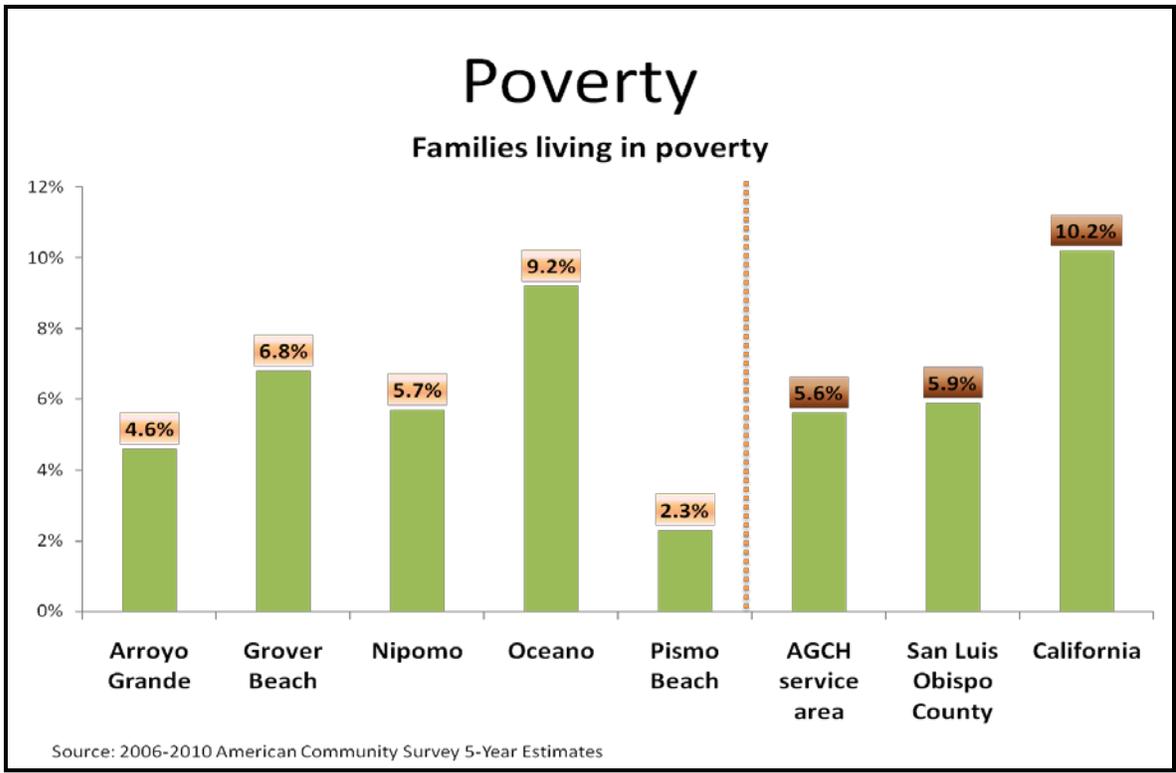
	Number of Households		Median Household Income
	2000	2010	2006-2010
93420 Arroyo Grande	6,750	7,628	\$58,725
93433 Grover Beach	5,382	5,748	\$49,010
93444 Nipomo	4,146	5,759	\$61,495
93445 Oceano	2,762	3,117	\$39,843
93449 Pismo Beach	5,496	5,585	\$63,802
<b>AGH service area</b>	<b>24,536</b>	<b>27,837</b>	<b>\$54,575</b>
<b>San Luis Obispo County</b>	<b>91,925</b>	<b>102,016</b>	<b>\$57,365</b>
<b>California</b>	<b>11,498,483</b>	<b>12,577,498</b>	<b>\$60,883</b>

Source: 2006-2010 American Community Survey 5-Year Estimates

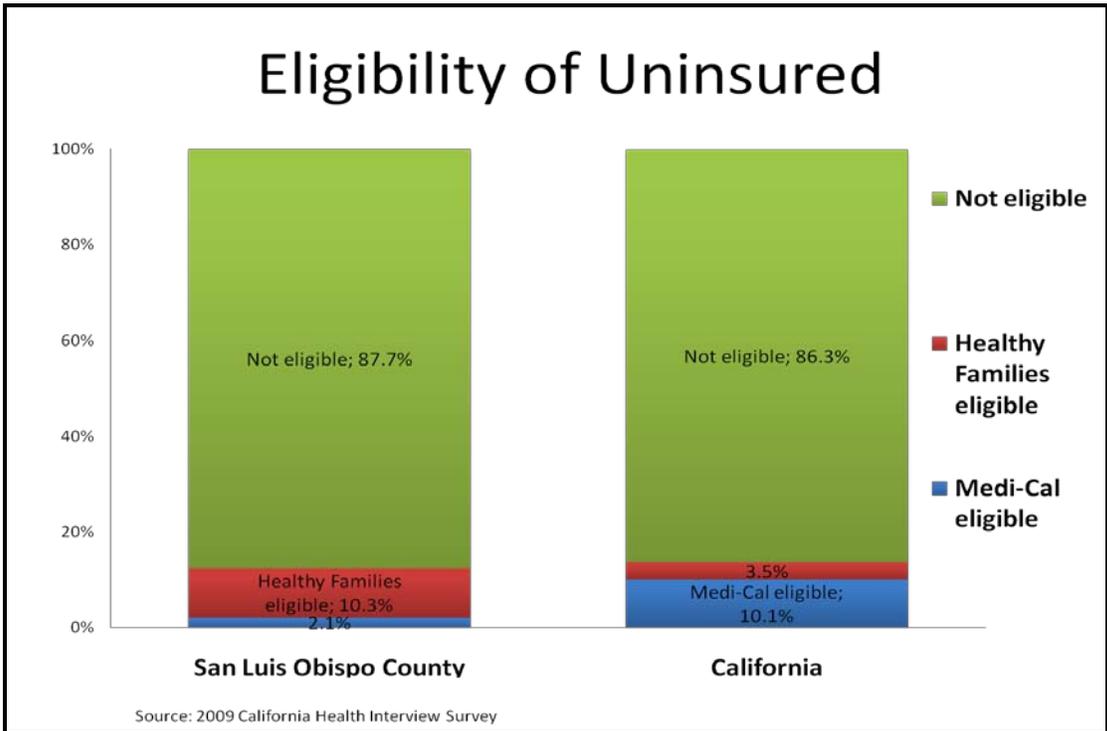
## Unemployment



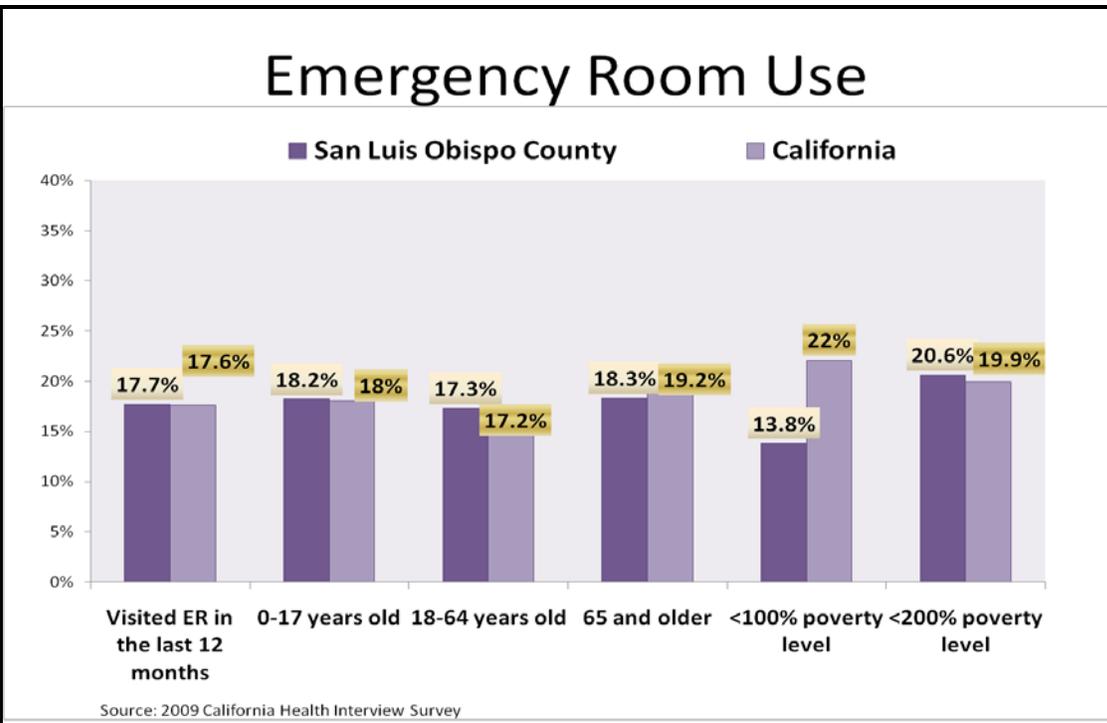
Source: 2006-2010 American Community Survey 5-Year Estimates, 2011 U.S. Bureau of Labor Statistics (county and state)



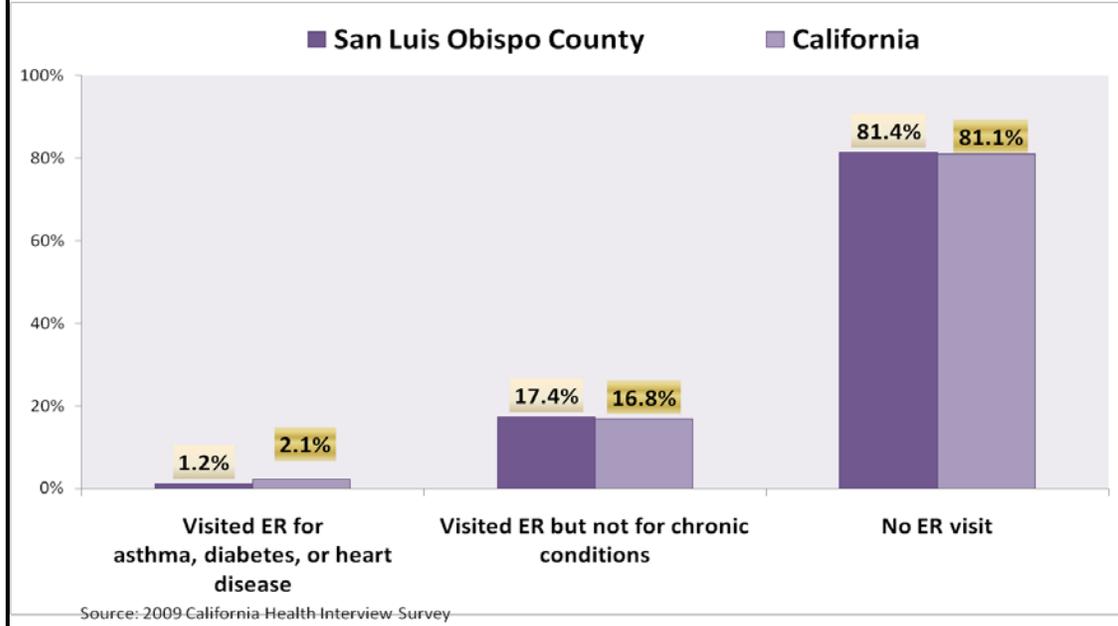
## Eligibility of Uninsured



## Emergency Room Use

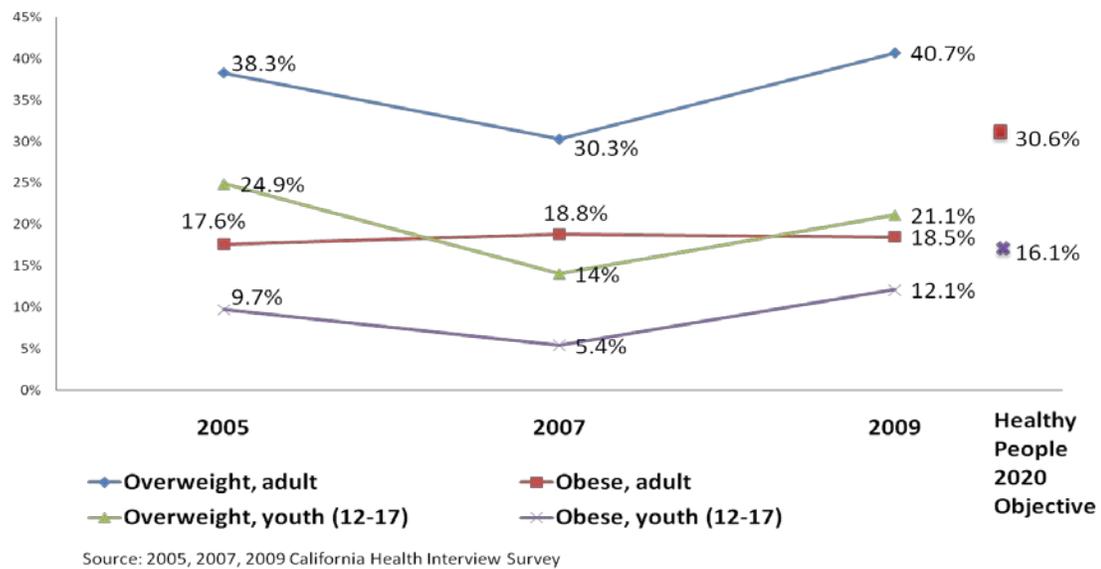


# Reasons for ER visits



# Overweight and Obesity

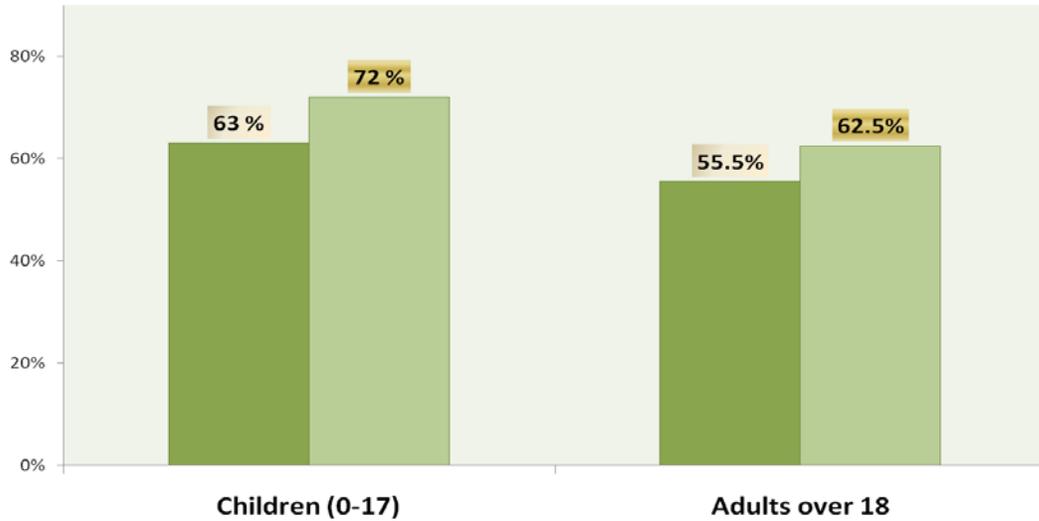
Overweight and Obesity, SLO County



# Fast Food Consumption

Fast food eaten at least one time in past week

■ San Luis Obispo County  
■ California

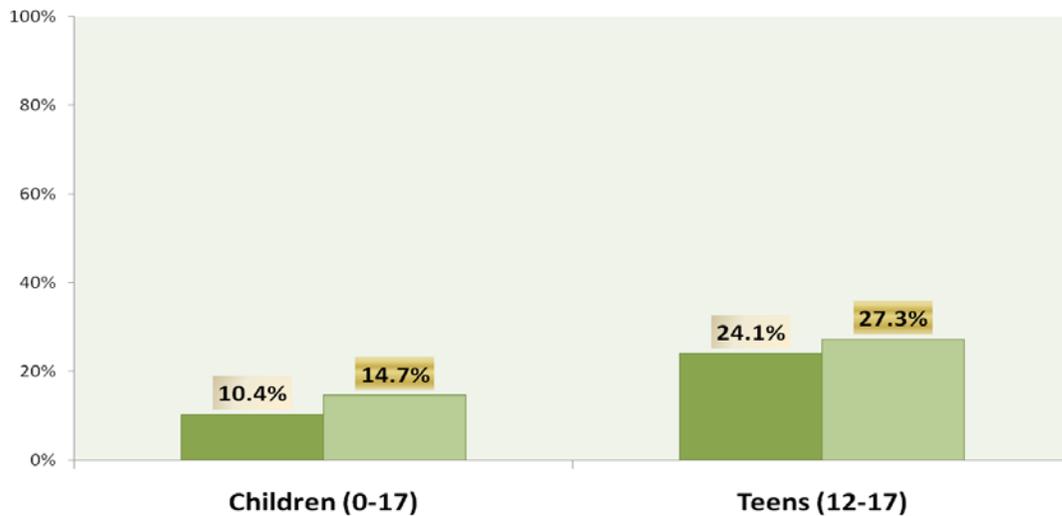


Source: 2009 California Health Interview Survey

# Soda Consumption

Drank two or more glasses of soda or other sugary drinks yesterday

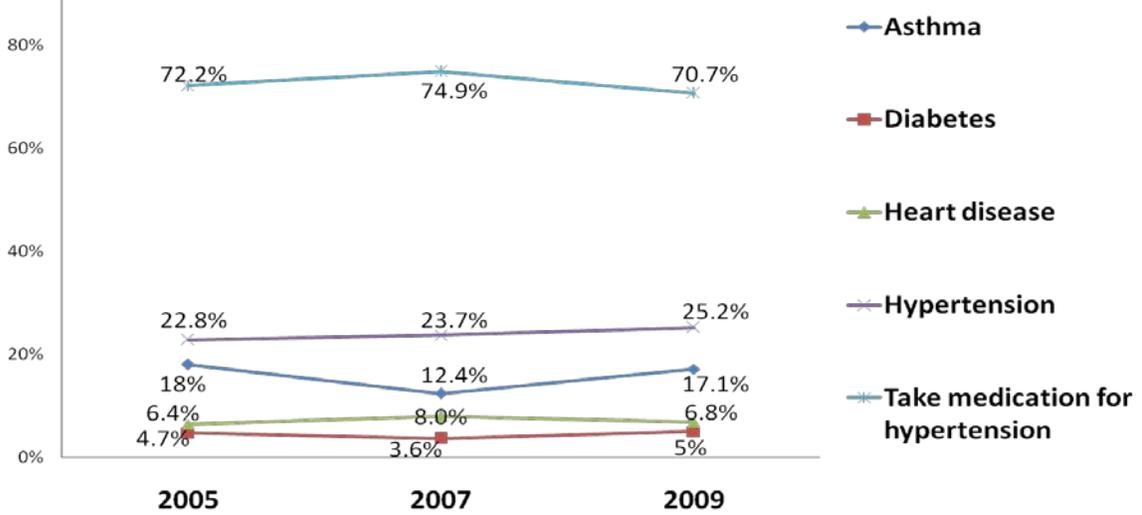
■ San Luis Obispo County  
■ California



Source: 2009 California Health Interview Survey

# Chronic Disease Prevalence

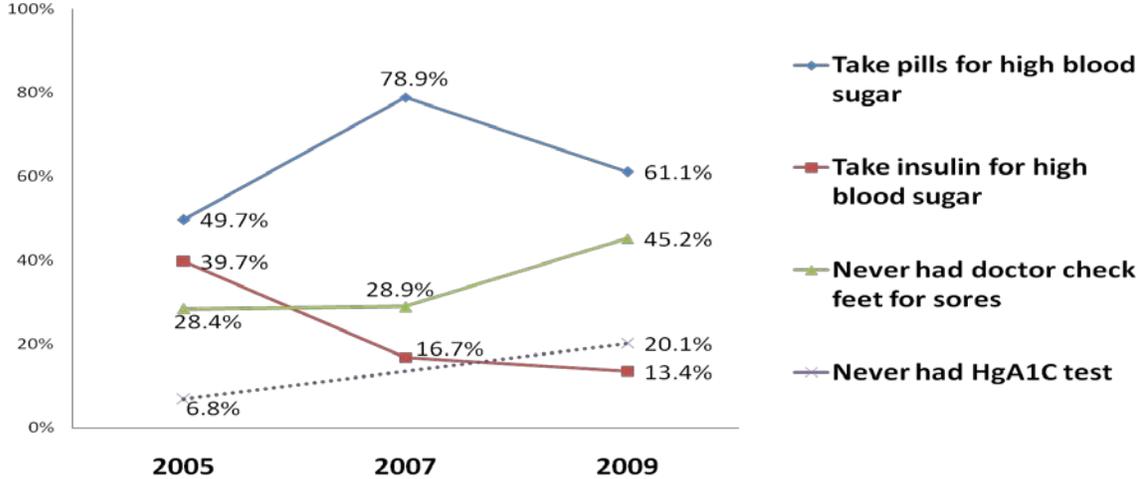
Chronic Diseases Among Adults, SLO County



Source: 2005, 2007, 2009 California Health Interview Survey

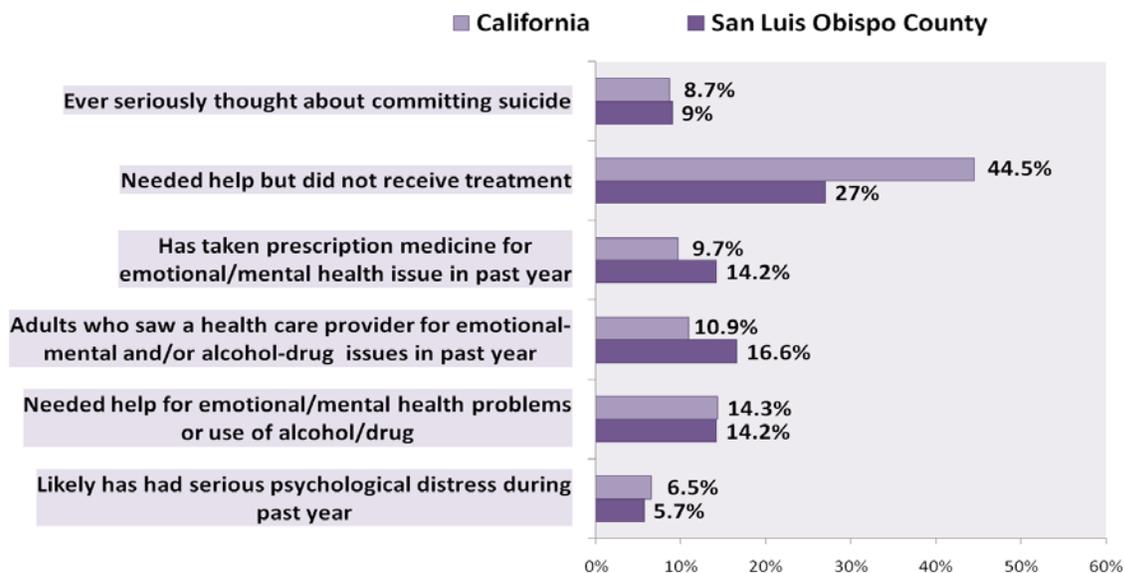
# Diabetes

Adults with Diabetes, Treatment and Screening, SLO County



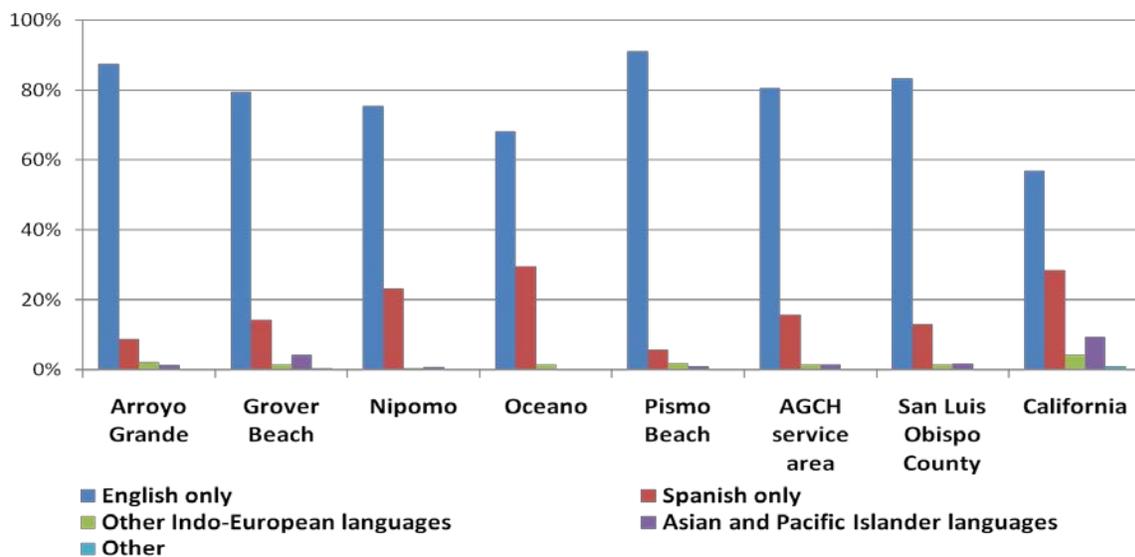
Source: 2005, 2007, 2009 California Health Interview Survey

# Mental Health



Source: 2009 California Health Interview Survey

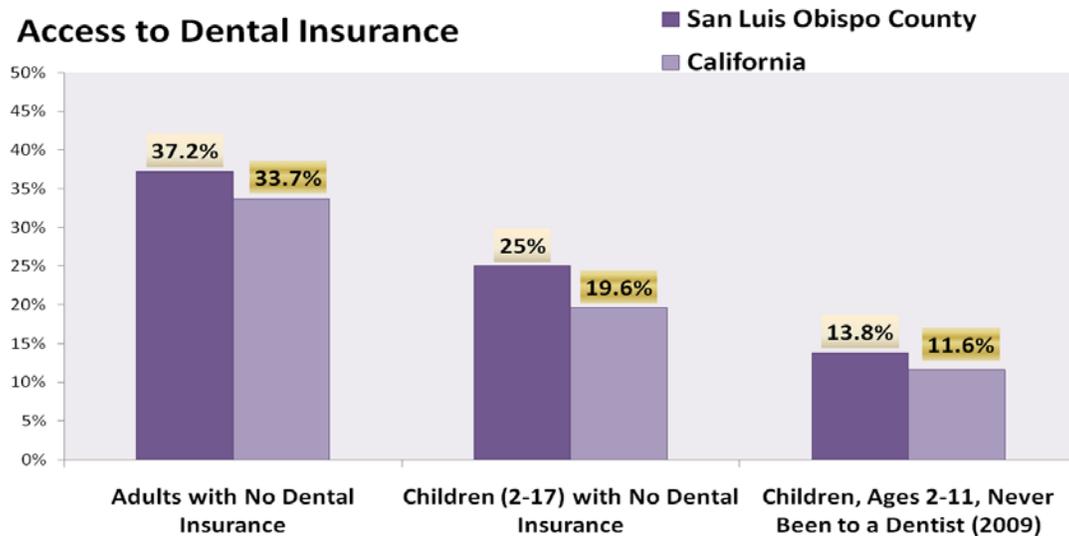
# Language Spoken at Home



Source: 2006-2010 American Community Survey 5-Year Estimates

# Dental Care

## Access to Dental Insurance



Source: 2007 California Health Interview Survey

# Teen Births

	Three-Year Average, 2007-2009		
	Births to teens	Live births	Rate per 1,000 Live Births
93420 Arroyo Grande	12	241	51
93433 Grover Beach	16	184	89
93444 Nipomo	22	259	86
93445 Oceano	10	109	95
93449 Pismo Beach	1	52	19
<b>AGH Service area</b>	<b>62</b>	<b>845</b>	<b>74</b>
<b>San Luis Obispo County</b>	<b>192</b>	<b>2,745</b>	<b>70</b>
<b>California</b>	<b>51,581</b>	<b>548,159</b>	<b>94</b>

Source: California Department of Public Health (CDPH), [www.healthycity.org](http://www.healthycity.org)