



Marian Regional Medical Center.

- Santa Maria Campus
- Arroyo Grande Campus

Community Benefit Report 2013 and Implementation Plan 2014



Dignity Health.

Marian Regional Medical Center

A message from Chuck Cova, President & CEO, Marian Regional Medical Center & Central Coast Services Areas and Mike McNulty, Community Board Chair Marian Regional Medical Center.

When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At Marian Regional Medical Center we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful care, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Marian Regional Medical Center we share a commitment to optimize the health of our community. In fiscal year 2013 Marian Regional Medical Center provided \$26,213,466 in financial assistance, community benefit and unreimbursed patient care and our second campus Arroyo Grande Community Hospital provided \$8,298,166. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Marian Regional Medical Center Hospital Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at its November 13, 2013, Board meeting.

Charles J. Cova
President & CEO
Marian Regional Medical Center; and
Senior Vice President, Operations
Dignity Health Central Coast

Mike McNulty, Chair
Hospital Community Board

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Executive Summary

Marian Regional Medical Center, a member of Dignity Health, is a Judeo-Christian healthcare ministry founded by the Sisters of St. Francis in 1940. Marian has a 25-acre campus located in Santa Maria, CA with a fully integrated healthcare delivery system. Marian Regional Medical Center's second campus, Arroyo Grande Community Hospital, located in Arroyo Grande and approximately 15 miles north of Marian, has been serving the health care needs of the Five Cities area since it became a member of Dignity Health in 2004.

Marian Regional Medical Center is rated among the top 10% in the nation for cardiac care and its cancer program is distinguished as the only comprehensive Community Cancer Center on the Central Coast. The need to meet the demand for quality, technologically-advanced care for a growing community led Marian to open its doors to a new state-of-the-art, 191-bed facility in the spring of 2012 with over 1400 employees, 284 physicians and 400 volunteers. The new facility houses the largest and most comprehensive perinatology/ neonatology service providing the highest level compassionate, quality care to the littlest of patients. Marian is a Dignity Health member of the Central Coast, which also includes the Arroyo Grande campus in Arroyo Grande, CA and French Hospital Medical Center in San Luis Obispo, CA. Dignity Health of the Central Coast is an integrated network of top quality hospitals, physicians from the most prestigious medical schools, and comprehensive outpatient services including primary care offices, ambulatory surgery centers, technologically-advanced laboratories and imaging centers; all recognized for quality, safety and service. Marian also has a 99-bed Extended Care Center, Homecare/Hospice and Infusion Service, and two primary care clinics.

Arroyo Grande Community Hospital (AGCH), a 67-bed state-of-the-art facility provides a full range of services, including medical-surgical, acute and emergency care. AGCH has been recognized with a "Blue Distinction" award for their Knee and Hip Replacement Services by Blue Cross and Blue Shield and continues to be nationally ranked in the top 15% of all U.S. hospitals for Joint Replacement surgical services. The Arroyo Grande campuses 14-bed Acute Rehabilitation unit serves patients who suffer functional loss from illnesses such as stroke, neurological and brain injury, spinal cord injury or other impairments requiring rehabilitation. Arroyo Grande Community Hospital has the second busiest Emergency Department in the San Luis Obispo County, treating an average of 1600 patients each month and consistently excels in patient satisfaction ratings. With an affiliation of approximately 109 active physicians, surgeons and other medical professionals and 357 employees, AGCH continues to be highly regarded for excellent healthcare.

Major community benefit activities for fiscal year 2013 focused on improving access to health care. Pacific Central Coast Health Centers' Community Clinics in Santa Maria and Guadalupe offer high quality health care and health education to these communities with a focus on providing services to the uninsured, under-insured, working poor and vulnerable populations. Each clinic is located in a primarily Hispanic, low-income area. The clinics provide primary care, pediatrics, OB/GYN and same day care services. Both clinics have bilingual staff. The Santa Maria Clinic also offers Saturday hours for working families that have children requiring CHDP (Child Health Disability Prevention) physicals and immunizations, as well as transportation resources to and from appointments for the OB patients. In concert with the goal of keeping our communities healthy and educated, the clinics also provide outreach and intervention for health issues such as diabetes, obesity, high blood pressure, as well as flu vaccination clinics.

Marian partners with the Santa Barbara County Public Health Department'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.

Marian Regional Medical Center's **Cancer Care Program** is accredited as a Comprehensive Community Cancer Center by the American College of Surgeons' Commission on Cancer. Marian Cancer Care has also received seven commendations and is a recipient of the Outstanding Achievement Award. Additional services within Mission Hope Cancer Center include a cancer resource center community education, patient family and caregiver support, cancer educational, personal appearance center, outpatient care coordination and genetic, nutritional and psychosocial counseling.

Support services at Arroyo Grande Community Hospital's Coastal Cancer Care Center include a dedicated breast cancer nurse navigator. Navigators are the community "411" information points for cancer care, and can answer many questions regarding cancer screening, treatment, follow-up and resources available to patient and family members touched by a cancer diagnosis. The Arroyo Grande campuses **cancer awareness and support program** offers extensive informative educational outreach efforts to the community about many types of cancer including but not limited to skin, prostate, lung, breast, and colon, particularly to those identified as poor, vulnerable, and underinsured. Outreach consists of on-sight screenings at health fairs and promotional events, mailers, newsletters and other informative tools to reach the poor and broader community on how to prevent cancer, treatment options if necessary and other resources available to the community.

Health education for both of Marian campuses 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. Both campuses offer 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 empowers participants in the development of their own action plan for healthy living. The two campuses also offer Healthy for Life, a nutrition lecture series, an interactive program providing both nutrition education and a physical activity component. Both programs are offered in English and Spanish. Arroyo Grande offers lectures for disease prevention focused on topics of heart health, hypertension and senior citizen services for the broader community. Yoga, Zumba and Zumbatomicms (for children) are physical activities offered at local community centers, churches and the hospital conducted with bilingual instructors.

Both campuses offer a **Congestive Heart Failure Program** (CHF) which 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 and Arroyo Grande. 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 programs use of patient tele-monitors builds a support of remote 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 life and clinical outcomes to include early detection, intervention and reductions in avoidable hospitalization. Tele-monitoring also improves physician engagement and patient

satisfaction while improving patient compliance with medications, diet, weight-monitoring and symptom management.

The **Diabetes Education Center**, offered at both campuses, continues to bridge the medical and educational needs of patients living with pre-diabetes and diabetes, along with multiple co-morbidities through a collaborative referral services with physician's offices, local clinics in the surrounding geographical area, Marian's Mission Hope Cancer Center and Congestive Heart Failure Program and the Santa Barbara County Public Health Department. The Diabetes Education Center provides a comprehensive evidence-based diabetes management program by meeting individually and in group settings with a registered dietitian/coordinator and a registered nurse both certified diabetic educators. Enhancement to this program includes consultation and education to the Spanish speaking community with the additional of a bilingual nurse educator. The Diabetes Education Center program continues to help patients improve self management practices, personal behavioral goals to meet positive measureable outcomes resulting in overall cost savings and, a reduction in hospital and emergency room readmissions. The Diabetes Education Center continues to strive to enhance and improve access and delivery of effective preventative healthcare services by providing the same benefit to those uninsured and underinsured through the Community Benefits program.

With the acknowledged need to support the development of qualified healthcare professionals, Marian Regional Medical Center's Santa Maria campus continues to identify and develop a projected priority recruitment plan for healthcare workers. Partnering with Allan Hancock College and Cuesta College, the Santa Maria campus 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. Both hospitals, as a means to foster professional development and improve patient care, continue 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.

Marian Regional Medical Center's two campuses will continue to support the recruitment of primary care and specialty physicians to meet the needs of the community. Marian has also expanded the network of health centers beyond the original two primary care sites to five additional primary care centers and various specialties while AGCH promotes 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 2013 are \$26,213,466, which excludes Medicare. Including the expenses incurred for the unreimbursed costs of Medicare, the total Community Benefit expense for Marian Regional Medical Center was \$38,702,454.

The total dollars quantified for Community Benefits for these and numerous other community benefit programs in FY2013 are \$8,298,166 which excludes Medicare. Including the expenses incurred for the unreimbursed costs of Medicare, the total expense for our second campus, Arroyo Grande Community Hospital was \$13,633,880.

Mission Statement

Marian Regional Medical Center and its second campus, Arroyo Grande Community Hospital 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. Organizational Commitment

The mission of Marian Regional Medical Center's two campuses is built on our vision to serve those most in need.

1. The Hospital Community Board has twenty two members including religious sponsors, the hospital President and CEO, Chief of Staff, CFO, COO, VPMA, medical staff, Foundation Board members and senior leadership. 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. Our commitment to identify opportunities and implement changes through collaboration with Dignity Health Central Coast entities continues to improve operational efficiency and performance. The Hospital Board Chair is an active member of the Community Benefit Committee contributing community expertise while monitoring programs to ensure continuing program focus. The hospital community board reviews community outreach statistics to ensure that programs target the economically disadvantaged and underserved. Program Coordinators are accountable for meeting their program's community benefit goals and reporting the outcomes of their program to the Community Benefit Committee on a quarterly basis.
 - Both campuses 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.
2. The Hospital Community Board and senior leadership provide support to Community Benefit as indicated below:
 - Budgets are approved by senior leadership at both campuses
 - The Community Health Needs Assessment is utilized as the planning guide for prioritizing community health needs priorities with the Community Benefit Report and Implementation Plan
 - Program content is based on the priorities identified through the CHNA and the hospital's available resources, capabilities and partnerships
 - Program design is guided by resources available internally and our community partnerships utilizing evidence-based programs and ensuring programs have measurable outcomes
 - Targeted populations are identified by using the Community Needs Index
 - Each program is monitored through quarterly data collection and outcomes identified for each program. Data is reviewed at quarterly Community Benefit Committee meetings.

B. Non-Quantifiable Benefits

1. There are many examples of non-quantifiable benefits related to the community contribution of Marian Regional Medical Center and our second campus, Arroyo Grande Community Hospital. Working collaboratively with community partners, our campuses provided leadership and advocacy, assisted with local capacity building, and participated in community wide health planning. The following are some non-quantifiable services:
 - The Environmental Team at AGCH regularly uses non-toxic paints on maintenance projects, and regularly promotes reducing waste through a recycling program.
 - Marian generated 1,319,300 pounds of solid waste increasing our poundage by 308,180 pounds when compared to last FY [1,011,120]. This increase was minimal, considering the construction and remodeling project presently underway. Additionally 32,839.68 pounds of medical waste have been diverted from the land fill. Our on-going paper and cardboard recycling has generated a total of 988,296 pounds, all of these being diverted from the landfill.
 - 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 from the landfill 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.
 - AGCH Transformational Care team worked with the Emergency Department to decrease the time from door to admit to doctor to discharge, and with the Inpatient Direct Care team to improve patient education, perception of care, home discharge needs and discharge time and improved identification of palliative care patients.
2. Marian's Vice President of Post Acute-Care Services is a Board Member for the Adult and Aging Network in Santa Barbara County. Other Marian staff members participate in Santa Barbara County Partners for Fit Youth, Santa Barbara County (SBC) First Five Strategic Planning Committee, THRIVE's Community Advisory Board and Executive Leadership Board and Board Chair for the Central Coast Gold Coast Collaborative. Involvement in these committee groups show support of Community Health Improvement Services for children in Santa Barbara County. SBC Department of Social Services Education and Outreach Committee (Affordable Care Act) and San Luis Obispo County Affordable Care Act (Education and Outreach) are county-wide collaborative groups providing education to the broader and underserved public regarding Healthcare Reform's Affordable Care Act. Marian Regional Medical Center's Santa Maria campus is represented at the Guadalupe Family Resource Center Board, and Guadalupe Senior Center. Involvement in the Santa Barbara County Coalition to Support Promotoras and San Luis Obispo (SLO) County Promotora Coalition show the dedication of the hospital to promote health education and wellness by engaging community health workers known as "promotora" to support programming through workshops and outreach events. These efforts demonstrate the hospital's commitment to building healthier communities and its leadership as a convener/capacity builder in the community.

Community

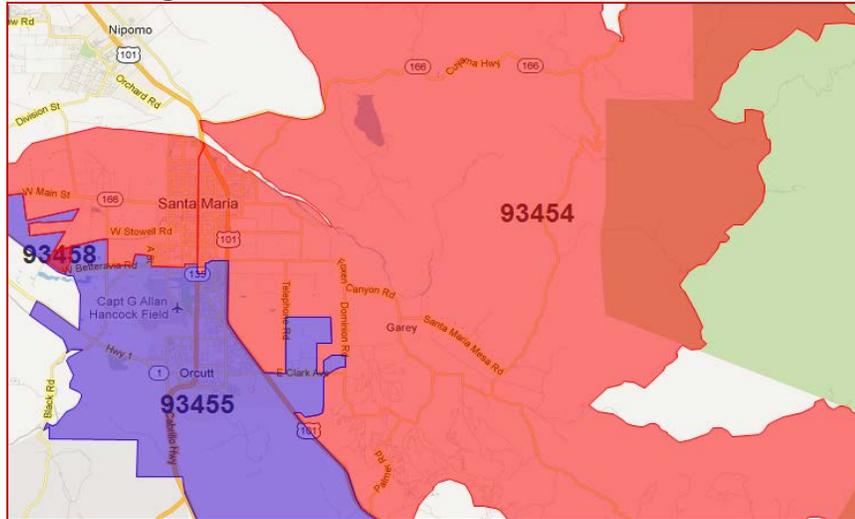
Dignity Health hospitals of the Central Coast define the community's geographic area based on a percentage of hospital discharges and as identified by the Community Needs Index.

Although Marian Regional Medical Center and Arroyo Grande Community Hospital 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. We rely heavily on our partners, Integrated Health Management Services (IHMS), to assist these patients with health coverage, including government and non government programs.

1. Marian Regional Medical Center is 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 the secondary service area being the City of Guadalupe, in the North County, and Nipomo, a community in southern San Luis Obispo (SLO) 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. 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 from Mexico that is 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. The poverty rate in the Marian service area is less than it is statewide, with about one in every five female heads of household with children are living in poverty. 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. Indigenous Mexicans reported a 43% average annual household income below \$10,000 per year.
2. The demographics of the Marian Regional Medical Center service area are more clearly defined below as identified in the 2010 Census data and which are reported on the Schedule H 990.
 - Population: 138,189
 - Diversity: Caucasian – 29.8%| Hispanic – 62.4%| Asian, Pacific Islander – 4.4%| African American – 1.2%| Other – 2.2%
 - Average Income: \$68,848
 - Uninsured: 15.4%
 - Unemployment: 8%
 - No HS Diploma: 28.8%
 - Renters: 38.6%
 - Medicaid Patients: 16.7%
 - Other Area Hospitals: 0

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 be primarily Latino/ Oaxacan there are pockets of low income seniors who also have Disproportionate Unmet Health Needs.

Marian Regional Medical Center CNI



Lowest Need

Highest Need

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

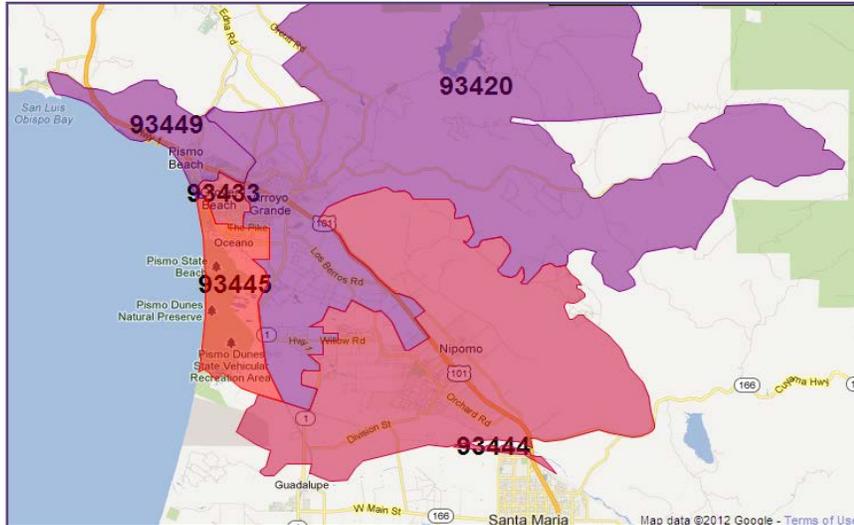
Zip Code	CNI Score	Population	City	County	State
93454	4.2	34668	Santa Maria	Santa Barbara	California
93455	2.4	40038	Orcutt	Santa Barbara	California
93458	5	52993	Santa Maria	Santa Barbara	California

Arroyo Grande Community Hospital (AGCH), the second campus of Marian Regional Medical Center, is located in south San Luis Obispo County. The largest cities in its service area are Arroyo Grande, Grover Beach, Nipomo, Oceano and Pismo Beach. Approximately 80% of AGCH service area population speaks English at home, and about 18% speak Spanish as their home language. Poverty in the AGCH service area is below the state of California with 5.6% of households indicating impoverished socioeconomic levels, but when the female is head of household with children, the poverty index rises to 18.3%. Unemployment throughout AGCH service area is 7.1%. It is also important to note approximately 17.3% of the population is comprised of seniors age 65 and older.

The demographics of the Arroyo Grande Community Hospital's service area are more clearly defined below as identified in the 2010 Census data and which are reported on the Schedule H 990.

- Population: 105,216
- Diversity: Caucasian – 69.6%| Hispanic – 23.4%| Asian, Pacific Islander – 3.2%| African American – 0.7%| Other – 3.1%
- Average Household Income: \$74,766
- Uninsured: 15.3%
- Unemployment: 8.1%
- No HS Diploma: 11.8%
- Renters: 37.1%
- Medicaid Patients: 11.0%
- Other Area Hospitals: 2

Arroyo Grande Community Hospital CNI



Lowest Need

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

Highest Need

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

Marian Regional Medical Center and its second campus, Arroyo Grande Community Hospital are part of the Dignity Health Central Coast network of hospitals which also includes French Hospital Medical Center in San Luis Obispo. Dignity Health serves the western United States and strives to be a spiritually-oriented and community-focused healthcare system with a passion for improving patient care and collaborating with others to create a just healthcare system.

- Other health care facilities and resource within the community that are able to respond to the health needs of the community in north Santa Barbara include Pacific Central Coast Health Centers' Community Clinics: one in Guadalupe and one in Santa Maria. Community Health Centers of the Central Coast have twenty-six community health clinics (one is a dental clinic) throughout the two counties. The Santa Barbara County Public Health Department has three community clinic locations: Betteravia's Government Center, Good Samaritan Homeless Shelter and the Women's Health Clinic. In San Luis Obispo County health care facilities and resources within the community that are able to respond are SLO Public Health (Paso Robles, Family Planning Clinic only) and SLO Noor Free Clinic.
- The Pacific Central Coast Health Center located in Guadalupe, a small community in the Santa Maria Valley, has been federally designated as a Medically Underserved Area (MUA).

Community Benefit Planning Process

A. Community Health Needs Assessment Process

Marian Regional Medical Center and our second campus, Arroyo Grande Community Hospital wanted to include the voices of the people who live in their service areas and who

represent the organizations and agencies that serve the hospital's population throughout the process of conducting its needs assessment. Community Benefit staff determined that conducting primary qualitative research would be the best way to achieve this goal. The Central Coast Service Area identified the primary service area which also link to the disproportionate unmet health-related needs for conducting this community health needs assessment. The Dignity Health Central Coast Service area thus engaged Massachusetts-based Helene Fuchs Associates and the California- based STRIDE program at Cal Poly. The research process began with Dignity Health staff working with Cal Poly's STRIDE program faculty and staff to design a qualitative study that would include focus groups with patients who use Dignity Health services, key informant interviews with representatives of area agencies and organization, and hospital providers. Helen Fuchs Associates completed a Community Health Needs Assessment for both the Santa Maria and Arroyo Grande campuses of Marian Regional Medical Center in 2012.

1. Dignity Health Central Coast Service area decided to use purposive expert sampling to identify key informants. Hospital staff members selected agency partners, key stakeholders, other healthcare providers, and staff colleagues such as case management as key informants who had special knowledge or expertise of the community. Twelve key informants were interviewed in the Marian Regional Medical Center's Santa Maria service area and 26 people participated in the Santa Maria campus focus groups. Two focus groups were conducted in Spanish with a total of 13 participants, and two focus groups were conducted in English with a total of 13 participants. Nine key informants were interviewed in the Arroyo Grande campuses service area and a total of 34 people participated in the AGCH focus groups. Two focus groups were conducted in Spanish with a total of 14 participants, and two focus groups were conducted in English with a total of 20 participants. Helene Fuchs (HF) Associates compiled, organized, and analyzed the primary and secondary data. The research associates were graduate students and alumni of Tufts University's Friedman School of Nutrition Science and Policy, alumni and graduate students from the Tufts University Master of Public Health Program, and alumni of Simmons College Graduate School of Health Sciences and School of Management. California Health Interview Survey (CHIS) from 2009 provided secondary data and is identified throughout this report.
2. Below is a summary including primary and chronic disease needs, health issues of the uninsured persons, low-income and minority groups for both campuses. Several key findings fit into more than one category.
 - Economic Disadvantage
 - Access to Care
 - ◊ Language Barrier
 - ◊ Transportation
 - Emergency Department Utilization
 - Cultural Awareness
 - Time Barrier (Santa Maria campus)
 - Preventive Care
 - Awareness of Existing Services
 - Maternal and Teenage Healthcare and Social Services
 - Alcohol and Tobacco Use (AGCH)
 - Senior Issues (Arroyo Grande campus)
 - Clinical Conditions
 - ◊ Obesity
 - ◊ Diabetes

- ◇ Heart Disease (Arroyo Grande campus)
 - ◇ Oral Health
 - ◇ Mental Health
 - ◇ Asthma (AGCH)
 - Nutrition and Physical Exercise
 - Crime and Social Cohesion
3. This assessment summary is on the websites of Marian Regional Medical Center and our second campus, Arroyo Grande Community Hospital respectfully. A copy can also be obtained by contacting the administrative offices of any of the three organizations.

B. Assets Assessment Process

An inventory of community assets can be described below and are categorized by the hospital community benefit priority areas of first Marian Regional Medical Center and the second campus of Arroyo Grande Community Hospital:

1. Pacific Central Coast Health Centers have two community 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). Community Health Centers of the Central Coast have twenty-six community health clinics (one is a dental clinic) throughout the two counties. The Santa Barbara County Public Health Department has three community clinic locations: Betteravia's Government Center, Good Samaritan Homeless Shelter and the Women's Health Clinic. Santa Maria-Bonita School District, local churches, Santa Barbara Coalition in Support of Promotora de Salud support outreach activities for health promotion and disease prevention. Alliance for Pharmaceutical Access, Marian Regional Medical Center's Congestive Heart Failure Program, Marian's Community Cancer Center and Diabetes Education Programs support outreach and community needs regarding disease management. The relationships established in the Arroyo Grande Community Hospital's service area continue to grow, offering AGCH strong partnerships that can assist in program design and implementation of identified community needs and shared expense. Lucia Mar Unified School District and City of Arroyo Grande offer facility use for community health education and nutrition programs. In San Luis Obispo County health care facilities and resources within the community that are able to respond are SLO Public Health (Paso Robles, Family Planning Clinic only) and Noor Free Clinic.

A variety of organizations, including San Luis Obispo Public Health Department, Community Health Centers of the Central Coast (CHCCC) and Arroyo Grande Community Hospital collaborate to offer health screenings at civic Health Fairs throughout the year. Active Aging Task Force in SLO, Alzheimer's Association, and AGCH collaborate to provide health lectures to our senior citizen population.

2. A number of community needs exists in the service areas of Dignity Health's three Central Coast hospitals. Marian Regional Medical Center, our second campus, Arroyo Grande Community Hospital, and French Hospital Medical Center may realize efficiencies by working together to address the following common unmet community needs:
 1. Access to Healthcare
 2. Emergency Room Utilization
 3. Mental Health
 4. Clinical Conditions
 5. Oral Health
 6. Transportation

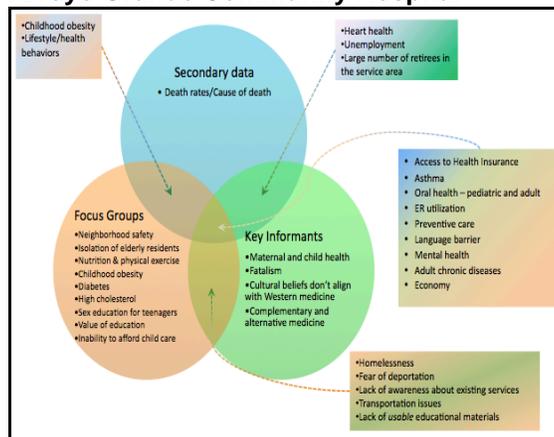
7. Cultural Awareness

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

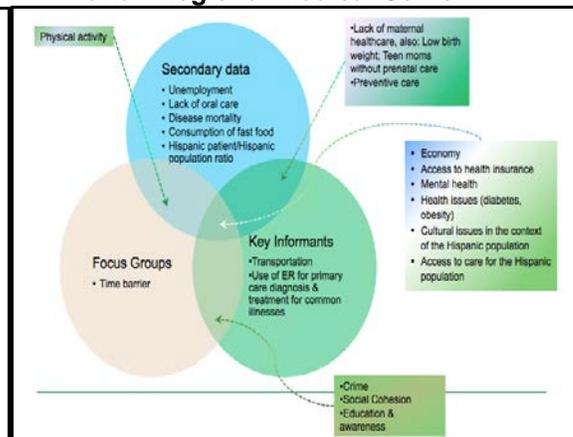
C. Developing the Hospital's Implementation Plan

1. 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.
2. To effectively impact the increase in charity care and Medi-Cal expense, Marian's campuses 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 Pacific Central Coast Health Center clinics in Santa Maria and Guadalupe to take referrals from the ER; d) Identify physician/staff champion within service area to promote disease management initiative; and e) Identify the availability of community partners that will collaborate with us in providing disease prevention education programs that target cost-effective prevention.
3. Factors considered in prioritizing the areas of opportunity identified by the needs assessment include the size of the target population and discovering that many residents in the Central Coast Service area do not know how to navigate the system for needed service. They are unaware of existing services and especially preventive care services. Venn diagrams were carefully reviewed which provided a visual representation of key findings from the data analysis. The diagram illustrates the community needs identified both by the primary research (focus group and key informant interviews) and secondary data. The core of the diagram shows where the secondary data supports the primary research. Other segments of the diagram show cases where overlap existed between two of the three data collection methods used.

Arroyo Grande Community Hospital



Marian Regional Medical Center



4. After a roundtable discussion, the Community Health Needs Strategic Planning Committee reflected how unaware they were of the many services currently being offered in Santa Barbara and San Luis Obispo County. Committee members reflected on the issues, whether the health need reflected health disparities and availability of community resources to address the need. Committee members were given an opportunity to rank the top seven identified community health needs. The prioritization process identified four priority issues for the community:
 - a. Access to Healthcare
 - b. Emergency Room Utilization
 - c. Mental Health
 - d. Clinical Conditions
5. The next step for Marian Regional Medical Center's two campuses along with sister hospital French Hospital Medical Center, community partners, and others was to determine which issues to address first. The Teams developed goals, measurable objectives and strategies indicating the effectiveness of the efforts. The team developed a work plan (program digest) or enhanced a current program digest.
6. These services specifically address a vulnerable population identified by zip codes and disproportionate unmet health related needs. The zip codes areas with the most need identified in Marian Regional Medical Center's service area are northeast (93454) and northwest (93458) of Highway 101 in Santa Maria; and a secondary service area (93434), eight miles west of Santa Maria, as indicated by the Community Needs Index. The two zip codes with most need identified by Marian's second campus, Arroyo Grande Community Hospital service area are west and south of the City of Arroyo Grande; Oceano and Grover Beach, 93445 and 93433 respectively.

The Community Health Needs Strategic Planning Committee for both campuses has selected four initiatives to address the Access to Healthcare priority

- Expand clinic hours (evenings and weekends)
- Communication campaign to promote existing programs currently being offered in the community
- Investigate feasibility of public transportation near clinics and hospitals
- Discharge Planning/Case Management link to patients discharged with emphasis on access to prescription drugs, transportation, food services (Meals On Wheels), and a continuum of care (telephonic support, community education)

In response to the identified need for more access to healthcare, Marian has just opened a Family Practice clinic on the Santa Maria campus. Marian's Transformational Care Readmission Team has been instrumental in moving the Access to Healthcare priority forward. Marian's Volunteer Services and Patient Care Coordinators contact the patient's doctor on admission and arrange appointments before discharge or help them find a medical home in the community to ensure continuity of care.

A Marian Regional Medical Center Patient Workbook has been developed in English at the Santa Maria campus to assist patients in how to navigate the healthcare system as an inpatient and upon discharge. The Patient Workbook will be translated into Spanish to address low literacy and pictures have been incorporated to assist in getting the message and information across for those who speak other languages of Oaxaca. Awareness of existing services is an underlying need related to the four priorities identified and the Patient workbook lists many resources to aid in medication management, and provides name and addresses of local pharmacies and the services

they offer such as weekend hours, or home delivery. TIGR is an education software module that plays on the patient television. TIGR offers health education in English and Spanish to address the language barrier priorities. Patients in Labor and Delivery who speak other languages from Oaxaca, Mexico, such as Mixteco have access to a DVD developed for mothers in labor. Upon discharge if patients do not have access to transportation, Marian offers free taxi vouchers and a list of transportation opportunities. There is also a bus stop located around the corner from the main entrance of Marian's campus.

Marian Regional Medical Center and Arroyo Grande Community Hospital can address Emergency Room Utilization by conducting a thorough review of all "inappropriate" patient utilization of ER. We will also conduct an internal chart review to evaluate whether the findings presented in the CHNA report reflect the reality of the care being provided. While these initiatives can reduce ER Utilization, people will continue to use the Emergency Room as a means of primary care. The newly opened Family Medicine Clinic on Marian's Santa Maria campus will help some ER discharged patients find a medical home if they do not already have one.

Mental Health is a substantial concern in both counties. While there are many services being offered by local partners in the community, more services are needed. Both campuses could explore the possibility of a collaborative with both local police department to provide an officer trained in mental health advocacy to be on call for mental health needs at the Emergency Room. Marian Regional Medical Center is collaborating with the County of Santa Barbara and a third party to evaluate and potentially develop a Behavioral Health inpatient facility in Santa Maria. This facility would include geropsychiatric care.

Both Marian Regional Medical Center campuses needs assessment indicated community members identified many related Clinical Conditions such as: obesity, diabetes, and nutrition and physical exercise. Both hospitals offer nutrition workshops in English and Spanish. Exercise classes have been offered in the Santa Maria Valley for three years and still expanding in the three identified target areas. AGCH recently kicked off exercise classes in the targeted areas with expansion of these classes coming soon. There is a Diabetes Program accredited by the American Diabetes Association based at the Santa Maria campus. The Diabetes Program needs to be enhanced and expand into the AGCH service area to serve the community in a more local capacity. Program Digests for Diabetes Prevention and Management and Healthy for Life Wellness Program and Healthier Living: Your Life Take Care (chronic disease self-management) will incorporate the identified community health needs in their programs for the upcoming fiscal year.

These areas are in need of improved access to healthcare and services for the underinsured and uninsured. Uninsured Latinos in the Santa Maria Valley and identified target populations in the AGCH service area do not have adequate access to clinical support or health education for chronic illnesses. Many Latinos are not aware that free and low-cost programs and health education classes even exist.

Both Marian campuses will also focus on building community capacity by strengthening our partnerships among community based organizations. 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.

7. Based on the comparison of each hospital's assessment reports, Marian cannot directly affect the following two community health needs but provides 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 Letters of Inquiry (LOI) to 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. Both campuses follow the Dignity Health Charity Care/Financial Assistance Policy and Procedures (Attachment A).
2. Both campuses train and educate 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. Both campuses keep 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

Programs were developed in response to the Community Health Needs Assessment, related data in the Community Need Index and hospital utilization data and 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 between clinical services and community health improvement activities.
- **Build Community Capacity:** Targets charitable resources to mobilize and build the capacity of existing community assets to reduce duplication of effort.

- **Collaborative Governance:** Engages diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Below are major initiatives and key community based programs operated or substantially supported by Marian Regional Medical Center in 2013. Programs intended to be operating in 2014 are noted by *. Programs were developed in response to the current Community Health Needs Assessment and are guided by the five priority areas.

Priority Area 1: Access to Healthcare Services

- Charity Care for uninsured/underinsured and low income residents*
- Clinical experience for medical professional students*
- Transportation vouchers for discharged patients*

Priority Area 2: Emergency Room Utilization

- Operation of Pacific Central Coast Health Center's community clinics in Guadalupe and Santa Maria*
- Alliance for Pharmaceutical Access*

Priority Area 3: Clinical Conditions

- Healthy for Life Nutrition Lecture Workshop*
- Physical Activity *
- Maternal Outreach*
- Screenings: Community Blood Pressure Checks and Memory Screenings*
- Grief and Stroke Support Groups*
- Oaxacan Advocacy*
- Marian Regional Medical Center designated as a "Tobacco Free Campus"*
- Congestive Heart Failure Program – Long term improvement program*
- Diabetes Prevention and Management – Long term improvement program*
- Mission Hope Cancer Care Services*
- Osteoporosis Program*
- Home/Care/Hospice Services*
- Healthy Living: Your Life Take Care*
- Outpatient Palliative Care*

Priority Area 4: Mental Health

- Financial support to Santa Barbara County Mental Health, CARES program*
- Dignity Health Community Grants process sent Letters of Inquiry (LOI) to local community agencies that support clients with mental health issues.*
- Work with community based organizations who provide mental health services by providing facility use; in kind printing for workshop and/or brochures*

Pacific Central Coast Health Centers' Community Clinics	
Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
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>The Santa Maria and Guadalupe Clinics assure 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. Pacific Central Coast Health Centers' Community Clinics in Santa Maria and 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. Pacific Central Coast Health Centers' Community Clinics collaborate with many community partners including the Santa Barbara County Public Health Department.</p>
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. Pacific Central Coast Health Centers' Community Clinics 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, Evaluate opportunities to further expand hours of service.
Results for FY 2013	<ol style="list-style-type: none"> Measurement Not Met – primary care did not increase by 25%; OB/GYN visits did not increase by 20%. This can be attributed to a shortage of one primary care physicians for both clinic sites. Recent crime activity at Santa Maria clinic it has made it unsafe for patients to walk to our location. <ol style="list-style-type: none"> Primary care – 15,731 (*-9% decrease compared to fiscal year ending 6/30/2012) OB/GYN – 2,842 (*-1% decrease compared to fiscal year ending 6/30/12) Measurement Not Met – there were no patients referred to the Healthy Living Your Life Take Care (chronic disease self-management workshop). Measurement exceeded by 11% over fiscal year 2012. Community Outreach involvement increased by 51% serving 1,048 participants.
Hospital's Contribution / Program Expense	\$1,065,694
FY 2014	
Goal 2014	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.
2014 Objective Measure/ Indicator of Success	<ol style="list-style-type: none"> Increase available clinic hours at Guadalupe and Santa Maria to include evening hours during the week Refer to MRMC Diabetes (ADA certified) Program 25 new diabetes patients to the program (uninsured, insured, underinsured). Recruit and train two promotoras to conduct Homeless survey in a culturally sensitive manner. Recruit and train two promotoras to conduct culturally sensitive health education informational sessions one day each week in the clinic waiting room regarding diabetes, nutrition, promotion of community classes (CDSMP, HFL, Zumba, Yoga) and provide a continuum of services available in the community. Currently the clinics EHR/Practice Management System project is in review with the Physician Connectivity IT Organization, (PCITO), within Dignity Health. IT has determined additional data points are necessary to fully understand the Hospital/Clinic Environment(s).
Baseline	<ul style="list-style-type: none"> Primary care - 15,731 (* -9% decrease compared to FYE 2012) OB/GYN - 2,842 (* -1% decrease compared to FYE 2012) Orthopedic – 0 (* -100% decrease compared to FYE 2012, the program moved over to the broader community and under a new Director) Marian New Life - 192 (* -64% decrease compared to FYE 2012; during the 2nd quarter of FY 12-13, the MNL Coordinator retired, we are currently collaborating with Carenet, Santa Maria and are looking a other opportunities to possibly integrate the program with our OB services) Community Outreach - 1,048 (* 51% increase compared to FYE 2012) <p>TOTAL FYE 2012 ENCOUNTERS: 19,813 – OVERALL DECREASE OF -13%</p>
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Search for a safer location to accommodate the Pacific Central Coast Health Center's Community Clinic in Santa Maria Work with Santa Barbara County Coalition to support promotoras.
Community Benefit Category	C-3 Hospital Outpatient Services

Santa Maria and Arroyo Grande Diabetes Prevention and Management

Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
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 2013

Goal FY 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 Measures/ 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 Pacific Central Coast Health Center's Community Clinics 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 Pacific Central Coast Health Center's Community Clinics, 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. 																									
Results for FY 2013	<ol style="list-style-type: none"> 1. Forty-seven (47) high risk patients were identified (from ER/MRMC/CHF/HH/PC/CA Center) 2. Forty-eight (48) high risk patients were identified from Pacific Central Coast Health Center's Community Clinics 3. 11 more identified from SB County clinics, CHC and Urgent Care. 4. Forty (40) Spanish speaking patients enrolled in program providing 50 visits. 5. Interpreters were provided unless seen by Spanish-speaking program staff. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="5" style="text-align: center;">Arroyo Grande LTIP Diabetes Prevention and Management 6 months in arrears</th> </tr> <tr> <th style="width: 20%;">Diabetes Prevention and Management</th> <th style="width: 15%;">Number of Persons Served this Quarter</th> <th style="width: 20%;"># of Participants Admitted to the Hospital or ED within six months of the Intervention*</th> <th style="width: 20%;">% of Participants Admitted to the Hospital or ED within six months of the intervention.</th> <th style="width: 25%;">Program Expense</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1st Quarter Total</td> <td style="text-align: center;">5</td> <td style="text-align: center;">0</td> <td style="text-align: center;">0</td> <td style="text-align: center;">\$3,998</td> </tr> <tr> <td style="text-align: center;">2nd Quarter Total</td> <td style="text-align: center;">5</td> <td style="text-align: center;">0</td> <td style="text-align: center;">0</td> <td style="text-align: center;">\$3,837</td> </tr> <tr> <td style="text-align: center;">3rd Quarter</td> <td style="text-align: center;">3</td> <td style="text-align: center;">0</td> <td style="text-align: center;">0</td> <td style="text-align: center;">\$4,735</td> </tr> </tbody> </table>	Arroyo Grande LTIP Diabetes Prevention and Management 6 months in arrears					Diabetes Prevention and Management	Number of Persons Served this Quarter	# 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 Quarter Total	5	0	0	\$3,998	2nd Quarter Total	5	0	0	\$3,837	3rd Quarter	3	0	0	\$4,735
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3rd Quarter	3	0	0	\$4,735																						

	Total				
	4th Quarter Total	7	0	0	\$9,147
Santa Maria LTIP Diabetes Prevention and Management 6 months in arrears					
	Diabetes Prevention and Management	Number of Persons Served this Quarter	# 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 Quarter Total	55	0	0	\$60,449
	2nd Quarter Total	111	1	.9%	\$68,657
	3rd Quarter Total	104	1 person (admitted 4x)	.96%	\$63,356
	4th Quarter Total	108	0	0%	\$50,738
Hospital Contribution/ Program Expense	\$219,701 for Santa Maria \$20,353 for Arroyo Grande TOTAL: \$240,054				
FY 2014					
Goal 2014	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted populations by incorporating health navigation, concise diabetes self-management skills and, health related education.				
2014 Objective Measure / Indicator of Success	<ol style="list-style-type: none"> 1. Identify 25 high risk patients for glycemic control issues that frequent ED/hospital (focusing on uninsured/underinsured patients without primary care physicians or healthcare access) using monthly MediTech reports. 2. Identify 25 Pacific Central Coast Health Center's Community Clinics and/or other community clinics with uninsured/underinsured high risk patients with glycemic control and enroll them in the ADA recognized program. 3. Track number of uninsured readmits to the ER for glycemic control issues. 4. Establish diabetes group classes in Spanish 				
Baseline	491 insured and underinsured participant visits				
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Engage and educate Pacific Central Coast Health Center's Community Clinics, Home Health, Emergency Dept, CHF program, Palliative Care, MRMC inpatient, Family Medicine Center and Physician's Groups regarding best processes for patient enrollment/referrals. 2. Collaborate with Dignity Health staff to study and improve process to refer and obtain signed Diabetic Education Center order forms for high risk diabetic patients after ED visits and/or hospitalizations that does not have primary care physicians to sign order forms, in order to enroll them in the Diabetes Education Program. 3. Identify and train promotoras to facilitate Spanish/English diabetes group classes 4. Recruit additional candidates for Dignity Health certified medical interpreters. 5. Research availability of part time Spanish speaking Registered Dietician to help meet needs of increasing number of Spanish speaking patient referrals. 6. Develop Diabetes Self Management Training group classes in Spanish (ADA guidelines) 7. Collaborate with CERNER build team with the Electronic Health Record Alliance methods – flow – tracking development. 8. Work with DH/IT staff to improve database to meet needs of program productivity and shared reports. 				
Community Benefit Category	A1c – Community Health Education – Individual Health Education for uninsured/under insured				

Santa Maria Community Health Education

Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	Provide health education to the Santa Maria Valley community addressing current needs as identified through the needs and assets assessment. Collaborate with other community based organizations to support education of the community to increase health awareness.
FY 2013	
Goal FY 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

Results FY 2013	<p>1. Spanish CDSMP decreased at Santa Maria campus by 16%; no English CDSMP were conducted.</p> <p>2. Spanish HFL attendance decrease at Santa Maria by 42%; no English HFL classes were held\</p>																																								
	<table border="1"> <thead> <tr> <th></th> <th>Unduplicated</th> <th>Post Survey</th> <th>3 month follow up</th> <th>6 month follow up</th> <th></th> </tr> <tr> <th># HFL Work shops</th> <th>Participants</th> <th>Participants completing work shop</th> <th>% changed behavior fruits and vegetable</th> <th>% changed behavior physical activity</th> <th>% + fruits and vegetable</th> </tr> </thead> <tbody> <tr> <td>7</td> <td>134</td> <td>84/62%</td> <td>89%</td> <td>66.5%</td> <td>93.5%</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>% + physical activity</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>% + fruits and vegetable</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>% + physical activity</td> </tr> </tbody> </table>							Unduplicated	Post Survey	3 month follow up	6 month follow up		# HFL Work shops	Participants	Participants completing work shop	% changed behavior fruits and vegetable	% changed behavior physical activity	% + fruits and vegetable	7	134	84/62%	89%	66.5%	93.5%						% + physical activity						% + fruits and vegetable					
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					% + physical activity																																				
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	<p>3. Physical Activity (Zumba and Yoga) attendance increased by 302% at Santa Maria campus. BMI results are as follows</p> <p>4. Zumba for kids continues to grow; second class has not yet been established.</p>																																								
	Alvin Elementary Children	Santa Maria campus	Robert Bruce Elementary	El Camino Elementary	Mary Buren Elementary School	Los Alamos																																			
	39 enrolled	134 enrolled	121 enrolled	140 enrolled	72 enrolled	21 enrolled																																			
	7.6% (3) participated in BMI's	23.1% (31) participated in BMI's	23.4% (28) participated in BMI	2.8% (4) participated in BMI	16.6% (12) participated in BMI	66% (14) participated in BMI																																			
	33.3% reduced the BMI	54.8% reduced the BMI	75.0% reduced the BMI	25% (1) reduced the BMI	91.6% (11) reduced the BMI	71.4% (10) reduced BMI																																			
	0% remained the same	9.6% (3) remained the same	14.2%(3) remained the same	0% remained the same	0% remained the same	28.5% (4) remained the same																																			
	66.6% (1) increased BMI	35.4% (11) increased BMI	10.7% (4) increased BMI	75% (3) increased BMI	8.3% (1) increased BMI	0% increased BMI																																			
	<p>5. There was a 69% decrease Dove Self-Esteem workshop (47 touches) Santa Maria Youth and Family (SMYF) and Santa Maria Bonita School District continue to (SMBSD) refer at-risk young girls to the workshop.</p>																																								
Hospital's Contribution / Program Expense	\$124,611 (does not included Dedicated Staff hours)																																								
FY 2014																																									
Goal 2014	Increase attendance of chronic disease / nutrition education and physical to targeted populations in the Santa Maria service area.																																								
2014 Objective Measure / Indicator of Success	<ol style="list-style-type: none"> Increase Zumba participation by 20% Increase participants for tracking BMI's Increase Zumbatomics for children by adding one location and increase attendance at both locations by 30%. Increase Spanish HFL attendance by 20% Provide 4 Spanish diabetes lectures in service area. Provide 4 CDSMP Spanish workshops Provide 2 CDSMP English workshops Train two bilingual Dove Self-Esteem instructors to conduct two classes per year. 																																								
Baseline	1660 nutrition education (Healthy for Life Workshop) 17,211 participants for Zumba, Zumbatomics and Yoga																																								
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Develop protocol for consistency in attendance at Zumba classes that will results in more consistent BMI results of participants Establish a continuum of care between clinics, case management, emergency department and other hospital programs to support increased attendance for HFL and CDSMP workshop attendance. Streamline data collection for HFL Develop promotion and marketing strategies for CDSMP/HFL workshops. 																																								
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops) A1a																																								

Arroyo Grande Community Health Education

Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
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 type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description	Provide south San Luis Obispo county with health-related programming that will empower community members to become proactive and assume responsibility for their health and to educate people to prevent and manage chronic disease conditions.

FY 2013

Goal FY 2013	Provide health-related opportunities to prevent or manage chronic disease.																																	
2013 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> Increase English and Spanish HFL and CDSMP attendance by 10% Train at least 4 promotoras to teach HFL workshops to increase attendance by 20%, and help recruit participants at health fairs in AGCH service area. Partner with Lucia Mar Unified School District (LMUSD) and other community based organizations to increase attendance at HFL/CDSMP lectures Gather community health needs data through screenings at health fairs. Partner with community based organizations to serve food to the homeless and underserved. 																																	
Baseline	99 chronic disease self management participants, 449 underserved participants received health education, 583 broader seniors participated in health related classes																																	
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Network, promote and establish a continuum of care with AGCH department managers, nurses, case managers and social workers to increase attendance at HFL/CDSMP/Senior and Zumba classes. Recruit participants for HFL and CDSMP at 3 Community-based Health Fairs. Collaborate with Lucia Mar Unified School District to offer health education to parents and students. Inform physician's offices, and local senior residential communities about our CDSMP and Senior Health lecture offerings. 																																	
Results FY 2013	<ol style="list-style-type: none"> Through networking and promotion increased HFL participation by 467% over 2012. CDSMP had no workshop conducted in this fiscal year. Zumba attendance served 3907 people with the following BMI results (Grover Beach did not conduct BMI's): Health related classes serving the broader community decreased 95% <table border="1" style="margin-left: 20px;"> <thead> <tr> <th>Class</th> <th># served</th> <th>Expense</th> </tr> </thead> <tbody> <tr> <td>Children's HFL at targeted elementary schools</td> <td>1072</td> <td>\$1288</td> </tr> <tr> <td>Cooking Demo Boys & Girls Club</td> <td>529</td> <td>\$2238</td> </tr> <tr> <td>Zumba</td> <td>3907</td> <td>\$1155</td> </tr> <tr> <td>Spanish HFL</td> <td>495</td> <td>\$11,757</td> </tr> <tr> <td>Health Lecture (English)</td> <td>29</td> <td>\$2,241</td> </tr> <tr> <td>Total</td> <td>6032</td> <td>\$18,679</td> </tr> </tbody> </table> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th colspan="2" style="text-align: center;">Zumba - Oceano Elementary School</th> </tr> </thead> <tbody> <tr> <td colspan="2">74 participants</td> </tr> <tr> <td colspan="2">17.5% participated in BMI (13 people)</td> </tr> <tr> <td colspan="2">76.9% decreased their BMI</td> </tr> <tr> <td colspan="2">23% increased their BMI (3 people)</td> </tr> <tr> <td colspan="2">0% remained the same</td> </tr> </tbody> </table> 	Class	# served	Expense	Children's HFL at targeted elementary schools	1072	\$1288	Cooking Demo Boys & Girls Club	529	\$2238	Zumba	3907	\$1155	Spanish HFL	495	\$11,757	Health Lecture (English)	29	\$2,241	Total	6032	\$18,679	Zumba - Oceano Elementary School		74 participants		17.5% participated in BMI (13 people)		76.9% decreased their BMI		23% increased their BMI (3 people)		0% remained the same	
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	<ol style="list-style-type: none"> 5. Day of the Child health Fair recruited a limited number of HFL participants; most attendees recruited were from Oceano, Grover Beach and Grover Heights Elementary School. 6. Lucia Mar Unified School District contracted with AGCH to provide Oceano and Grover Beach Elementary Schools as classrooms for HFL and Zumba during the school year. 7. Partnership was not developed with senior residential communities or physician offices regarding CDSMP or Senior Health Lectures.
Hospital's Contribution / Program Expense	\$20,786 (does not include salary for dedicated staff)
FY 2014	
Goal 2014	Increase attendance of chronic disease / nutrition education and physical activity to those with disproportionate unmet health related needs in the Arroyo Grande Community Hospital service area.
2014 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Increase Zumba participation for tracking BMI outcomes 2. Add two locations for Zumbatomic; one in Nipomo and one in Oceano 3. Increase Spanish HFL attendance by 20% 4. Provide 3 Spanish diabetes lectures in service area. 5. Provide 2 CDSMP Spanish workshops 6. Provide two English senior nutrition workshops
Baseline	<p>3907 Zumba participants 1601 nutrition and food demo for children 495 adults participants HFL 29 English broader community health lectures</p>
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Promote BMI's at Zumba/Zumbatomic classes 2. Train 4 more Spanish instructors for HFL. 3. Train promotores to promote HFL, CDSMP and Diabetes lectures for awareness of chronic illness. 4. Develop promotion and marketing strategies for CDSMP/HFL workshops.
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops) A1a

Marian's Santa Maria Cancer Care Program	
Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
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 type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<input checked="" type="checkbox"/> Broader Community <input checked="" type="checkbox"/> Underserved, Poor
Program Description:	The Marian's Santa Maria Cancer Care Program` 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, 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 registered dietician.
FY 2013	
Goals FY 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.
2013 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 in-service for Promotoras, physicians and healthcare personnel treating new or returning Mission Hope Cancer Center patients on how to refer patients to Marian's Santa Maria Cancer Care Program. 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's Santa Maria Cancer Care Program. 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's Santa Maria Cancer Care Program. 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.
Results FY 2013	<ol style="list-style-type: none"> 1. Patient Orientation-1510 participants (11 participants in FY12); (newsletter distribution increase 66%) 2. Nutritional Counseling-262 participants; 22% increase (215 participants in FY12) 3. Patient Transportation; 2911 participants (this is the first year this has been a service for the entire fiscal year) 4. Outpatient Palliative Care Community Presentations/Informational Articles: SPOHNC (Support for People with Head & Neck)-11 participants 5. The following presentations were designed to educate the community on cancer and cancer prevention: <ul style="list-style-type: none"> <u>English</u> <ul style="list-style-type: none"> Exercise for Hope Mended Hearts Boast for Breast Cancer Girls' Night Out SMCC Women's Division Golf Tournament Santa Ynez Valley YMCA Your Cancer Journey-Hope for Every Moment Managing Loss & Grief During the Holidays St. John's Lutheran Church Spirituality in Cancer Dealing with Anxiety & Depression Intimacy and Cancer Treating Your Healthcare Like a Business AGCH Health Classes Educate Before You Medicate Mother's Day Tea Las Brisas Assisted Living Facility LLG/LLS & MHCC Services Presentation <u>Spanish</u> <ul style="list-style-type: none"> Flu Shot, High BP & Prevention of Diabetes HPV Immunization CHC Social Services <p><u>Total English Participants:</u> 1,404 (116% increase) <u>Total Spanish Participants:</u> 86 (49% decrease)</p> <ol style="list-style-type: none"> 6. Provided education through distribution of over 7,700 skin cancer pamphlets and sunscreen during the month of November to schools within the Lucia Mar and San Luis Coastal School Districts. Schools included: Nipomo, Nipomo New Tech, Arroyo Grande, Lopez, St. Joseph's, Santa Maria, Pioneer Valley, Righetti, Delta, Orcutt Academy Mission Prep, San Luis, Morro Bay and Pacific Beach High Schools. 7. 27 POLST forms completed 8. Prostate Cancer Screening-63 participants with two (2) Oaxacan participants (103% increase from FY 11/12)89% with no recommendations; 11% will need follow-up (8% broader and 92% poor). 9. Identified one Oaxaca promotora to promote prostate screening; while in-service directions were not clear it is also noted that a male promotore would be better suited to provide this outreach.
MMC Contribution/ Program Expense	2,101,343
FY 2014	
Goal 2014	Improve health and well-being of Marian's Santa Maria campuses primary and secondary service area by providing health education, cancer screenings, and educational seminars, support services to the poor and vulnerable, elderly and underinsured community, to provide earlier detection of cancer in an effort to reduce preventable cancer-related deaths.
Objective Measure/ Indicator of Success	<ol style="list-style-type: none"> 1. Educate the physicians, nurses, health professionals and medical office staff on genetic testing and colon cancer screening. 2. Educate the community on colon cancer, prevention, screenings and genetic testing. 3. Increase number of participants in bone marrow drives, prostate and skin cancer screening by 10%. 4. Increase by 10% the number of Patient and Palliative Assessment Forms (Wellness Forms).

	5. Increase community education on cancer and stress prevention
Baseline	FY11/12 total is: 20,862: Support Groups: 528; Educational/Lectures: 1,118 (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 a presentation on genetic testing. 2. Provide a presentation and work with the Promotoras in identifying the underserved, uninsured being referred to cancer screenings, expanding to senior centers and focus marketing on Hispanic communities. 3. Utilize the media, Marian's Santa Maria campus Cancer Care Newsletter, Santa Maria Times Newspaper, mailers and radio spots in promoting upcoming drives. 4. Initiate use of wellness forms in Mission Hope Infusion Center to reach patients in need of support. 5. Educate the general community with an Educational Forum.
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops; Support Groups, Self-help; Information and Referral) A1a, A1d, A1e, A3e, E1b

Arroyo Grande Cancer Awareness	
Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
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 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	<p>Marian's Arroyo Grande campus and Coastal Cancer Center will partner to provide education, support groups, screenings and health information to encourage prevention, early detection and disease and disability management for cancer patients. The Coastal Cancer Center provides resources for patients and their families in the Arroyo Grande campus service area and referrals to the Hearst Cancer Resource Center and Marian's Santa Maria Cancer Program and other community partners.</p>
FY 2013	
Goal 2013	<p>Improve health and well-being of Marian's Arroyo Grande primary and secondary service area by providing health education, cancer screenings, and 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>
2013 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Increase the number of participants seeing the nurse navigator by 10%. 2. Educate high school students with the awareness and focus on skin cancer, prevention and tanning beds. 3. Provide 10% increase in skin and establish breast cancer screenings to facilitate early detection focusing on the poor vulnerable and Hispanic community. Provide follow-up care and/or referrals. 4. Identify the number of people for cancer prevention or screenings.
Baseline	<p>Served 419 through screenings, lectures and support groups FY 2011-2012. Served 1160 walk-ins, calls, patient meetings and referrals.</p>
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Provide in-service to Internal Medicine, Family and Primary Physicians and healthcare personnel treating new or returning patients to refer to the Nurse Navigator. 2. Work with the high school district's Physical Education and Health Education Departments in our service area (public and private) in presenting cancer awareness education regarding skin cancer and danger of tanning beds. Nurse Navigator to be available to speak to classes individually. Provide education through annual report on skin cancer and melanoma. 3. Work with promotoras in targeting DUHN community to provide cancer screenings, expanding to senior centers and focus marketing on Hispanic communities. 4. Work with promotoras in tracking, providing in-service and taking questionnaires out into the community.

Result FY 2012	<ol style="list-style-type: none"> 1391 participants seeing the Nurse Navigator (20% increase) General Support Group established in March 2013; 18 total participants. Provided education by distributing over 7,700 skin cancer pamphlets and sunscreen during the month of November to schools within the Lucia Mar and San Luis Coastal School Districts. Schools included: Nipomo, Nipomo New Tech, Arroyo Grande, Lopez, St. Joseph's, Santa Maria, Pioneer Valley, Righetti, Delta, Orcutt Academy Mission Prep, San Luis, Morro Bay and Pacific Beach High Schools. Free Mammogram Screening Clinic (09/22/12); 24 participants Skin Cancer screening 03/30/13; total of 36 participants; 69% broader community, 31% poor and vulnerable. (27% decrease from prior year) Newly identified patients are provided an assessment tool and 64 people identified through assessment showed indicators for cancer prevention related health concerns.
Hospital's Contribution / Program Expense	\$133,203
FY 2014	
Goal 2014	Improve health and well-being by providing health education, cancer screenings, educational seminars and support services to the poor and vulnerable, elderly and underinsured community, to provide earlier detection of cancer in an effort to reduce preventable cancer-related deaths.
2014 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> Increase the number of participants seeing the nurse navigator. Provide 10% increase in skin and breast cancer screenings to facilitate early detection focusing on the poor, vulnerable and Hispanic community. Provide follow-up care and/or referrals. Increase the number of Patient Assessment Forms (Wellness Forms).
Baseline	FY11/12 total is: 20,862: Support Groups: 528; Educational/Lectures: 1,118 (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"> Work with Breast Imaging to coordinate care of all newly diagnosis breast cancer patients. Provide in-service to Internal Medicine, Family and Primary Physicians and healthcare personnel treating new or returning patients to refer to the Nurse Navigator. Work with promotoras in targeted-community to provide cancer screenings, expanding to senior centers and focus marketing on Hispanic communities. Initiate use of wellness forms to identify needs and assist.
Community Benefit Category	Community Health Improvement Services (Lectures/Workshops; Support Groups, Self-help; Information and Referral) A1a, A1d, A1e, A3e, E1b

Santa Maria and Arroyo Grande Congestive Heart Failure Program

Hospital Community Benefit Priority Area	<input checked="" type="checkbox"/> Access to Healthcare Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
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 2013

Goals 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/Indicator 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 located at both campuses of 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.

Result FY 2013

1. 867 patients with a CHF diagnosis at high risk for readmission were identified and enrolled in the CHF program at Santa Maria campus.
2. MRMC maintained the telephone based monitoring for 867 patients and Philips Home Monitoring Programs to prevent readmissions within 6 months of enrolling for 33 patients.
3. Program satisfaction survey results are measured as a central coast service area as indicated below.

Santa Maria Campus				
	Number of Persons Served this Quarter	# of Participants Admitted to the Hospital or ED within three months of the Intervention*	% of Participants Admitted to the Hospital or ED within three months of the intervention.	Program Expense
1st Quarter Total	217	1	Less than 1%	\$66,856
2nd Quarter Total	216	9	4%	\$99,971
3rd Quarter Total	234	8	3%	\$114,488
4th Quarter Total	200	7	4%	\$97,508

1. 406 patients with a CHF diagnosed at high risk for readmission were identified and enrolled in the CHF program at Marian Regional Medical Centers Arroyo Grande campus.
2. The Arroyo Grande campus maintained the telephone based monitoring for 406 patients and Philips Home Monitoring Program to prevent readmissions within 6 months of enrolling for 7 patients.
3. Results of Patient Satisfaction Survey indicate the following for both all three hospitals:

Telehealth Patient Satisfaction Survey – 8 weeks					
	Definitely Not	I don't think so	Maybe	Yes, I think so	Yes, Definitely
Telehealth equipment was easy to use	2.3%	2.3%	2.3%	14.0%	79.1%
I would recommend Telehealth	0.0%	2.3%	2.3%	23.3%	72.1%

- Patient Satisfaction Survey Data for the period 7/1/2012-6/30/2013

Arroyo Grande Campus				
	Number of Persons Served this Quarter	# of Participants Admitted to the Hospital or ED within three months of the Intervention*	% of Participants Admitted to the Hospital or ED within three months of the intervention.	Program Expense
1st Quarter Total	124	5	4%	\$4,407
2nd Quarter Total	77	5	6.5%	\$6,588
3 rd Quarter Total	109	4	3.7%	\$22,411
4 th Quarter Total	96	5	5.2%	\$29,952

Hospital's Contribution/ Program Expense	\$427,012 Marian Regional Medical Center, Santa Maria campus (telemonitor monthly costs are all collected under MRMC) \$80,272 Arroyo Grande campus TOTAL: \$507,284
FY 2014	
Goal for FY 2014	Avoid hospital and emergency department admissions for persons with chronic disease failure.
2014 Objective Measure / Indicators of Success	<ol style="list-style-type: none"> 1. Identify 100% of patients hospitalized at Marian Regional Medical Center's two campuses with a diagnosis of CHF and at risk for readmissions. 2. Provide evidence-based health education to 100% of participants enrolled in the CHF program 3. Maintain Philips telemonitoring program for 50 patients in the Central Coast Service Area. 4. Returned satisfaction surveys on the questions " your overall evaluation of program" will be "very good" or "excellent" 5. Avoid hospital and emergency department admissions for 3 months among 80% of the enrolled participants in the CHF program.
Baseline	<ol style="list-style-type: none"> 1. 867 patients with a CHF diagnosis at high risk for readmission were identified and enrolled in the CHF program at Marian Regional Medical Center's Santa Maria campus. 2. 406 patients with a CHF diagnosed at high risk for readmission were identified and enrolled in the CHF program at the Arroyo Grande campus.
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Offer the CHF program to all inpatients with a diagnosis of CHF 2. Implement telephonic assessment utilizing the newly constructed dignity health data-base with the ultimate goal of integrating it into Cerner. 3. Track data-base and Midas reports for both the telemonitored and telephonic participants for outcomes and make program adjustments based on data derived 4. Collaborate with Dignity Health Facilities, Community Health Center, CDMSP, local skilled nursing facilities and cardiologist's offices 5. Partner with Dignity Health Home Health for referrals to the CHF program and collaborate on treatment plans with home health case managers. 6. Refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical 'Access and other identified community partners.
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.

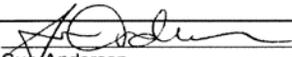
Community Benefit and Economic Value

B. Classified Summary of Quantifiable Community Benefit Costs

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

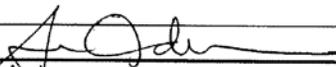
365 Arroyo Grande Community Hospital
 Complete Summary - Classified Including Non Community Benefit (Medicare and Bad Debt)
 For period from 7/1/2012 through 6/30/2013

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<u>Benefits for Poor</u>						
Financial Assistance	2,242	689,752	0	689,752	1.0	1.0
Medicaid	8,596	10,709,701	5,382,469	5,327,232	7.9	8.0
Means-Tested Programs	625	2,461,493	766,225	1,695,268	2.5	2.5
<u>Community Services</u>						
Community Benefit Operations	17	25,358	0	25,358	0.0	0.0
Community Health Improvement Services	16,552	323,623	0	323,623	0.5	0.5
Financial and In-Kind Contributions	3,290	59,335	0	59,335	0.1	0.1
Totals for Community Services	19,859	408,316	0	408,316	0.6	0.6
Totals for Poor	31,322	14,269,262	6,148,694	8,120,568	12.1	12.2
<u>Benefits for Broader Community</u>						
<u>Community Services</u>						
Community Benefit Operations	14	4,040	0	4,040	0.0	0.0
Community Health Improvement Services	1,452	132,043	0	132,043	0.2	0.2
Health Professions Education	28	41,515	0	41,515	0.1	0.1
Totals for Community Services	1,494	177,598	0	177,598	0.3	0.3
Totals for Broader Community	1,494	177,598	0	177,598	0.3	0.3
Totals - Community Benefit	32,816	14,446,860	6,148,694	8,298,166	12.3	12.5
Medicare	20,404	30,649,539	25,313,825	5,335,714	7.9	8.0
Totals with Medicare	53,220	45,096,399	31,462,519	13,633,880	20.3	20.5
Totals Including Medicare and Bad Debt	53,220	45,096,399	31,462,519	13,633,880	20.3	20.5

 Sue Andersen Chief Financial Office Central Coast Service Area	8/26/13 Date
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**364 Marian Medical Center
Complete Summary - Classified Including Non Community Benefit
For period from 7/1/2012 through 6/30/2013**

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<u>Benefits for Poor</u>						
Financial Assistance	11,364	4,043,694	0	4,043,694	1.5	1.4
Medicaid	50,927	78,287,583	64,949,530	13,338,053	4.8	4.7
MIA	917	2,024,157	773,373	1,250,784	0.4	0.4
Community Services						
Community Benefit Operations	43	110,343	0	110,343	0.0	0.0
Community Building Activities	1,356	5,186	0	5,186	0.0	0.0
Community Health Improvement Services	62,491	2,876,835	0	2,876,835	1.0	1.0
Financial and In-Kind Contributions	6,557	1,434,064	32,181	1,401,883	0.5	0.5
Subsidized Health Services	18,800	1,065,694	0	1,065,694	0.4	0.4
Totals for Community Services	89,247	5,492,122	32,181	5,459,941	2.0	1.9
Totals for Poor	152,455	89,847,556	65,755,084	24,092,472	8.7	8.5
<u>Benefits for Broader Community</u>						
Community Services						
Community Benefit Operations	0	29,053	0	29,053	0.0	0.0
Community Building Activities	0	1,402	0	1,402	0.0	0.0
Community Health Improvement Services	16,213	745,165	0	745,165	0.3	0.3
Health Professions Education	144	1,345,374	0	1,345,374	0.5	0.5
Totals for Community Services	16,357	2,120,994	0	2,120,994	0.8	0.8
Totals for Broader Community	16,357	2,120,994	0	2,120,994	0.8	0.8
Totals - Community Benefit	168,812	91,968,550	65,755,084	26,213,466	9.4	9.3
Unpaid Cost of Medicare	53,214	77,420,983	64,931,995	12,488,988	4.5	4.4
Totals with Medicare	222,026	169,389,533	130,687,079	38,702,454	13.9	13.7

 Sue Andersen Chief Financial Officer Central Coast Service Area	8/26/13 Date
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B. Telling the Story

As a member of Dignity Health, both campuses of Marian Regional Medical Center are committed to serving the health needs of our community with particular attention to the needs of the economically disadvantaged members of our community. 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, donations of cash or services to other non-profit organizations supporting our efforts to address 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 and Arroyo Grande service areas. Both campuses support the outreach and education with the rolling out of the Affordable Care Act.

The Community Benefit Report and Implementation Plan is submitted to the State of California OSHPD.

The Dignity Health Community Grant program offered through both campuses derives direction from the Community Benefit Report and Implementation Plan requiring community partners to address their LOI's to one of the identified priorities.

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 A) Summary of Patient Financial Assistance Policy (Attachment B) Hospital Community Board Membership Roster (Attachment C), Community Benefit Committee Roster (Attachment D).

Community Needs Index

Santa Maria Campus

Zip Code	City	COUNTY	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	SB County	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	SB County	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	SB County	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%

Arroyo Grande Campus

93420	Arroyo Grande	San Luis Obispo	28,603	3	3	5.4%	6.8%	18.7%	2	1.3%	19.0%	4	10.6%	2	5.6%	14.3%	3	28.7%	4	20.5%	19.0%	10.6%	15.3%	28.7%
93433	Grover Beach	San Luis Obispo	12,844	3.6	3.6	9.3%	10.5%	19.7%	2	4.8%	33.9%	4	15.6%	3	7.2%	19.0%	4	50.6%	5	23.7%	34.2%	15.6%	20.3%	50.6%
93444	Nipomo	Santa Barbara	18,894	3.4	3.2	5.9%	7.7%	24.3%	2	6.7%	40.4%	5	18.7%	4	7.8%	11.4%	3	24.2%	3	26.1%	40.9%	18.7%	13.2%	24.2%
93445	Oceano	San Luis Obispo	7,441	4.8	4.6	3.4%	18.5%	40.6%	4	14.0%	59.5%	5	30.3%	5	12.7%	22.0%	5	48.6%	5	44.2%	60.6%	30.3%	24.8%	48.6%
93449	Pismo Beach	San Luis Obispo	8,440	3	3	5.6%	9.0%	16.7%	2	1.3%	15.6%	3	7.0%	1	6.8%	18.8%	4	38.6%	5	19.6%	15.6%	7.0%	20.0%	38.6%

Attachment A

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

Policy Overview:

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

Eligibility for Patient Payment Assistance:

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

Determination of Financial Need:

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

Patient Payment Assistance Guidelines:

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

- Services eligible under the policy will be made 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.

Attachment B

Hospital Community Board Roster for Fiscal Year 2014

Rebecca Alarcio, Community Educator
Lupe Alvarez, Businessman
Todd D. Bailey, Jr., M.D., Physician / Emergency Medicine
Sister Amy Bayley, RSM, Religious Sponsor/Housing Development
Peggy Blough, Real Estate
Kathy Castello, Business Finance/Communications
Terry Fibich, (Secretary), Retired Fire Chief
Steve Flood, DDS, Dentist
Jacqueline Frederick (Vice Chair), Attorney
Angelica Gutierrez, Business Finance / Banking / Human Resources
Michael S. Hardy, Attorney
Ernest Jones, M.D., Physician / Family Medicine
Mike McNulty (Chair), Businessman
Sister Sheral Marshall, OSF, Religious Sponsor/Advocate
Vincent Martinez, Esq., Attorney
Juan Reynoso, M.D., Physician / Emergency Medicine
Sister Barbara Staats, OSF, Religious Sponsor/Retired Dietician
John F. Will, Businessman / Construction

MRMC Representatives

Sue Andersen, Vice President & Chief Financial Officer
Charles J. Cova, President & CEO
Kenneth R. Dalebout, Administrator/Chief Strategy Officer-AG Campus
Kevin Ferguson, M.D., President, Medical Staff
Larry Foreman, D.O., Vice President, Medical Affairs, AG Campus
Jonathan E. Fow, M.D., Chief of Staff
Villa Infanto, Vice President, Patient Care Services
Kerin Mase, RN, Chief Operating Officer / CNE
Charles Merrill, M.D., FACEP, Vice President, Medical Affairs, MRMC
Al Schultz, M.D., Chair, MRMC Foundation Board
Kathleen Sullivan, RN, Vice President, Post Acute Care Services
Kathy Tompkins, Chair, AGCH Foundation Board

Sponsor Representative

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

Dignity Health Representative

Marvin O'Quinn, EVP / COO
Dignity Health, San Francisco

Attachment C

**Community Benefits Committee
Roster 2013-2014**

Kathy Castello, Community Board Member

Jo Ann Costa, Facility Privacy and Compliance Officer;
Interim Director, Mission Integration, Dignity Health Central Coast Service Area

Sister Pius Fahlstrom, MRMC Community Benefit Committee

Terry Fibich, Community Board Member

Bill Finley, Controller

Katherine Guthrie, Cancer Center Regional Director,
Dignity Health Central Coast Service Area

Joan McKenna, Case Management Director/Social Worker

Janna Pruitt, AGCH Foundation Board Member

Dr. Mary Oates, Osteoporosis Program Director,
Dignity Health Central Coast Service Area

Al Schultz, M.D., Chair, MRMC Foundation Board

Kathleen Sullivan, RN, Vice President, Post Acute Care Services

Lupe Terrones, Director of Clinic Operations

Sandy Underwood, Senior Community Education Coordinator