



Marian Regional Medical Center

Community Benefit Report 2012

Community Benefit Implementation Plan 2013



At Marian Regional Medical Center 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 what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

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 \$18,697,517 million in charity care, community benefits, and unreimbursed patient care.

At Marian Regional Medical Center 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.

A handwritten signature in black ink that reads "Charles J. Cova".

Charles J. Cova
President & CEO
Marian Regional Medical Center

A handwritten signature in black ink that reads "Kathy Castello".

Kathy Castello, Chair
Hospital Community Board
Marian Regional Medical Center

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EXECUTIVE SUMMARY

Marian Regional Medical Center, a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940, became a member of Dignity Health, formerly Catholic Healthcare West (CHW)¹, in 1997 and has a 25-acre campus with a fully integrated healthcare delivery system. In response to the rapidly growing population of the Santa Maria Valley, Marian Regional Medical Center's celebration and dedication was held on March 7, 2012 with a new hospital opening on May 22, 2012. Central to the new hospital project is a new Patient Tower. This state-of-the-art, four-story tower includes a 191-bed acute care facility with private rooms and baths, providing room-in capability for loved ones visiting patients. It also includes an expanded emergency department, further increasing the ability of Marian to provide life-saving care when patients need it most. Finally, the new hospital provides specialized care for patients and families including an expanded Neonatal Intensive Care Unit for babies needing special care.

Marian also has a 99-bed Extended Care Center, Homecare/Hospice and Infusion Service, and two primary care clinics. Marian Regional 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.

Major community benefit activities for FY 2012 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 and 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.

Marian partnered with the Santa Barbara County's Women's Health Clinic to serve expectant mothers speaking Mixteco. Marian provides a monthly hospital orientation to these mothers to familiarize them with the hospital prior to the delivery of their child. DVD's in **Mixteco** support **Labor and Delivery** services which may seem culturally strange to the Mixteco mother. There are also certified Mixteco interpreters available to assist new mothers with cultural and language barriers helping them to feel more comfortable during the stay in the hospital.

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. Marian's Healthy for Life Nutrition Lecture Series is an interactive program providing nutrition education and a physical activity component. Both programs are offered in English and Spanish. Yoga, Zumba and Turbo Kick are physical activities offered at local community centers, churches and the hospital conducted with bilingual instructors.

¹ For more information about the name change, please visit www.dignityhealth.org

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 be successful in minimizing 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 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.

Marian Cancer Care Services' new home is located in **Mission Hope Cancer Center** (which is affiliated with the University of California Los Angeles (UCLA) Jonsson Cancer Center). This is the first integrated facility for cancer care in the region. Opening in early 2012, the center is home to medical and radiation oncology, selective oncologic subspecialists and surgeons, as well as a pain management center. It also houses a UCLA clinical research network where patients have access to a multitude of clinical trials without the need for travel. Cancer support services at Mission Hope includes nurse navigators with one 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.

With the acknowledged need to support the development of qualified healthcare professionals, Marian Regional Medical Center continues to identify and develop a projected priority recruitment plan for healthcare workers. Partnering with Allan Hancock College and Cuesta College, MRMC 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. MRMC, 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. MRMC 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.

The total dollars quantified for Community Benefits for these and numerous other community benefit programs in FY 2012 are \$18,697,517, which excludes Medicare. Including the expenses incurred for the unreimbursed costs of Medicare, the total Community Benefit expense for Marian Medical Center was \$25,961,105.

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. Marian's organizational commitment to the community benefit process begins with our Strategic and Operating Plan which focuses on enhancing the 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 Dignity Health Central Coast entities continues to improve operational efficiency and performance.

- Marian's commitment to Dignity Health's 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 Dignity Health's Community Investment program, we are stepping up the promotion of this program offering this opportunity to community partners who may be eligible for low interest loans or lines of credit to support operations.
- A subcommittee of Hospital and Community Board Members participates in quarterly Community Benefit Team meetings. These Board members contribute community expertise while monitoring programs to ensure continuing program focus (roster of participants Attachment D).
- 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 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.
- 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 Joe White Park, a local Santa Maria park and meets once a month to clean the Park.
 2. Marian also plays a key role collaborating on the Communities of Excellence in Nutrition, Physical Activity and Obesity Prevention (CX3) project by working with the public health department's community educator bringing cooking and exercise classes which enhance the existing Health for Life Nutrition program. Marian also participates on the HEALTHY SBC, an advocacy group for local nutrition policy change. This 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. In 2010 data was collected and analyzed to gain a realistic picture of the overall quality of the nutrition environment in these two Santa Maria neighborhoods. The low-income neighborhoods are out-of-balance from a nutrition and health perspective. A second evaluation has been conducted and the county is waiting on comparative results. 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 obesity epidemic.
 3. Marian generated 935,040 pounds of solid waste increasing our poundage by 55,560 pounds when compared to last FY [879,480]. This increase was minimal, considering the construction and remodeling project presently underway. Marian Medical Regional Center's medical waste program has increased their pounds of medical waste by 784.94 pounds, when compared to last FY [29,052.02]. Additionally 29,836.96 pounds of medical waste have been diverted from the land fill. Our on-going paper and cardboard recycling, has generated a total of 1,101,264.64 pounds, all of these being diverted from the landfill. For example, 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.
 4. The People for Non-Violence committee is a Marian Regional Medical Center 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. The 15th Annual Peace Week activities included: an opening ceremony with a free community luncheon, a special celebration focusing on cultural diversity, clearing city parks of debris and a tree planting on "Respect for Creation Day." The People for Non-Violence also assess local crime rates by reviewing police statistics.
 5. Marian Regional Medical Center, one of only a few hospitals in the nation to have a cogeneration plant that operates on methane gas, will save the hospital between \$300,000 and \$500,000 in energy costs each year. The 2,000 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.

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 collaboration with Marian Regional Medical Center and Aramark 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. Marian Regional Medical Center defines its community as located in northern Santa Barbara County with the Santa Maria Valley as the largest region in its service area. The largest communities in Marian's primary service area include the City of Santa Maria with secondary service area being the City of Guadalupe, in the North County, and Nipomo, a community in southern San Luis Obispo County. Throughout this report, comparisons are made to SLO County since Nipomo is located in SLO County and is part of Marian's secondary service area.

1. The poverty rate in the Marian 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 Santa Maria that number jumps to 50% and in Guadalupe, it is 43%.

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

Language

More than 40% of the people in the Marian service area speak Spanish at home and a slight majority speaks English at home. It was revealed during the primary research that some segments of the Latino population do not, in fact, speak Spanish. They speak Mixteco or other languages that are not tracked by the U.S. Census. 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.

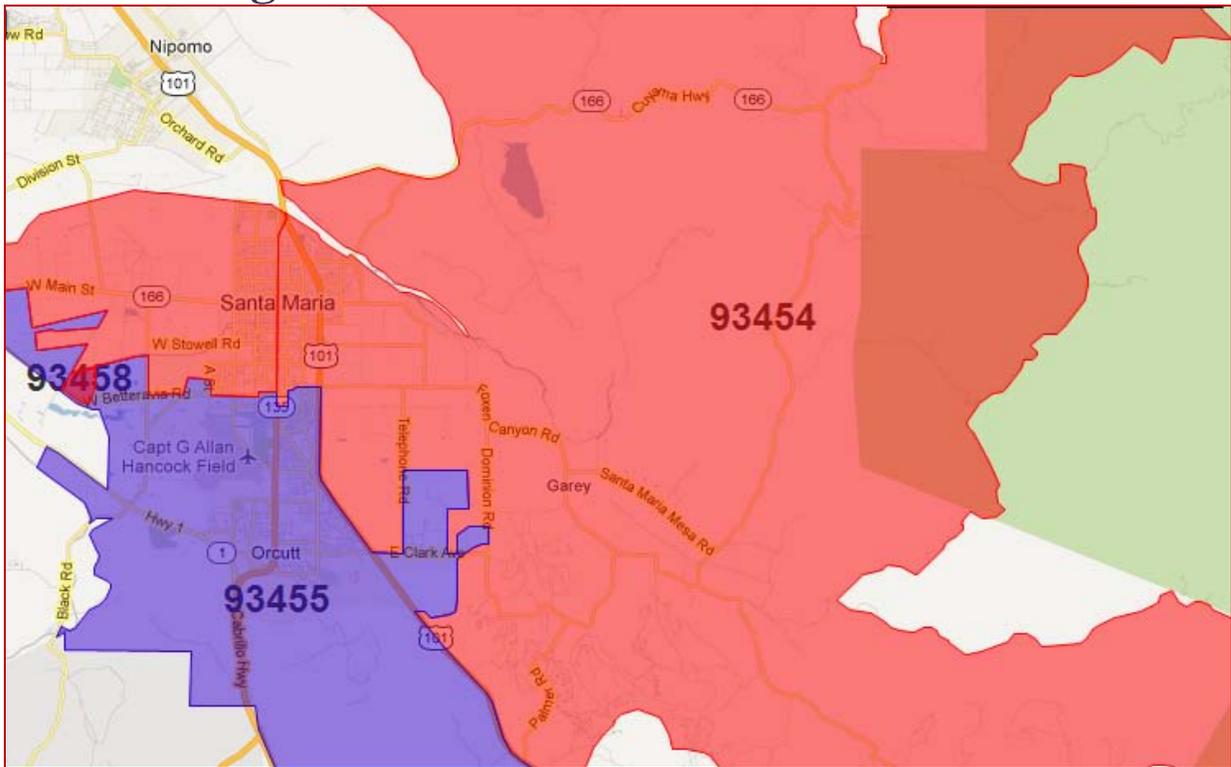
Economic Indicators

- 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. 43% of indigenous Mexicans reported average annual household incomes below \$10,000 per year.
- 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.

- 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.
- C. The demographics of the Marian Regional Medical Center service area is more clearly defined below as identified in the 2010 Census data and which is reported on the Schedule H 990.
- Population: 153,540
 - Diversity: Caucasian – 30.6% | Hispanic – 61.6% | Asian, Pacific Islander – 4.5% | African American - 1.2% | Other – 2.1%
 - Average Income: \$64,804
 - Uninsured: 18.72%
 - Unemployment: 5.2%
 - No HS Diploma: 28.1%
 - Renters: 38.42%
 - Medicaid Patients: 17.87%
 - Other Area Hospitals: 0

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 eight community health clinics (one is a dental clinic): four in Santa Maria, one in Nipomo, and one in Guadalupe, one in Lompoc; and 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: Betteravia's Government Center, Good Samaritan Homeless Shelter and the Women's Health Clinic. Using Dignity Health's Community Needs Index (CNI), zip code area of 93458 and 93454 (Santa Maria) are neighborhoods with Disproportionate Unmet Health Needs (DUHN). While the community residents who face multiple health problems might primarily be Latino/ Oaxacan there are pockets of low income seniors who also have Disproportionate Unmet Health Needs.

Marian Regional Medical Center



Lowest Need

Highest Need

1 - 1.7
Lowest

1.8 - 2.5
Lower

2.6 - 3.3
Mid

3.4 - 4.1
Higher

4.2 - 5
Highest

Zip Code	CNIScore	Population	City	County	State
93454	4.2	34668	Santa Maria	Santa Barbara	California
93455	2.4	40038	Orcutt	Santa Barbara	California
93458	5	52993	Santa Maria	Santa Barbara	California

CNIScore MEDIAN: 5.0

Community Benefit Planning Process

A. Community 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 – 1st 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.

Marian's Community Health Needs Assessment (CHNA) was conducted during the current tax year, and will be made publicly available by January 2013. Marian Regional Medical Center's Implementation Strategy Report will be posted no later than March 25, 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 programs to address the top identified priorities. While implementations strategies will be reflected in the FY 2013/2014 Community Benefit Report and Implementation Plan, Marian 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 17% of Santa Barbara County residents reported being uninsured.

1. 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 Marian 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 Marian 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 Marian 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 Marian 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. The shortage of bilingual providers is particularly serious. To address the community mental health needs, alternative treatment approaches are being explored, such as telephone or video-teleconference consultations and remote mental health visits for patients by telephone or with video-teleconferencing.
- e. **Language** is a barrier to care particularly for those who speak Mixteco. Increase the number of interpreters and broaden translation offerings to include Mixteco. Many patients depend on family and friends as non-certified medical interpreters raising an issue of privacy. 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.
- f. The primary research findings also indicate that some providers are not **culturally sensitive** and some educational programs are not culturally appropriate, while the secondary findings indicate that a majority of the population in the Marian service area is Latino. 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 a costly clinic appointment.
- g. While addressing poor diet and exercise habits is important to improving the health of residents in the Marian 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 Marian service area children have never even been to a dentist and more than one-third of adults report having no dental insurance.
- h. Transportation is a major barrier to accessing healthcare in the Marian 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. Residents need more education about which services are available to them, while others say residents are **aware of available programs** and services but choose not to use them. If additional research shows that a lack of awareness exists, a communication campaign is required. Residents are unable to attend educational classes as they are held while they are at work.
 - j. Services for pregnant women in the area have been cut. There appears to be a problem with **teen pregnancy**. This topic warrants further attention and study to determine whether, and to what extent, community need exists.
- B. An inventory of community assets can be described below and are categorized by the hospital community benefit priority areas of Marian Regional Medical Center:
- a. Access to Primary Healthcare Services;
 - i. Marian Community Clinic has two clinics: one in Guadalupe and one in Santa Maria. Guadalupe, a small community in the Santa Maria Valley, has been federally designated as a Medically Underserved Area (MUA).
 - ii. Community Health Centers of the Central Coast have eight community health clinics (one is a dental clinic): four in Santa Maria, one in Nipomo, and one in Guadalupe, one in Lompoc.
 - iii. The Santa Barbara County Public Health Department has three community clinics: Betteravia's Government Center, Good Samaritan Homeless Shelter and the Women's Health Clinic.
 - b. Health Promotion/Disease Prevention
 - c. Santa Maria-Bonita School District, local churches, Santa Barbara Coalition in Support of Promotora de Salud
 - d. Disease Management
 - i. Alliance for Pharmaceutical Access; Marian Regional Medical Center'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 such as the following: (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 statistics 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. 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. The plan is as follows:
 - 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 areas of focus identified in Santa Maria were the northwest corner of Santa Maria and the Newlove community. Marian's secondary service area of Guadalupe is also a focus area of need. These 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.

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 FY 2013/2014:

- Access to Healthcare/insurance
- Emergency Department Utilization
- Chronic Disease
- Mental Health
- Cultural Awareness
- Transportation
- Oral Health

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.

The recommendations above are not ranked. A next step is for Marian, along with French Hospital Medical Center, Arroyo Grande Community Hospital, community partners, and others to determine which issues to address. There are resources available that may assist Marian Regional Medical Center's strategic planning committee in determining which needs to address and how best to allocate resources. Implementation strategies, identified focus areas and populations, how the major needs were prioritized, a description of what MRMC will do to address Community Needs and the subsequent Action Plan will be completed and part of Marian Regional Medical Center'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.

Based on the comparison of each hospital's assessment reports, Marian cannot directly affect the following two community needs but support through partnership and collaboration. Marian provides a monthly donation to the County of SB Mental Health, CARES program to offset the monthly rent cost. The Dignity Health Community Grants process has sent Request for Proposals (RFP) to two local community agencies that support clients with mental health issues. The Community Benefit Department works with community based organizations assisting the community with mental health issues with facility use; in kind printing for workshop and/or brochures. Community Health Centers of the Central Coast are a leader in supporting dental care for the Central Coast. Marian works with CHCCC to provide families with dinner during the Brush, Brush, Brush program at local elementary schools. Community Action Commission holds a yearly children's screening and Marian recruits dentists, dental assistants and provides medical supplies for this event.

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. Marian follows the Dignity Health Charity Care/Financial Assistance Policy and Procedures (Attachment A).
2. Marian Regional 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 Regional 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 Regional Medical Center in 2011/12. Based on our findings in our assessment data statistics, related data in the Community Need Index and hospital utilization data, Marian 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 five key programs for FY 2012. For FY 2013 Marian 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 FY 2013.

Below are the major initiatives and key community based programs operated or substantially supported by Marian Regional Medical Center 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*
- 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*
- Exercise *
- Maternal Outreach*
- Community Blood Pressure Checks*
- Kid Friendly Farmers Market*
- Grief and Stroke Support Groups*
- Stroke / Glucose/ Memory Screenings*

Priority Area 3: Disease Management

- Conversion of Marian Regional 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*

Marian Community Clinics	
Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Quality Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/Disease Prevention <input checked="" type="checkbox"/> Chronic Disease Management
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 checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	<input type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	<p>Marian Community Clinics, Inc. assures access to quality primary health care for the residents of North West Santa Maria and Rural Guadalupe, while focusing on the underserved, uninsured/underinsured and those most vulnerable facing economical or social barriers. MCC Santa Maria & Guadalupe are able to address cultural differences in health care disparities that can impact the health of their patients. In addition to primary care services, both clinics also offer the following program services:</p> <ul style="list-style-type: none"> • Obstetrics & Gynecological Care include: pregnancy testing, wellness and preventive care; well woman annual visits including PAP tests, breast and pelvic examinations; prenatal care and in-office ultrasound; prenatal testing and monitoring, (NST's), for high-risk pregnancies; delivery and postpartum care; gynecologic surgery; LEEP and Laser procedures. • Every Woman Counts (EWC) provides free clinical breast exams, mammograms, pelvic exams, and Pap tests to our underserved women. • Marian New Life Program for crisis pregnancies offers counseling, support groups, adoption referrals, and clothing for mother and baby. • Child Health and Disability Prevention Program (CHDP) from birth through 19 years. CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. Services include child physicals and immunizations. <p>A staff of board-certified physicians, nurse practitioners, physician's assistants, and support personnel provide quality, compassionate care to all, regardless of ability to pay. Bilingual staff serves at both clinics. Marian Community Clinics collaborate with many community partners including the Santa Barbara County Public Health Department.</p>
FY 2012	
Goal 2012	Increase access to healthcare for those with disproportionate unmet health related needs by continuing to provide preventive services, obstetrics and gynecological exams, children's physicals and immunizations, as well as educate patients by providing education and resources for chronic disease management
2012 Objective Measure/Indicator of Success	1. Total Clinic visits will grow by 30% in FY 12 over FY 11. 2. Marian Community Clinics, Inc. will add 50 chronic disease self-management class referrals (Healthy Living Your Life Take Care) of existing and new patients in the FY11/12.
Baseline	Total MCC Encounters: FYE 2011 20,733
Intervention Strategy for Achieving Goal	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.

Results for FY 2012	<ol style="list-style-type: none"> 1. Goal not met, will set as priority in 2013 2. Goal not met, will set as priority in 2013 3. Marian Community Clinic staff members were available to provide community outreach to the communities, however, continued efforts to recruit and license additional facilities have made it challenging to have committed staff. The goal for 2013 is to identify a Nurse Practitioner/Medical Assistant that can be the coordinator, as well as provide and oversee the health screenings provided by MCC. 4. In 2011 French Health Center, San Luis Obispo and Coastal Valley Health Center, Santa Maria were both licensed by the State of California as affiliate health centers of Marian Community Clinics, Inc. 5. Goal not met, will set as priority in 2013 6. Marian Community Clinics, Inc. provides a Child Wellness clinic 1-2 Saturdays per month. The goal to expand hours of service during the week has been placed on hold indefinitely due to the recent crime activity at the Santa Maria Clinic, deeming it unsafe.
Hospital's Contribution / Program Expense	\$1,344,231
FY 2013	
Goal 2013	Increase access to healthcare for those with disproportionate unmet health related needs by continuing to provide preventive services, obstetrics and gynecological exams, children's physicals and immunizations, as well as educate patients by providing education and resources for chronic disease management, specifically diabetes. Implementation of a new practice management system.
2013 Objective Measure/ Indicator of Success	<ol style="list-style-type: none"> 1. Total primary care visits will increase by 25%, OB/GYN visits will increase by 20%, this includes services for both, Santa Maria & Guadalupe, in FY 2013 2. Marian Community Clinics, Inc. will enroll 30 chronic disease self-management class patients in the Healthy Living Your Life Take Care workshop of existing and new patients in the FY12/13. 3. Increase community outreach involvement by 40%
Baseline	<p>Primary care: 17,227 (* 5% increase compared to FYE 2011) OB/GYN: 2,857 (* 42% increase compared to FYE 2011) Orthopedic: 1,030 (* -35% decrease compared to FYE 2011) Marian New Life: 540 (* 45% increase compared to FYE 2011) Community Outreach: 694 (* 110% increase compared to FYE 2011) Total FYE 2012 Encounters: 22,348</p>
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Implement new practice management system with electronic health record. 2. Implement the CPSP (Comprehensive Perinatal Services Program) that both the clinics and perinatal services could benefit from. 3. Identify a bi-lingual diabetes educator/dietitian to work with clinic patients. 4. Identify nursing staff to help expand community outreach and involvement with events. 5. Update the clinic brochure for promotion/Increase Marketing
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
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 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 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	468 patients were seen but none qualify as community benefit
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	<p>1. Marian has identified a dietician and nurse who specialize in diabetes management. This accredited diabetes program saw 468 patients in FY 2012 with 1.2% readmitted to the ER/Hospital with the six month intervention.</p> <table border="1" data-bbox="513 201 1422 569"> <thead> <tr> <th></th> <th>Number of Persons Served</th> <th># of Participants Admitted to the Hospital or ED within six months of the Intervention*</th> <th>% of Participants Admitted to the Hospital or ED within six months of the intervention.</th> <th>Program Expense</th> </tr> </thead> <tbody> <tr> <td>1st Qtr</td> <td>83</td> <td>1</td> <td>1.2%</td> <td>\$0</td> </tr> <tr> <td>2nd Qtr</td> <td>147</td> <td>0</td> <td>0.0%</td> <td>\$0</td> </tr> <tr> <td>3rd Qtr</td> <td>117</td> <td>0</td> <td>0.0%</td> <td>\$0</td> </tr> <tr> <td>4th Qtr</td> <td>121</td> <td>0</td> <td>0.0%</td> <td>\$0</td> </tr> <tr> <td>FY2012 Total</td> <td>468</td> <td>1</td> <td>0.2%</td> <td>\$0</td> </tr> </tbody> </table> <p>2. Participants speaking Spanish were provided an interpreter when services were delivered.</p> <p>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.</p> <p>4. Zero participants from this program were enrolled in the CDSMP or HFL programs for FY 2012</p>		Number of Persons Served	# of Participants Admitted to the Hospital or ED within six months of the Intervention*	% of Participants Admitted to the Hospital or ED within six months of the intervention.	Program Expense	1st Qtr	83	1	1.2%	\$0	2nd Qtr	147	0	0.0%	\$0	3rd Qtr	117	0	0.0%	\$0	4th Qtr	121	0	0.0%	\$0	FY2012 Total	468	1	0.2%	\$0
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Hospital Contribution/ Program Expense	“\$0”																														
FY 2013																															
Goal 2013	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.																														
2013 Objective Measure / Indicator of Success	<ol style="list-style-type: none"> 1. Identifying 25 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. 2. Identify 25 Marian Community Clinic uninsured high risk patients for glycemic control and enroll them in the ADA program. 3. Identify culturally appropriate messaging for Spanish diabetic patients, (use of medical interpreter, flyers and brochures that are culturally sensitive for education) 4. Establish diabetes support for English and Spanish. 																														
Baseline	468 Insured and underinsured participants																														
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Engage Marian Community Clinic, Home Health and Emergency Department case management for patient enrollment. 2. Track number of uninsured re-admittance to the ER for glycemic control issues. 3. Diabetes Association best Practice guidelines and educational tools will be used. 4. Update Meditech to include a checkbox for uninsured (not just self-pay). 5. Identify promotora to train as Spanish / English diabetes support for community outreach. 																														
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
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 2012	
Goal FY 2012	Increase attendance of chronic disease / nutrition related education and physical activity 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"> 1. Increased English HFL and CDSMP attendance by 20% 2. Increase physical activity/exercise attendance by 30% 3. Train 3 promotoras to teach HFL and Zumba workshops 4. Utilize Healthy Start and SMBSD advocates for promotion of Self-Esteem workshop for at risk girls; increasing workshops by 50% 5. 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> 590 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 Regional 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.
Results FY 2012	<ol style="list-style-type: none"> 1. Increased Spanish Chronic Disease Self Management Program (CDSMP) by 28%; decreased English CDSMP (“zero” classes held). There has been no continuum of care established between clinics, case management, emergency department and other hospital programs to support increase in HFL and CDSMP workshop attendance. 2. Increased Spanish Health for Life (HFL) 50%; decrease in English HFL “zero” classes held 3. Trained 3 promotoras to teach HFL and four certified for Zumba instruction. 4. Increased Yoga attendance by 17%, increased monthly Zumba attendance 97% 5. Conducted a Dove Self-Esteem workshop training 2 promotoras and six staff from Teen Court and two additional staff from Santa Maria Valley Youth and Family 6. 9 girls completed the July 2011 and 12 completed the June 2012 Dove Self-Esteem workshop partnered with SMBSD 7. Home Health is to hire a chronic disease self-management coordinator. 8. SBPHD committee meets bi-monthly regarding California’s Obesity Prevention Plan to effect local policy change
Hospital’s Contribution / Program Expense	\$39,835 was the total expense for this program. This does not include the staff time for 2 FTE’s (\$199,563)

FY 2013

Goal 2013	Increase attendance of chronic disease / nutrition related education and physical activity to those with disproportionate unmet health related needs in the Santa Maria Valley.
2013 Objective Measure / Indicator of Success	<ol style="list-style-type: none"> 1. Increase Spanish CDSMP and HFL attendance by 20% and English by 20% holding a minimum of 2 English CDSMP classes for FY2013. 2. Expand Zumba exercise to two more sites for adults and two locations for children. 3. Increase attendance by 30% for Dove Self-Esteem workshop by partnering with Santa Maria Valley Youth and Family and Santa Maria Bonita School District.
Baseline	254 Spanish speaking CDSMP participants; 1763 HFL participants; 154- Dove Self Esteem 4252 Zumba exercise
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Establish a continuum of care between clinics, case management, emergency department and other hospital programs to support increase in HFL and CDSMP workshop attendance. 2. Work with Community Partners in Care and Corporate Office to provide support to CDSMP leaders. 3. Develop strategies for Mixteco health education
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops) A1a

Marian Cancer Care Center	
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
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	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	<p>The Marian Cancer Care Center addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, cure and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurse, social workers and nutritionist.</p>
FY 2012	
Goals FY 2012	<p>Restructure Arroyo Grande Community Hospital 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 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.</p>
2012 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. 2. Increase by 3% number of patients receiving nutritional counseling. 3. 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. 4. 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	<p>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 Support Group: 132; Information & Referral: 15,357 and Spanish Calls: 729</p>
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.
Results FY 2012	<ol style="list-style-type: none"> 1. Prostate Cancer Screening-31 participants (69% decrease from FY 10/11)10%

	<p>needing follow-up (32% broader and 68% poor). Women's Health Screenings-20 participants (33% decrease from FY 10/11). No follow-up required. Local television station interviewed physician interviews to discuss importance of prostate education and screening. Skin Cancer Screening-49 participants (7% increase from FY 10/11)29% needing follow-up (71% broader and 29% poor).</p> <p>2. Nutritional Counseling-215 participants (8% decrease from FY 10/11). There were 570 new patient referrals for this FY, an increase of 3% over FY10/11</p> <p>3. 496 participants engaged in broader community lectures that were the results of Community Focus Groups that identified mammograms and colonoscopies as focal areas. Increased newsletter distribution by 6%. Identified seven new programs to promote good health, wellness and cancer prevention</p> <p style="text-align: center;"><u>New</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Patient Orientation Class</td> <td style="width: 50%;">Book Club Group</td> </tr> <tr> <td>Massage Therapy</td> <td>NIA Fitness Class</td> </tr> <tr> <td>Tai Chi Class</td> <td>Yoga for Cancer Patients and Survivors</td> </tr> <tr> <td colspan="2" style="text-align: center;">Warm Yarns Knitting and Crocheting Support Group</td> </tr> </table> <p>4. Partnered with UniVision in providing a public service interview in Spanish on various resources available through Mission Hope Cancer Center. Spanish presentation provided at Teixeria Farms-25 participants regarding available resources. Increased Spanish Lecture Groups by 51%-141 participants</p> <p><u>Total existing programs attended 85% broader and 15% poor and 17% increase FY 10/11</u></p>	Patient Orientation Class	Book Club Group	Massage Therapy	NIA Fitness Class	Tai Chi Class	Yoga for Cancer Patients and Survivors	Warm Yarns Knitting and Crocheting Support Group	
Patient Orientation Class	Book Club Group								
Massage Therapy	NIA Fitness Class								
Tai Chi Class	Yoga for Cancer Patients and Survivors								
Warm Yarns Knitting and Crocheting Support Group									
MMC Contribution/ Program Expense	\$1,216,472								
FY 2013									
Goal 2013	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, elderly and underinsured community for 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 Patient Orientation by 10%. 2. Increase number of participants attending nutritional counseling by 3%. 3. Identify the patients in the poor and vulnerable, elderly and underinsured community who require transportation to cancer treatments. 4. Increase awareness with physicians, healthcare personnel and the community the role of outpatient palliative care in relation to late stage cancer. 5. Present an Educational Forum in English and Spanish. 6. Provide education at local high schools focusing on skin cancer, prevention and tanning beds. 7. Increase number of people completing POLST form. 8. Identify the Oaxacan community for participation in prostate screening. 								
Baseline	FY 11/12 total is: 20,862: Support Groups: 528; Educational/Lectures: 1118 (13,350 received educational articles in the newsletter); Self-Help: 2,239; Spanish Group: 183; Information & Referral: 16,174 and Spanish Calls: 620								

Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Provide an inservice for Promotoras, physicians and healthcare personnel treating new or returning Mission Hope Cancer Center patients on how to refer patients to Marian Cancer Care. 2. Translate Patient Orientation presentation packet in Spanish, train promotoras to support start of new program which calls patients to attend Spanish Patient Orientation, nutrition, preventive and early detectable screenings, advanced directives and other available resources offered through Marian Cancer Care. 3. Invite and engage dietitian to attend weekly patient orientation meetings to offer individual counseling. 4. Work with Promotoras, physicians and healthcare personnel in identifying the Hispanic and senior citizen community with cancer requiring referrals to the patient van use, gas card or taxi vouchers. 5. Palliative Care Nurse to provide the number of POLST forms completed. 6. Train promotora and staff at Mission Hope Cancer Center with a presentation on nutrition, clinical trials, preventive and early detectable screenings, advanced directives, technology and available resources through Marian Cancer Care. 7. Work with the high school district's Physical Education and Health Education Departments in our service area (public and private) in presenting cancer awareness educational regarding skin cancer and danger of tanning beds. Nurse Navigator to be available to speak to classes individually. 8. Work with the promotoras in becoming familiar with the Oaxacan culture and promote prostate screening and van transportation.
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops; Support Groups, Self-help; Information and Referral) A1a, A1d, A1e, A3e, E1b

Congestive Heart Failure Program	
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
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 checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	The Congestive Heart Failure (CHF) program provides consistent telephonic patient follow-up and education thereby decreasing the number of their admissions to the hospital. This program also provides discharge instructions to nurses to use when patients are hospitalized
FY 2012	
Goals FY 2012	Avoid hospital and emergency department admissions for 6 months among 60% of participants enrolled in the CHF Program.
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Enhance the telephone based monitoring program by implementing Philips Telemonitoring to prevent hospital readmissions within 6 months of enrolling in the CHF Program. 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 3. Measure quality of life changes for all participants enrolled in the CHF Program by the completion of program (6 months).
Baseline	July 1, 2011 100 clients enrolled in CHF Program
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 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 Regional 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.

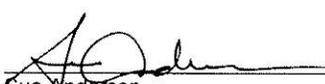
Result FY 2012	1. Telemonitoring was started 6/2011. A total of 50 monitors were available to be used in all 3 hospitals. Of the 50 monitors available 29 were placed in patient's home in Santa Maria. In FY 2012, 555 patients were served by the CHF program in Santa Maria.			
	2. We did not use the Probability of Readmission (PRA) tool for telephonic patients. We utilized BNP reports, hospital census, Meditech, Home Health & MD referrals. For the telemonitor patients we used the PRA upon enrollment to the telemonitoring program.			
	3. Quality of life changes assessment was not done as it was deemed not feasible and not recommended by Center for Technology & aging (CTA).			
	Quarter/Year	# of Participants	# of Participants Admitted to Hospital or ED within 6 mo. of the intervention*	% of Participants Admitted to Hospital or ED within 6 mo. of the intervention
	Q1/2012	82	3	3.6%
Q2/2012	126	5	3.9%	
Q3/2012	126	10	7.9%	
Q4/2012	221	20	9%	
Hospital's Contribution/Program Expense	\$190,083			
FY 2013				
Goal for FY 2013	Avoid hospital and emergency department admissions for 6 months among 80% of participants enrolled in the Congestive Heart Failure (CHF) Program.			
2013 Objective Measure / Indicators of Success	<ol style="list-style-type: none"> 1. Identify all patients with a CHF diagnosis at high risk for readmission 2. Maintain the telephone based monitoring and Philips Home Monitoring Programs to prevent readmissions within 6 months of enrolling 3. Measure program satisfaction with a Satisfaction survey 			
Baseline	29 telemonitors placed in patient homes in SM; 555 patients served during FY2012			
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Continue to offer the CHF Program to all inpatients 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 of the Central Coast service areas. 4. Implement telephonic assessments in Philips software for remaining participants. 5. Continue to collaborate with Dignity Health facilities as well as partners in the community (Community Health Clinics, 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 Regional 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 to the telemonitor and telephonic program. 			
Community Benefit Category	Health Care Support Services A3e			

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

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

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<u>Benefits for Poor</u>						
Financial Assistance	4,314	3,197,245	0	3,197,245	1.4	1.3
Medicaid	45,658	53,203,662	43,618,279	9,585,383	4.3	3.8
MIA	1,084	1,883,666	1,490,642	393,024	0.2	0.2
Community Services						
Community Benefit Operations	0	218,409	0	218,409	0.1	0.1
Community Building Activities	266	9,483	0	9,483	0.0	0.0
Community Health Improvement Services	29,183	1,675,728	0	1,675,728	0.8	0.7
Financial and In-Kind Contributions	5,773	786,070	0	786,070	0.4	0.3
Subsidized Health Services	13,367	1,351,940	0	1,351,940	0.6	0.5
Totals for Community Services	48,589	4,041,630	0	4,041,630	1.8	1.6
Totals for Poor	99,645	62,326,203	45,108,921	17,217,282	7.7	6.9
<u>Benefits for Broader Community</u>						
Community Services						
Community Benefit Operations	0	34,642	0	34,642	0.0	0.0
Community Building Activities	0	2,301	0	2,301	0.0	0.0
Community Health Improvement Services	20,208	420,264	0	420,264	0.2	0.2
Health Professions Education	116	923,635	0	923,635	0.4	0.4
Research	161	99,393	0	99,393	0.0	0.0
Totals for Community Services	20,485	1,480,235	0	1,480,235	0.7	0.6
Totals for Broader Community	20,485	1,480,235	0	1,480,235	0.7	0.6
Totals - Community Benefit	120,130	63,806,438	45,108,921	18,697,517	8.4	7.5
Unpaid Cost of Medicare	48,603	66,511,390	59,247,802	7,263,588	3.3	2.9
Totals with Medicare	168,733	130,317,828	104,356,723	25,961,105	11.6	10.4

 Sue Andersen Chief Financial Officer	Date 9/25/12
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*Benefits for the Poor; Subsidized Health Services should show an additional 5041 people served through both of Marian Community Clinics.

Telling the Story

As a member of Dignity Health, Marian Regional 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 Regional Medical Center. Each year a report of progress is posted to the Marian Regional 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 economically disadvantaged 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.

In 2009, Marian Regional Medical Center, Santa Barbara County Public Health Department and Marian's Community Education Department partnered to provide Spanish-speaking community members an opportunity to voice their opinion on services not available to them they would like to see. Requests for services that surfaced were: keep lights on in evening at the City of Santa Maria basketball courts so Dad's could play basketball with their kids, summer camp for children (it's too expensive for one and reduced rates for 2nd, 3rd child still do not help), exercise classes (they can't afford the gym). Two years later, Marian in partnership with the city of Santa Maria, and Santa Maria Bonita School District provided a free week of nutrition summer camp to 20 children ages 6-12 whose parents completed the Healthy for Life Nutrition Lecture series. A Kohl's Grant funded the Healthy for Life workshops and 20 students to attend two more weeks of summer camp. Yoga and Zumba exercise classes are so impacted through attendance participants are waiting outside the facility 45 minutes ahead of class time to get their spot to exercise. Marian is now looking for two more locations for adults and child Zumba classes.

Postcards are available for distribution key community partners and elected officials with website "links" to our online Community Benefit Report.

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

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
93455	Santa Maria	40,038	2.4	2.4	5.6%	6.7%	18.6%	2	3.2%	33.7%	4	11.0%	2	6.1%	11.2%	2	19.6%	2	20.5%	33.9%	11.0%	12.6%	19.6%
93454	Santa Maria	34,668	4.2	4.2	6.2%	16.6%	35.2%	3	8.2%	60.2%	5	21.6%	4	7.2%	20.0%	4	42.9%	5	39.2%	60.7%	21.6%	21.2%	42.9%
93458	Santa Maria	52,993	5	5	9.6%	25.8%	50.2%	5	31.1%	88.0%	5	54.5%	5	11.7%	24.6%	5	51.8%	5	57.0%	90.8%	54.5%	27.0%	51.8%

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 2012-2013

BOARD MEMBERS

Lupe Alvarez
Sister Amy Bayley, RSM
Todd D. Bailey, Jr., M.D.
Peggy Blough
Kathy Castello, Chair
Ethan Etnyre, M.D., Vice Chair
Michael S. Hardy, Attorney
Mike McNulty, Secretary
Sister Sheral Marshall, OSF
Tom Martinez
Vincent Martinez, Esq.
Sister Barbara Staats, OSF
John Will
Charles J. Cova, Hospital President/CEO

MRMC REPRESENTATIVES

Sue Andersen, VP & Chief Financial Officer
Sister Janet Corcoran, OSF, VP Mission Services
Mark C. Juretic, M.D., Chief of Staff
William Burress, Foundation Board President
Kathleen Sullivan, RN MBA, VP HHC/Hospice
Charles Merrill, M.D., FACEP, VP Medical Affairs
Kerin Mase, RN MBA, Chief Operating Officer / CNE

DIGNITY HEALTH CORPORATE REPRESENTATIVE

Marvin O'Quinn, EVP/COO, Dignity Health

SPONSOR REPRESENTATIVE

Sr. Pat Rayburn, OSF, Provincial Minister, Sisters of St. Francis

**Community Benefits Team Roster
2012-2013**

Sue Andersen
Chief Financial Officer

Susan Cedars
VP Human Resources, Educational Services

Heidi Summers, MN, RN
Director, Education Services and Community Benefit Central Coast Service Area

Sister Janet Corcoran, OSF
VP, Mission Services

Jo Ann Costa
Privacy Officer and Director, Plaza Surgery Center

Janet Davila, RN
Perinatal Outpatient Education Coordinator

Lupe Terrones
Director, Marian Community Clinics

Kathleen Sullivan
Vice President, Home Care Services

Katherine Guthrie, RN
Executive Director, Cancer Care Services, Dignity Health Central Coast Service Areas

Stephanie Grogan
Executive Director, Marian Foundation

Sandy Underwood
Senior Community Education Coordinator

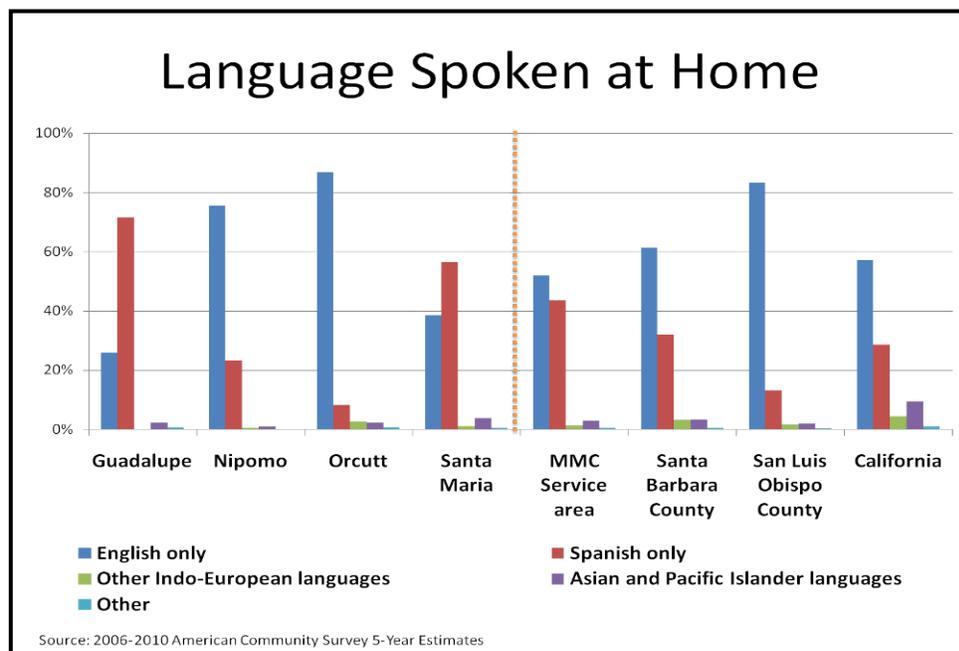
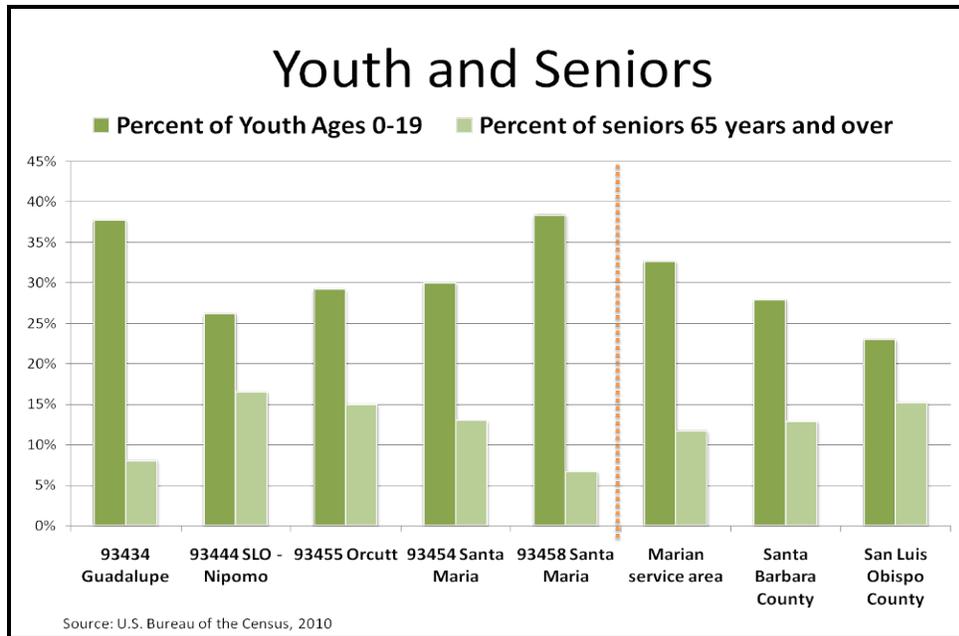
Raul Segura
Member, Marian Foundation Board and Marian Community Clinics Board

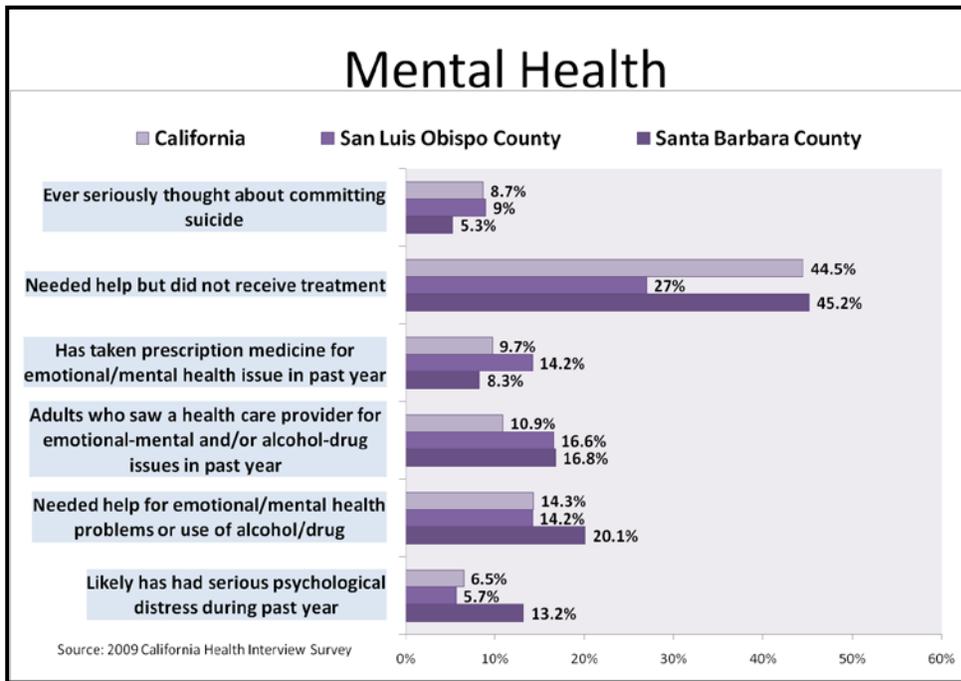
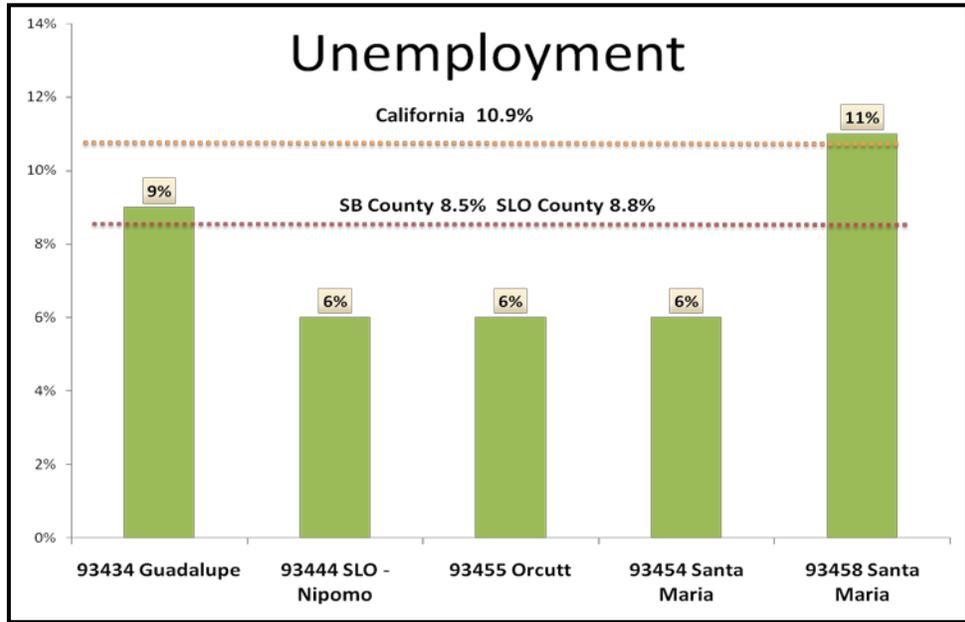
Kathy Castello
President, Hospital Community Board

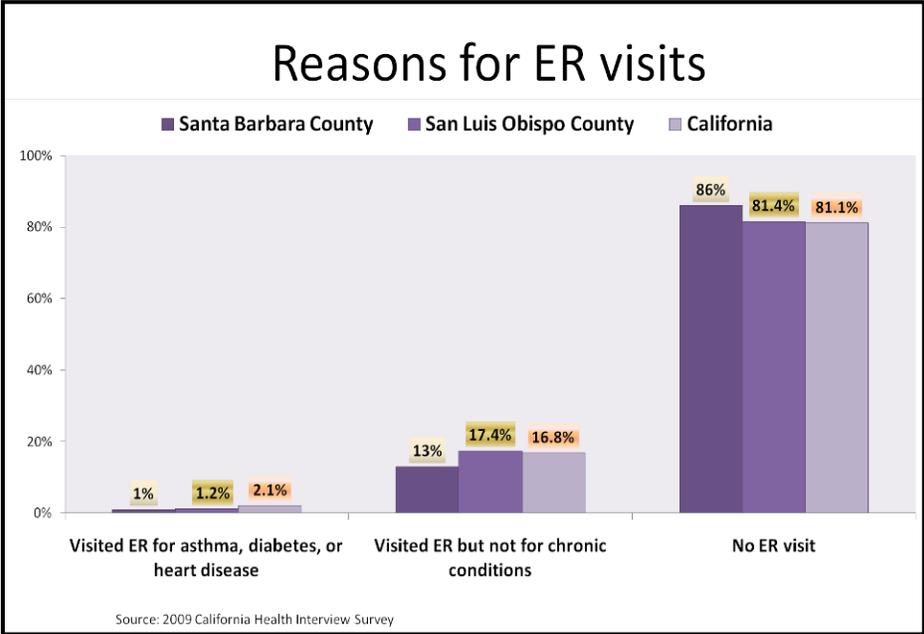
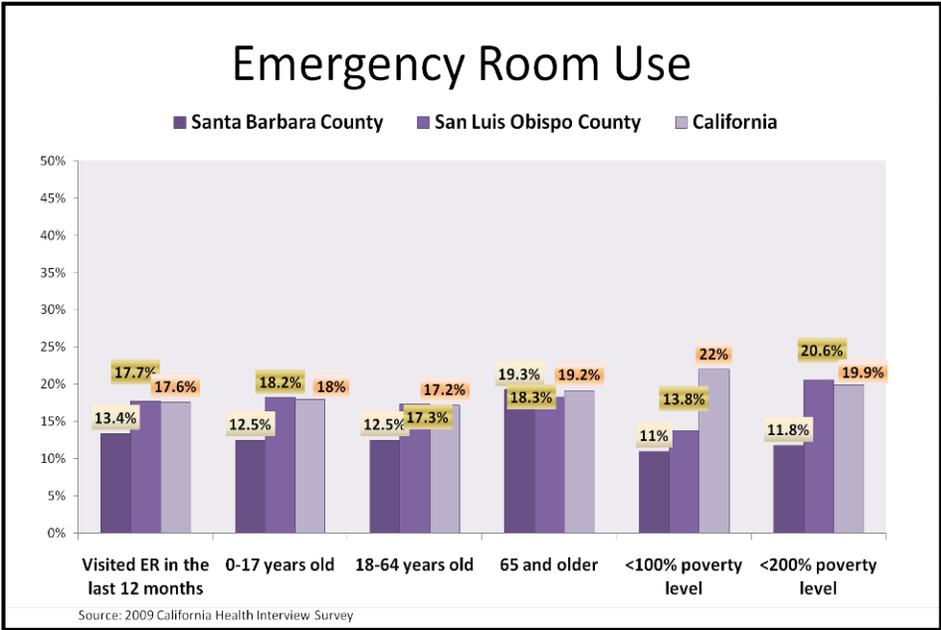
Mary K. Oates, M.D.
Medical Director, Marian Osteoporosis Center

Sister Pius Fahlstrom, OSF
Project Consultant

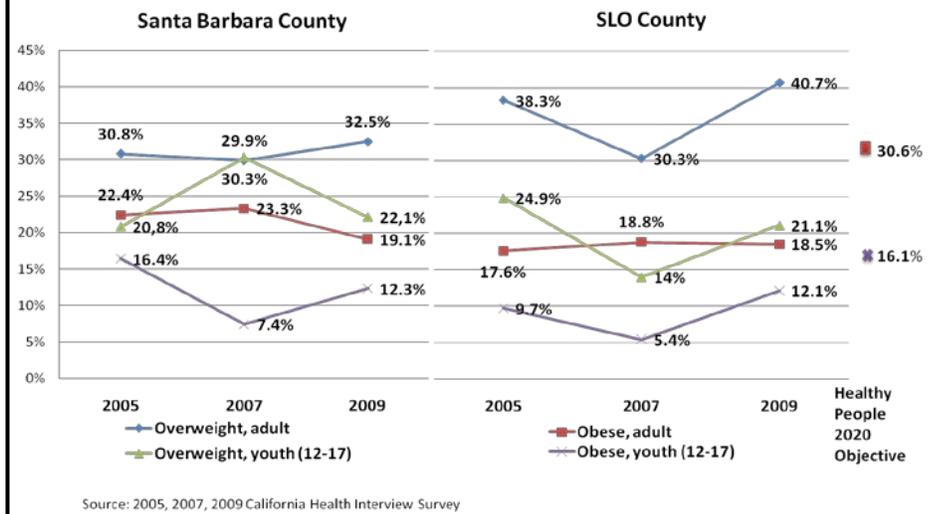
APPENDIX



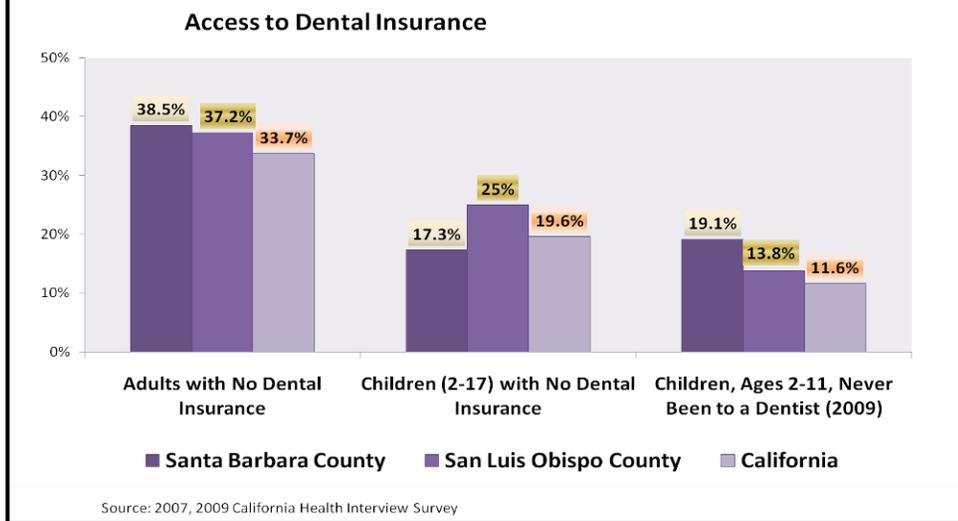




Overweight and Obesity

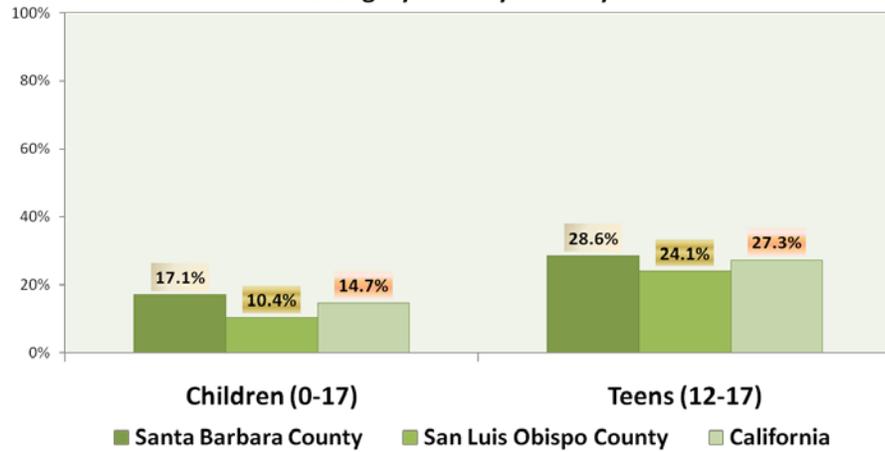


Dental Care



Soda Consumption

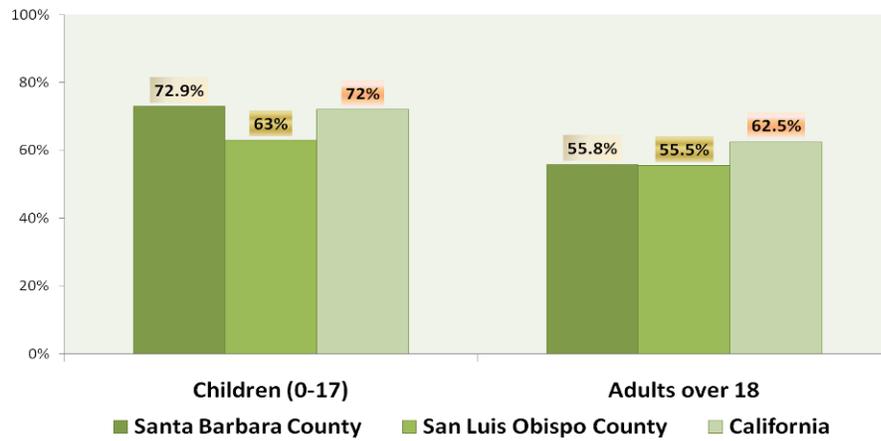
Drank two or more glasses of soda or other sugary drinks yesterday



Source: 2009 California Health Interview Survey

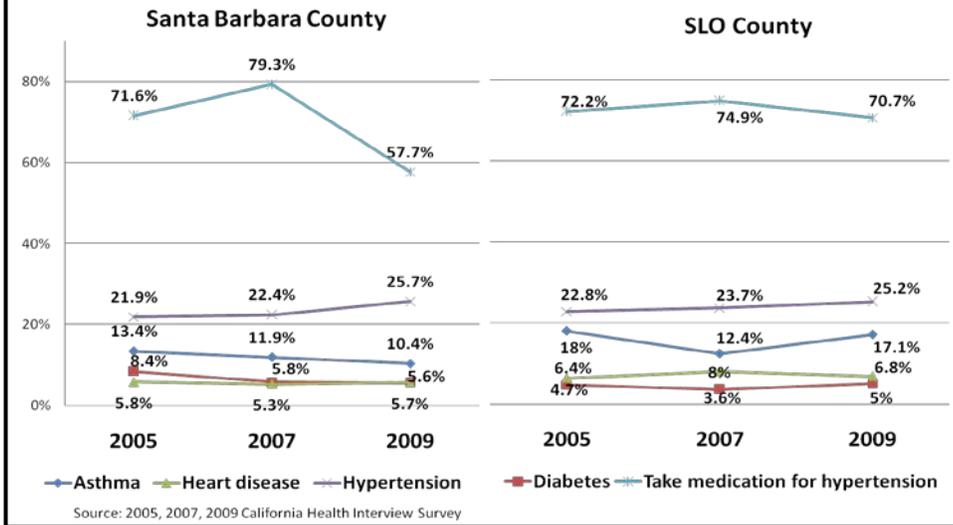
Fast Food Consumption

Fast food eaten at least one time in past week

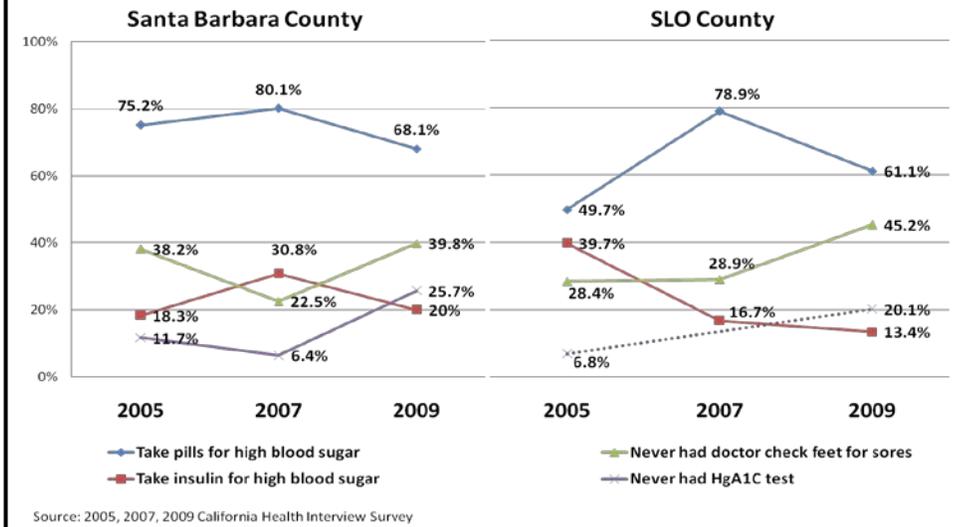


Source: 2009 California Health Interview Survey

Chronic Disease Prevalence



Diabetes



Teen births

	Three-Year Average, 2007-2009		
	Births to teens	Live births	Rate per 1,000 Live Births
93434 Guadalupe	19	154	124
93444 SLO - Nipomo	22	259	86
93455 Orcutt	34	463	73
93454 Santa Maria	105	787	133
93458 Santa Maria	245	1,457	168
Marian service area	426	3,119	136
Santa Barbara County	651	6,216	105
San Luis Obispo County	192	2,745	70
California	51,581	548,159	94

Source: California Department of Public Health (CDPH), www.healthycity.org