



French Hospital Medical Center

A member of CHW



French Hospital Medical Center

Community Benefit Report 2011 Community Benefit Plan 2012

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EXECUTIVE SUMMARY

French Hospital Medical Center (FHMC), founded in 1946, is located at 1911 Johnson Avenue, San Luis Obispo, CA. It became a member of Catholic Healthcare West (CHW) in 2004. Though the facility has 112 licensed beds, 68 are currently available and the campus is approximately 15 acres in size. FHMC has a staff of more than 520 and professional relationships with more than 314 local physicians. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics.

During FY2011 FHMC focused on increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major Community Benefit activities for FY2011 focused on increased programming, coalition building within our primary and secondary service area and health education for those with disproportionate unmet health related needs (DUHN).

Health education was selected as a priority to address prevention of disease, to empower community members to assume responsibility for their health. To educate people about various medical conditions and the ability they have to make informed choices, by our Healthy for Life Nutrition series and our evidence-based Chronic Disease Self Management program was offered at multiple community sites within our service area. Community lecture topics included nutrition, heart health, dementia, cancer, and diabetes. Provided screenings at community events included blood pressure, height, weight, lipid panel, blood glucose checks, Flu, and Pertussis vaccinations.

The Diabetes Prevention and Management Program expanded its services to our sister hospital Arroyo Grande Community Hospital by offering our Diabetes Conversation Program which included ideas on lifestyle modification, such as diet and exercise, testing blood sugars, and education regarding managing diabetes. FHMC has continued to offer a Diabetes II support group that meets monthly offering participants the latest diabetes information and education. A Diabetes I monthly support group has also been developed.

The **Prenatal and New Parent Education Program** provided education in English and Spanish to mothers, pregnant teens, and their partners regarding prenatal preparation, birth classes and family support classes. Our breastfeeding clinic in San Luis Obispo and lactation counseling at the local WIC (Women, Infant, and Child) clinics has provided 2,127 lactation consultations for FY 2011.

The **Cardiac Wellness Program** provided education to the broader community regarding heart disease, its prevention, early detection and treatment. HeartAware™ provides individual heart disease risk assessment, followed up by one-on-one counseling, lipid panel screening and goal setting for lifestyle change to prevent heart disease. Outreach efforts have resulted in providing free lipid and glucose screening, heart disease risk assessment, and follow up one-on-one counseling to the underserved population.

The Hearst Cancer Resource Center (HCRC) continued to provide support and resources to residents of FHMC's service area. The HCRC located on FHMC campus is an excellent resource center that addresses the medical, physical and emotional needs of cancer patients and their families. In 2011 the services of a Nurse Navigator helped 1,910 families touched by cancer to better navigate the health care system and the unique needs of the cancer patient. The HCRC has served approximately 21,406 cancer patients and their families since 2007, providing one-on-one counseling sessions, lectures, workshops and referral services.

Congestive Heart Failure Program (CHF) is one of our Long Term Improvement Plan (LTIP) whose goal is to demonstrate a decrease in readmissions of participants in the hospital's preventive health intervention. In 2011 the CHF program had a total of 620 patient contacts in the community. There was a 4.7% hospital readmission rate for those enrolled in the program. The goal of the Congestive Heart Failure Patient Navigation Program is to increase the ability of people in our community who are diagnosed with a chronic heart condition to build and maintain their health and quality of life. The program objectives to build and maintain partnerships with community based providers and senior advocacy organizations and develop shared referral protocols and outreach strategies were met. The CHF program coordinator is a participant in the Adult Services Policy Council and has been invited to participate in an interactive Community Senior Symposium this fall. The French Hospital Medical Center Foundation submitted a grant application to the San Luis Obispo County for a Community Based Organization/Preventive Grant. The Chronic Disease Self-Management/CHF Program was awarded \$2,000 for FY 2010-11.

FHMC has chosen Diabetes as its second Long Term Improvement Plan (**LTIP**) focus. The goal of this program is to avoid admissions to the hospital or emergency department for 50% of the participants in the hospital's preventive health intervention and will be monitored quarterly between FY2011 and FY2013.

FHMC's FY2011 Community Benefit Report and FY2012 Community Benefit Plan document our commitment to the health and improved quality of life in our community. The total value of community benefit for FY2011 is \$8,389,505 which excludes the unpaid costs of Medicare of \$7,747,170.

MISSION STATEMENT

I. Hospital's Mission

A. Mission Statement (CHW Mission Statement)

Catholic Healthcare West and our Sponsoring Congregations 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. French Hospital Medical Center

1. FHMC's organizational commitment to the Community Benefit process is evidenced through the Strategic Plan, which focuses on enhancing community benefit planning through collaboration with community organizations and leaders, implementing policies and reporting systems to accurately document and report the hospital's community benefits and charity care. In addition, one of the goals of FHMC is to partner with other non-profit organizations in the community thereby increasing outreach and education capabilities.
2. The French Hospital Medical Center Community Benefits Committee provides oversight for the Hospital's Community Benefits Programs. The Committee is made up of members of the Hospital Community Board, representatives of the community, Hospital Leadership Team, and Community Benefit Program Coordinators. The committee provides input for program design, content, goals and objectives, and monitors progress throughout the year, with an emphasis on ensuring appropriate focus on the poor, underserved, and disadvantaged in the Community.
 - The Committee reviews the annual Community Benefit Report, and forwards a final draft, recommended for approval, to the Hospital Community Board.
 - The Committee ensures that the Community Benefit Programs are in alignment with the hospital's strategic plan.
 - The FHMC Community Benefit Committee reviews outreach programs on a quarterly basis.
 - The Chair of the Community Benefit Committee reviews Community Benefit Activities and minutes from the quarterly meetings with the Community Board.
 - The Committee reviews applications for the CHW Community Grant process, and makes recommendations for funding to CHW Corporate.

The Community Benefit Committee is structured as follows:

- The Community Benefit Committee Chair. The Committee will nominate and appoint a representative to Chair the Community Benefit Committee, the nominee will be a member of the Hospital Community Board.
- The Vice President of Human Resources for the Central Coast Service Area
- Senior Community Benefits Coordinator for the Central Coast Service Area
- FHMC Community Benefits Coordinator

- Program Digest Owners
- Additional (maximum of 5) Community Board Members
- Roster of Community Board and Community Benefit Committee members is found at Appendix C and D.

B. Non-quantifiable Benefit

1. Our executive senior management team is actively involved in community non-profit and community organizations on a volunteer basis. Their leadership helps to develop partnerships in the community to address the needs of the underserved.

Alan Iftiniuk, President FHMC – San Luis Obispo Fiscal Sustainability Task Force, YMCA Board of Directors.

Ken Hritz, Vice President of Professional Services - American Heart Association Heart Walk Executive Leadership Team.

Debby Nicklas, Foundation Executive Director – Secretary - Children’s Health Initiative Board of San Luis Obispo County, Committee Member; San Luis Obispo Chamber of Commerce Issues Evaluation Committee, San Luis Obispo Rotary, San Luis Obispo County Homeless Advisory Council Member.

Megan Maloney, Director of Mission Services and Communications – Pave the Way Committee for the Family Care Network.

Patricia Herrera, Committee member- Member of the following: Latino Outreach Council, HEAL-SLO, ACTION: For Healthy Communities, SLO Benefits-ARCH, Community Service Alliance, and SLO County Food Systems Coalition

Jean Raymond, Committee member - Member of the San Luis Obispo Health Commission, Member of Adult Services Policy Council and an active member of the Central Coast Coalition for Compassionate Care POLST initiative

Sandra Miller, Committee member- HEAL- SLO, Destination Imagination, local chapter member and state board member of the American Dietetic Association
2. Physicians, social workers, nurses and other health professionals voluntarily participate in a variety of healthcare/informational forums or lectures.
3. Employees donated their time to raise money and awareness of the American Heart Association Heart Walk, Go Red for Women Day, and Breast Cancer Awareness Denim Day.
4. FHMC employees donate clothing to our Caring Closet which provides clothing to patients upon discharge.
5. FHMC also provides our homeless population a hot lunch every other month at the Prado Day Center.
6. FHMC has a robust environmental program and continues to make great strides in its recycling, reducing, reusing, and conservations programs. The Environmental Action Committee (EAC) meets weekly. During FY11, many successful programs have been introduced into the facility such as:
 - a) The Terracycle pen recycling program wherein old pens are accepted at various drop boxes throughout the facility and up-cycled to make new pens and products. For every donation made, Terracycle donates .2 cents back to the FHMC Foundation;
 - b) The facility set and met its goal to reduce total waste from 525,700/apd to 499,700/apd. Highlights of this goal include a 38% decrease in solid waste which

is a savings of more than \$12,000 from FY10. The medical waste total has been decreases by 67% which resulted in a savings of more than \$14,000 compared to FY10;

- c) FHMC replaced all bulbs/ballasts with low energy bulbs/ballasts. This was accomplished through a \$5000 grant from PG & E and a \$4000 rebate check as well. These replacements translate into a 40% reduction in lighting usage and increase recycling in those areas by at least 35%.
 - d) FHMC continues to implement successful recycling programs throughout the hospital, in non-clinical and clinical departments, to help raise awareness and participation in our recycling initiatives. FHMC continues to use sparingly, paper agendas for meetings, replacing them with electronic versions. The paper copies of FHMC's monthly newsletter have also been reduced by emailing the newsletters to those with email capability. All outdated technology, such as computers and printers are safely and environmentally disposed of. Equipment and materials no longer needed in the hospital are donated to non-profits rather than to a landfill.
 - e) Since June 2010 to June 2011 our battery recycling program has recycled 1422 lbs of batteries.
7. FHMC's non-quantifiable benefit is not only present throughout its campus but also extends well beyond institutional walls deep into many areas of its service area.
- a) In 2009 the California Health Interview Survey reported 13.4% (under 18 years old) of children living in San Luis Obispo as being uninsured. French Hospital Medical Center donated \$7,500.00 to Healthy Kids program to cover the children insurance premiums of families that could not afford it.
 - b) French Hospital Medical Center sponsored an infant car seat drive in the month of May 2011 on behalf of ALPHA Pregnancy and Parenting Support Inc. which is an agency that distributes free infant car seats to families that need them. Over 30 infant care seats were donated.

COMMUNITY

A. Definition of community

1. French Hospital Medical Center is located in central San Luis Obispo County along the central coast. Sierra Vista Medical Center, a Tenet owned facility shares essentially the same service area as FHMC. Twin Cities Hospital, another Tenet owned facility mainly serves the community in northern San Luis Obispo County. The primary service area for FHMC is San Luis Obispo, Morro Bay, Los Osos, Atascadero and Paso Robles, a secondary service area identified as Arroyo Grande, Pismo Beach, Grover Beach, Oceano, and Avila Beach. (See map Attachment B) FHMC offers community outreach to this secondary service area as needed, partnering with sister hospital Arroyo Grande Community Hospital.
2. The population of FHMC's primary service area is approximately 223,498 with the greatest population being San Luis Obispo City and Paso Robles at 44,948 and 30,072, respectively. San Luis Obispo County has an estimated total population of 273,231. The county is comprised of 71.8% Caucasians, 19.6% Hispanic or Latino, 3.1% Asian, 2.1% Black or African American and 3.4% of persons reporting two or more races. As of 2009, the percentage of families whose income in the past 12 months was below the poverty level was 13.6%. Those families who had children less than 18 years of

age living with them calculate to 11.9% below the poverty level. A description in this service area is provided to assist in better understanding the community setting.

Culture and Language

- Languages spoken in the San Luis Obispo County : 83% of residents of San Luis Obispo County speak English at home, 14% of residents speak Spanish at home.
- North San Luis Obispo County, (Paso Robles area) is seeing an increase growth in the Latino population. The city of Paso Robles is comprised of 70.9% Caucasians, 22.3% Hispanic, 2.2% Black, 1.3% Asian, 0.5% Native Hawaiian or other Pacific Islander, 2.4% two or more races, and .1% other race alone.
- Indigenous farm workers from the states of Oaxaca and Guerrero are currently the fastest growing population in the northern part of San Luis Obispo County.
- According to the US Census one in five San Luis Obispo residents is 60 years or older. The elderly population is more prone to chronic health problems, hospitalization due to illness, fall injures, and elder abuse.

Economic Indicators

- San Luis Obispo County's population has an estimated per capita family income of \$72,500, slightly higher than state and national per capital income levels.
- The Federal Poverty Level (FPL) for one person is currently \$10,890 annually and for two is \$14,710. In San Luis Obispo County 13.6% of residents live in poverty, 11% medical eligible, and 11.9% of children live in poverty .
- In San Luis Obispo County according to the US census there has been about a 20% increase of households (all family sizes) living in poverty from 2003-2009. From 2003 to 2009 there was an additional 6,493 individuals living in poverty.
- Between 2002 and 2009, participation in school meal programs in San Luis Obispo County increased modestly from 32% to 34%. These percentages were slightly lower than the state overall which ranged from 49% to 54% during those same years.
- San Luis Obispo County has the highest percentage of seniors citizens compared to the six other Central Coast Counties. According to San Luis Obispo Council of Governments 7% of seniors age 65 and over had household income 200% below the Federal poverty level.
- According to ACTION for Healthy Communities survey one in five people surveyed said they did not have at least \$300 in a savings account.
- More than 1 in 10 telephone survey respondents on the ACTION for Healthy Communities 2010 survey stated that they had to go without at least one basic need in 2010. Of those surveyed who reported going without basic needs, more than 55% went without health care and 42% went without food in 2010.
- ACTION for Healthy Communities 2010 Comprehensive Report indicated 34% of dependent adults, 68% of homeless, and 32% of Spanish-speaking parents said they had to go without basic needs such as food, clothing, childcare, housing, or health care in 2010.

Housing status

- Compared to the United States, San Luis Obispo County and the state of California have a higher cost of housing (for a median-priced home). The gap had been

widening significantly. In 1999, California's median home price was about 28% higher than the national figure, and increased to 250% higher by 2006. Despite recent depression of housing prices around the nation, San Luis Obispo is still one of the least affordable housing markets in the nation.

- According to the ACTION for Healthy Communities 2010 survey 1 in 4 San Luis Obispo county residents said they used more than one-half of their income on housing and utilities. The average monthly cost for a two bedroom rental was \$1,230 in 2010, up from \$975 in 2004.
- According to the San Luis Obispo County 2011 Homeless Enumeration there approximately 3,774 homeless persons in the San Luis Obispo County and 49% of those homeless are children.

Education and Literacy Indicators

- Education level is often interrelated with health status. According to the National Center for Education, the better educated a person is, the more likely that person is to report being in very good or excellent health, regardless of income.
 - San Luis Obispo County has a higher percentage of residents with some college or more 65%, compared to California's average 59.6%.
 - San Luis Obispo County has seen a slight increase of drop out rates among their high school students from 3.3% in 2008 to 5.7% in 2009. The highest increase was among Latino youth at 5.0%.
 - According to the Department of Health and Human Services dropping out of high school during adolescence is associated with multiple social, and health problems, including substance abuse, delinquency, intentional and unintentional injury, and unintended pregnancy.
3. The service area of French Hospital Medical Center has been designated as a Medically Underserved Area (MUA) or as a medically Underserved Population (MUP). The Community Health Centers of the Central Coast have six primary care health centers including a dental clinic in Templeton. All have FQHC status.

COMMUNITY BENEFIT PLANNING PROCESS

A. Community Needs and Assets Assessment Process

French Hospital Medical Center conducted its needs and assets assessment for FY 2011/2012 for our primary service area by utilizing secondary data from various agency reports such as: ACTION for Healthy Communities 2010 report, California Health Interview Survey (CHIS), Children's NOW California Report Card 2010, California Cancer Facts and Figures-2010, the Health Status Report San Luis Obispo County Public Health Department 2010 and, the Community Needs Index.

The Community Need Index (CNI) developed by CHW and Thomson-Reuters formerly Solucient is a tool that pinpoints communities in service areas with the greatest barriers to health care access. It uses socio-demographic information data to provide an "at a glance" view of disproportionate unmet health care needs (DUHN) in a given geographic area.

See Map of SLO County Zip Codes in Attachment B

| French Hospital Medical Center Service Area | | | | |
|--|--------------------|--|--------------------|-----------------------------------|
| <i>Zip Codes*</i> | <i>Town</i> | <i>Community Need Index (CNI) Scores</i> | <i>Population*</i> | <i>Total Discharges from FHMC</i> |
| 93401 | San Luis Obispo | 3.4 | 28,150 | 5,244 |
| 93402 | Los Osos | 2.8 | 14,017 | 1,543 |
| 93405 | NW San Luis Obispo | 4.2 | 31,236 | 1,713 |
| 93422 | Atascadero | 3.0 | 32,011 | 1,212 |
| 93442 | Morro Bay | 3.8 | 10,970 | 1,096 |
| 93446 | Paso Robles | 3.8 | 45,375 | 892 |
| 93428 | Cambria | 2 | 6,582 | 495 |
| Totals | | 3.8 | 168,341 | 12,195 |

These published reports and statistics are the foundation for the Community Benefit reports and reflect needs of the underserved community who work and live in San Luis Obispo County.

Analyzing the data from these published reports for FY 2010/2011, we find commonalities that reflect identified health and socio-economic needs by specific population which includes Access to Primary Health Care Services, Disease Management, Health Promotion/Disease Prevention and Maternal Health.

Access to Primary Health Care Services

- Lack of health insurance is a significant barrier to quality health care due to rising health care costs. Expenditures in the United States on healthcare surpassed \$2.3 trillion in 2008, more than three times the \$714 billion spent in 1990, and over eight times the \$253 billion spent in 1980. According to the ACTION for Healthy Communities 2010 telephone survey the percentage of currently uninsured increased from 2006, 83.7% to 88.5% in 2010. The majority of those who were uninsured stated that it was due to the high costs of health insurance.
- According to the ACTION for Healthy Communities 2010 telephone survey respondents, indicated an increase in the percentage of household members who have been unable to receive care due to financial barriers, from 10% in 2006 to 14% in 2010. The highest percentage among telephone respondents were Spanish speaking parents at 74.1%.
- Over one-third (37%) of San Luis Obispo County Action for Healthy Communities 2010 telephone survey respondents went without dental insurance in the past year.
- According to the California Health Interview Survey 2009 more than 16% of San Luis Obispo County residents had to delay or go without medications they needed during the past 12 months, compared to 11% in California in 2009.

- Healthy Families is a low cost insurance program for children and teens. Currently 5,234 youth enrolled in San Luis Obispo County, a 12% increase in enrollment since 2001.
- According to the ACTION for Healthy Communities 2010 survey Spanish speaking parents' the number one reason for not obtaining health care services is financial hardship and the second reason is the lack of awareness of where to get it.

Disease Management

- According to the Community Health Status Report 2010, San Luis Obispo County Public Health Department, the three leading causes of death in San Luis Obispo County are heart disease, malignant neoplasm (cancer), and cerebrovascular diseases (strokes).
- According to the American Heart Association Cardiovascular disease (CVD) ranks first among all disease categories in hospital discharges for women.
- According to the American Heart Association nearly 37 percent of all female deaths in America occur from CVD, which includes coronary heart disease (CHD), stroke and other cardiovascular diseases.
- The CDC (Center for Disease Control) estimates that 6.0% of adults in the San Luis Obispo County have diagnosed diabetes.
- Diabetes contributes to coronary heart disease, which was the 3rd leading cause of death in San Luis Obispo County in 2010.
- Cancer was the second leading cause of death in San Luis Obispo County in 2010. Identified below are expected new cases and expected deaths for San Luis Obispo County in 2010.
- According to the American Cancer 2010 statistic report Prostate cancer is the most common cancer among men in almost all the racial/ethnic groups in California with an estimated 20,120 (30%) new cases reported.

| Type of Cancer | Expected New Cases in SLO County 2010 | Expected Deaths in SLO County |
|-----------------------|--|--------------------------------------|
| Prostate | 165 | 30 |
| Breast | 170 | 35 |
| Lung | 135 | 135 |
| Colon/Rectal | 115 | 30 |

- In 2008, in San Luis Obispo County, 631 patients were admitted to San Luis Obispo County acute care hospitals with a principal diagnosis of influenza or pneumonia. The majority of these individuals 97.5% were 18 years of age or older while 2.5% were below the age of 17 years.
- Exposure to environmental pollutants within a child's first year increases his or her risk of developing asthma.
- In 2007, San Luis Obispo County reported a higher percentage of residents diagnosed with asthma to others counties in California.

| Asthma Prevalence | | |
|--------------------------|----------------------|-------------------|
| 2007 | | |
| Geographic Region | Children (ages 0-17) | Adults (ages 18+) |
| San Luis Obispo County | 22.1% | 12.4% |
| California | 15.4% | 13.0% |

* Persons who reported being diagnosed with asthma by a physician at any time. Data CHIS 2007

- The percentage of overweight adults in San Luis Obispo was 42.1% and obese adults were 19.8% in 2009. According to the Center for Disease control overweight is define as a person having a BMI (body mass index) between 25.0-29.9 and obese is a BMI over 30.
- Poor diet and physical inactivity are the second leading causes of death and disability, resulting in nearly 30,000 deaths each year in California.
- In California, more than 33% of children are obese or overweight. Forty percent of Latino children are most likely to be overweight or obese; while 24% of Asian American and Caucasian children are least likely to be overweight or obese.
- According to the 2007 California Health Interview Survey (CHIS) nearly half (49%) of adults and 39% of children (5-19 years old) residing in SLO County are considered overweight or obese.
- In California, an estimated 776,000 children, ages 2-17, have never seen a dentist. Latino and Asian children are least likely to access oral health care.
- More than one quarter of elementary school children in California have untreated cavities, and half of kindergarteners and two thirds of third graders have experienced tooth decay. This limits their performance in school and endangers their health.

Health Promotion/Disease Prevention

- According to the 2010 ACTION for Healthy Communities telephone survey, only 42% of teens in San Luis Obispo County and less than half (47%) adult survey responded that they had consumed the recommended daily serving of fruits and vegetables.
- Fifty-three percent of the telephone survey adults of the 2010 ACTION for Healthy Communities ate fast food at least once in the last week.
- Sixty percent of the residents surveyed by phone 2010 ACTION for Healthy Communities reported that their children ate 5 or more servings of fruits and vegetable a day.
- According to the 2010 ACTION for Healthy Communities 71% of the children spent at least 5 or more hours after-school per week on screen time-using computers, watching TV or videos, or texting.

Maternal Health

- The California Department of Public Health reports that during 2006-2008, the average overall percent of pregnant women beginning prenatal care in the first trimester was 80.5%. This indicator has been steadily decreasing since 2000 for all population, but racial and ethnic minorities remain less likely then Caucasians to enter care early and to receive adequate care.

- Racial and ethnic disparities continue to exist for access to early prenatal care in the first trimester, with infant mortality rate for Latino infants is 5.2 per 1,000 births as compared to 4.6 per 1,000 for non-Hispanic White.
- During 2008-2009, San Luis Obispo ranked 10th among California's 58 counties for breastfeeding.
- Between July 2008 and June 2009, 74.9% of post delivery women enrolled in the San Luis Obispo County Women, Infant, and Children (WIC) program were breastfeeding their infants. These data, however, may not be representative of all infants born in San Luis Obispo County because not everyone enrolled in WIC delivered in San Luis Obispo County.
- In 2009, San Luis Obispo County birth rate among 15-17 years and among 18-19 year old hit an all time low since 2004 at 29.8 to 22.8 in 2009.

The data has revealed that the current economic climate both on a national and local scale has influenced how individuals prioritize their health needs. In 2009 according to the California Health Interview Survey (CHIS) 15.1 % of the adult population and 13.4% of the children (0-17 years) in San Luis Obispo County were uninsured. Many San Luis Obispo residents chose to go without medication or seek health and/or dental services to accommodate more pressing needs.

While a timeline has been established at this writing we are still in the process of gathering data, identifying key indicators to further our assessment process. The results of the needs assessment will be published in March 2012 and the data analyzed by conducting this assessment will be used to identify disproportionate unmet health needs for program enhancements as well as for program development.

B. Assets Assessment

An inventory of community assets can be described below and are categorized by the hospital community benefit priority areas of FHMC: Access to Primary Healthcare Services; Health Promotion/Disease Prevention; and Disease Management.

Access to Primary Healthcare Services

- The Community Health Centers of the Central Coast have 6 primary care health centers throughout the FHMC service area all Federally –Qualified Community Health Centers.
- The Community Health Centers of the Central Coast provide a primary care mobile clinic at the Prado Homeless Day Center.
- In an effort to reduce unnecessary emergency room visits that can include long waiting room times, many CenCal primary care providers in San Luis Obispo County have extended their office hours to 6pm to see patients.
- French Hospital Medical Center donated \$7,500.00 to Healthy Kids program to cover the children insurance premiums of families that could not afford it.
- French Hospital Medical Center is an active member of the SLO-Benefits-ARCH committee which has as its main focus to expedite the SSI application process among the disabled and homeless populations.

Disease Management

- The Central Coast Service Area received a grant from the Center for Technology and Aging for the use of remote patient monitoring. Partnering with Philips, French Hospital Medical Center will acquire 10 home tele-station monitors for use in educating community-based patients throughout the service area living with heart failure and in the monitoring and reporting of critical vital signs such as blood pressure, pulse oximetry and weight.
- French Hospital Medical Center provides English and Spanish evidence-based chronic disease self management workshops developed by Stanford University School of Medicine. Healthy for Life Nutrition Lecture Series is also offered at no cost to all community members.
- French Hospital Medical Center offers monthly support groups for Diabetes I and II to the community for free.

Health Promotion/Disease Prevention

- First 5 and Community Health Centers of the Central Coast are the leading agencies to address the disparities among children with respect to oral health in San Luis Obispo County.
- Childhood obesity is the focus of the Healthy Eating Active Living – San Luis Obispo coalition of which FHMC is an active member.
- San Luis Obispo County Public Health Tobacco Control Program offers free Cessation classes.
- FHMC offers their Cardiac Wellness program offsite in the community and provides free lipid screening and risk assessments.
- French Hospital Medical Center’s Hearst Cancer Resource offers cancer patients resources, expertise and support services needed to manage a cancer diagnosis.

Maternal Health

- Both French Hospital Medical Center and Sierra Vista Medical Center offer a variety of community classes such as childbirth, breastfeeding, and infant CRP.
- French Hospital Medical Center provides English and Spanish lactation consultations at their breastfeeding clinic as well as the local WIC clinics.
- French Hospital Medical Center offers a free monthly breastfeeding support group to the community.

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

1. The community benefit planning process considers the fiscal year 2010-2011 plan, which also serves as a springboard for the continuation of most current programs. Priorities considered when selecting community involvement for a focused need include adherence to the mission statement of CHW and if that need relates to the strategic plan for FHMC, the Community Needs Index (CNI) and the other assessment tools and reports. To ensure CHW values are integrated into these programs and services, there are a number of checks and balances set to maintain goals of the programs. These stakeholders help review the community’s needs, establish goals in line with our strategic plan.: (a) The Hospital’s Strategic Planning has impact on factors of involvement for specific program implementation: (b) The FHMC

Community Benefit Committee reviews outreach program on a quarterly basis thereby ensuring commitment to the hospital's strategic plan, and; (c) The FHMC Hospital Board reviews community outreach activities through monthly board meetings; (d) Finally the community needs and assets assessment process provided a data analysis that program coordinators can use for the program improvement and sustainability of their program.

2. Factors considered in planning for outreach programs include analysis of the high utilization rate of the hospital's emergency room by those uninsured or underinsured families and the severity of their health problems. In the last five years French Hospital Medical Center has seen an increase in the number of uninsured residents and underinsured residents covered by MediCal which resulted in a greater than 105% increase in charity care and shortfall from care provided to MediCal recipients. 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 hospitalizations or need for emergency care. To effectively impact the increase in charity care and Medi-Cal expense, FHMC has established a plan to address these issues internally while providing quality healthcare service to this population.
 - a. Partner with physicians and share ambulatory care sensitive condition admission / readmission data
 - b. Collaborate on improved healthcare education and referral plan addressing those patients within our control
 - c. Identify physician/Staff champion within service area to promote disease management initiative.
 - d. Availability of community partners that will collaborate with us in providing disease prevention education programs that target cost-effective prevention.

The community benefit priority areas that French Hospital Medical Center will focus on for FY 2011/2012 include Access to Primary Health Care, Disease Management, Health Promotion/ Disease Prevention, and Maternal Health. The key targeted areas that the Community Needs Index (CNI) has identified as the neediest are northwest San Luis Obispo, Paso Robles and the small communities of Morro Bay and San Miguel. Continued outreach to these areas and focusing on building community capacity by strengthening our partnership among community based organizations will lead to improving healthcare access among these communities.

3. Identified health issues will be addressed to the best of our abilities and resources with program enhancement and services as suggested below. All of these services specifically address the vulnerable population as described in the definition of community.

Access to Primary Health Care Services

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

Hospital Care Coordinator position. The CHW Sacramento Service Area has established a Community Health Referral Network that connects patients, build capacity and improve systems of care. The Network shows remarkable program outcomes for the first three months of implementation

- To address collaboration to improve healthcare education and referrals for those patients within our control and to collaborate with Community Health Centers of the Central Coast referrals from the ER would be both cost effective and good stewardship. An unprecedented number of uninsured and underinsured patients are turning to the emergency department for basic care because of lack a primary care provider and/or are unable to navigate a dramatically altered health care landscape. Poor communication and collaboration among Community Health Centers of the Central Coast and minimal patient outreach further exacerbates barriers to care. The Community Health Referral Network mentioned above can shift the paradigm.

Disease Management

- French Hospital Medical Center has identified two prevalent illnesses that reflect both outpatient and inpatients of the last three fiscal years; Congestive Heart Failure and Diabetes (long term and short term complications and uncontrollable). French Hospital Medical Center chronic disease self-management workshop: Healthier Living: Your Life Take Care and Healthy for Life Nutrition Lecture Series can be promoted. Identifying a physician/Staff champion within this service area to promote disease management initiative will also help.
- The Congestive Heart Failure program will enhance their case management of their patients by providing home visits, telephonic follow ups and the implementation of the Telehealth monitors to high risk patients as best practice strategies to reduce hospital readmissions.
- Support groups for both Diabetes I and II will continue and expand to the Templeton and Paso Robles service area.

Health Promotion/Disease Prevention

- Senior citizens on limited income and below the Federal Poverty Level will continually be encouraged to participate in community lectures and programs focused on a variety of chronic disease and health-related topics. Participation in health fairs throughout the county by the Cardiac Wellness program, Congestive Heart Failure Program, the Hearst Cancer Resource Center will continue as well as having hospital nursing staff provide blood pressure, lipid panels, glucose screening, Flu vaccinations and Pertussis vaccinations per request.
- Lack of awareness and access to care are key barriers for Latino families. Health programs need to engage in effective, culturally sensitive outreach to the parents and children to encourage trust and participation. French Hospital Medical Center will continue their commitment in offering outreach programs in both English and Spanish, collaborating with other community based organizations to increase awareness among the Latino population.
- The FHMC San Miguel Promotora program which is a peer education model which is an effective tool in reaching the Latino Community as well as other underserved populations will continue and expand to the Paso Robles and San Luis

Obispo city areas. The Promotora model identifies key community leaders and trains them to become peer educators. The Promotoras become a bridge between the community and resources that are available for their neighborhoods.

Maternal Health

- French Hospital Medical Center will continue to support the ongoing efforts of our lactation consultants in our Breastfeeding clinic as well as in the WIC clinics in the 5 cities area.
 - Teen childbirth classes will expand to include outreach and possible implementation into continuation/alternative high school campuses.
 - French Hospital Medical Center will continue offering free a weekly breast feeding support group.
4. Housing is a need identified in the hospitals most recent assessment that was not addressed by the hospital. Though housing is ranked among the 5 highest needs in our service area, limited resources are focusing on the issues of access to care and disease management. French Hospital Medical Center will continue to support the efforts of the CHW corporate office, which recently renewed the SLO County Housing Trust Fund loan to help provide low income housing.
- D. Planning for the Uninsured/Underinsured Patient Population
1. FHMC follows the CHW Charity Care/Financial Assistance Policy and Procedures. For patients who are unable to pay, a determination is made of their need for financial assistance, a payment plan, or assistance with other resources, making available the maximum level of charity care to those needing fiscal assistance. (See CHW Summary of Patient Financial Assistance Policy, Attachment A)
 2. FHMC trains and educates all staff regarding the Eligibility & Application Policy and Procedures for Payment Assistance. Payment assistance brochures are located throughout the hospital as well as posted on our website: www.frenchmedicalcenter.org Admitting staff educate all patients about the payment assistance policies and have been trained when it is appropriate to give payment assistance information and applications to patients.
 3. FHMC keeps the public informed about the hospital's Financial Assistance/ Charity Care policy by providing signage and brochures in both English and Spanish. CHW has assigned a name to describe these efforts: The FAIR cause Project; Financial – Assistance – Implementation – Review. Business Office staff and admitting/registration staff are provided training and scripting information about payment assistance to be given to patients during the registration process. Letters are sent to self-pay patients informing them of the program. Lobby and waiting areas have brochures and information available to patients as well. In addition, FHMC states that it turns no-one away regardless of his/her ability to pay in advertisements, if applicable.
 4. FHMC has contracted with an outside vendor to work with patients as a Financial Counselor. This counselor will help link them to the various financial assistance programs available through the federal, state, local government programs and if they qualify through FHMC's payment assistance program. In FY 2011/2012 there were 1085 people who benefited from this program.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

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

- **Disproportionate Unmet Health-Related Needs:** Seeks to accommodate the needs of communities with disproportionate unmet health-related needs.
 - **Primary Prevention:** Addresses the underlying causes of a persistent health problem.
 - **Seamless Continuum of Care:** Emphasizes evidence-based approaches by establishing operational linkages (i.e., coordination and redesign of care modalities) between clinical services and community health improvement activities.
 - **Build Community Capacity:** Targets charitable resources to mobilize and build the capacity of existing community assets.
 - **Collaborative Governance:** Engages diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.
1. To increase cancer awareness and prevention among the Latino population the Hearst Cancer Resource Center sponsored a healthy cooking nutritional series in Spanish in Paso Robles. The series offered a cooking demonstration in which a traditional Mexican dish recipe was modified with healthier choices for cancer prevention.
 2. The Cardiac Wellness program brings lipid and glucose screenings and cardiac risk assessments and appropriate follow up as needed to workplaces, health fairs, and community based organizations. Assessment for risk for cardiovascular disease at the Canyon Creek Apartments in Paso Robles disclosed a number of young women who were overweight, some with elevated lipids and/or glucose in the pre-diabetes range. Upon follow-up, one woman took the cardiac nurse advice to expand her walk to school with the kids in the morning, with a goal of one hour daily. She was actually walking 2 hours a day, had lost 20 pounds in 6 months, and her blood sugar and triglycerides had normalized. Another, older woman with very elevated triglycerides upon screening was referred to Community Health Clinic for follow-up. Retesting showed levels within normal limits with the addition of a medication. Heart disease is the leading cause of death among women.
 3. The Prenatal and New Parent Education Program collaborated with the Teen Academic Parenting Program (TAPP) to offer a prenatal class to their pregnant teens in the Paso Robles area. The teens welcome the information presented by the childbirth nurse educator. Pregnant teens often feel embarrassed to attend the regular scheduled prenatal classes because of their age and their situation. French Hospital's prenatal program this year expanded services to pregnant teens in Nipomo and Arroyo Grande area. Here are some sample quotes from TAPP staff and participants.

- From Case Manager of TAPP, @ Teen Childbirth Class: "I wanted to let you know she had her baby girl. Labor was good, she had her natural. I know you would be proud considering she wanted to ask for a C-Section!"
- From student in Breastfeeding Class: "Felt that class was balanced... encouraged breastfeeding, but not over-the-top. Love Julie's calming presence and voice."
- From student at Baby Basics Class: "Truly enjoyed the class. Tamra does an amazing job answering questions, being clear and making us feel peaceful and comfortable. Felt more at ease after the class. Thank You!!!"

PROGRAM DIGEST

| Healthcare Education and Disease Prevention | |
|--|--|
| Hospital CB Priority Areas | <input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal 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 checked="" type="checkbox"/> Collaborative Governance |
| Link to Community Needs Assessment | Underserved, poor, and broader communities: Health Promotion/Disease Prevention |
| Program Description | Provide San Luis Obispo population with opportunities to become proactive in their health by providing health- related education events in the French Hospital Medical Center (FHMC) service area. |
| FY 2011 | |
| Goal FY 2011 | Promote through enrollment the chronic condition self management program, related prevention lectures and screening to FHMC service area. |
| 2011 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. The Chronic Disease Self-Management program will decrease the number of visits to the ED room by 5% among it participants within 6 months from graduation. 2. The Healthy For Life Nutrition Lecture program will increase attendance by 20%. Post telephonic follow-up will indicate better eating habits, increased consumption of vegetables and fruits of those participants by 5% within 6 months of graduating from the program. 3. The Dine Out for Your Health program both in English and Spanish will increase awareness of community resources by the participants by 80%. 4. 4. Annual Health fairs will show a 50% increase in screenings ensuring each participant is provided a referral to a primary care provider and/or assistance to access to care focusing on the under and uninsured |
| Baseline | 1140 persons served for community education and 544 people served at health fairs 47 people participated in CDSMP, 11 people participated in Healthy for life Nutrition lectures |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Offer 2 Chronic Disease Self Management Program (CDSMP) workshops and do telephonic follow up surveys to participants at 6 month after graduation. Work with case management and other caregivers for referrals. Train Community Benefits coordinator as instructor for CDSMP program to have the capacity to offer the course in Spanish. 2. Collaborate with San Luis Obispo Parks and Recreation Department and People Self Help Housing to implement the Healthy For Life Nutrition Lecture program in CNI area zip codes. Do telephonic follow up to participants at 3 and 6 months of graduating. Develop and implement Promotora training to increase outreach among the Latino and underserved population. 3. Collect surveys at all Dine for your Health lecture series and provide appropriate referrals to other community programs. 4. Partner with other community based organizations to sponsor 3 annual health fairs/screening events. |
| Result FY 2011 | <ol style="list-style-type: none"> 1. Two CDSMP workshops were scheduled one in May 2011 in English and the other in Spanish scheduled for September 2011. Presently there is no telephonic data available since it has not been 6 months from the graduation date of both programs. Eight people attended and completed the May 2011 workshop. The Community Benefit coordinator was trained as a Spanish instructor. 2. There was 45% increase of attendance in our Healthy for Life nutrition series. All 5 program sites were within the CNI zip codes. Thirteen participants completed the 6 month telephonic survey and indicated a 13% increase in consuming more fruits and vegetables after graduating form the program. Promotora program was developed and implemented in San Miguel and 4 completed the program. 3. Surveys at Dine out increased over 80% of awareness among the participants. 4. Increased screening at 3 health fair events by 65%. |
| Hospital's Contribution / Program Expense | Hospital has provided in-kind space, nutrition services, advertising, printing, supplies for health fairs and screenings. \$ 124,920 |

| Y 2012 | |
|--|--|
| Goal 2012 | Promote the chronic disease self-management program, related prevention lectures and screenings to FHMC service area. |
| 2012 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. The Chronic Disease Self-Management program will decrease the number of visits to the ED room by 5% among the participants within 6 months from graduating date of hospital's preventive health intervention. 2. The Health for Life Nutrition lecture series will increase consumption of vegetables and fruits among the program participants by 5% within 6 months of graduating date of program. 3. Annual health fairs will show a 30% increase in screening ensuring each participant is provided a referral to a primary care provider and /or assistance to access to care focusing on the underserved and uninsured. |
| Baseline | Number of people served through community education 4,443 screenings 1,711 |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Conduct outreach efforts to form partnerships with community based organizations to implement Chronic Disease Self Management (CDSMP) and Healthy for Life (HFL) programs. 2. Increase enrollment of participants by 10% in the CDSMP and HFL workshops. 3. Implement telephonic follow up of participants in the CDSMP and HFL programs at 3 and 6 months intervals after participants' graduation date from the program. 4. Partner with other community based organizations to sponsor 3 annual health fairs/screenings events. |
| Community Benefit Category | A1a. Community Health Education: Lectures/Workshops |

| Diabetes Prevention and Management | |
|--|--|
| Hospital CB Priority Areas | <input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal 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 checked="" type="checkbox"/> Collaborative Governance |
| Link to Community Needs Assessment | Underserved, poor, and broader communities: Access to Primary Healthcare, Disease Management |
| Program Description | Provide a comprehensive evidence-based diabetes management program providing education with registered dietitian and/or nurse specialized in diabetes management. The program will in prove behavior and self management practices of diabetic patients: enhance and improve the access and delivery of effective preventive health care services. |
| FY 2011 | |
| Goal FY 2011 | Monitor effectiveness of Diabetes Prevention and Management Program in reducing diabetes complication risk factors and hospital admission for those participants enrolled in the program. |
| 2011 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Increase diabetes support group participation by 3%. 2. Launch Diabetes Aware program which is an on-line risk assessment program. 3. Monitor effectiveness of Diabetes Management Program by 50% which will include glucose monitoring, exercise, diet, and A1C, levels for those participants enrolled in the program. |
| Baseline | Diabetes education 40 persons serves, no diabetes support groups |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Increase publicity of support group through media outlet and community outreach: health fairs and community lectures at Arroyo Grand Hospital and Morro Bay area. 2. Identify high risk clients from Diabetes Aware and offer consultation and support group. 3. Implement follow up calls at 1,3,6, months to track weight loss, exercise, diet, glucose readings, A1C, hospitalizations due to related diabetic events, reassess goals and objectives. 4. |
| Result FY 2011 | <ol style="list-style-type: none"> 1. There was a 1.3% increase in participation in the Diabetes II support group. Due to demand Diabetes I support group was started. 2. Diabetes Aware program was not launched due to lack of funding. 3. Fifty-five participants attended the Diabetes Management Program, 19 participants agree to be monitor during 1, 3, and 6 months after the program. Of the 19 participants 50% increases exercise, 40% increased checking blood sugars, 88% improved their diet, 50% lost some weight, and 30% reduced their A1C. <p>* This program digest has been incorporated to the second LTIP FY 2011-2013.</p> |
| Hospital's Contribution / Program Expense | Hospital provided n kind space, nutritional services, advertising, and printing. Expense \$ 6,219 |
| FY 2012 | |
| Goal 2012 | Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education. |
| 2012 Objective Measure/Indicator of Success | Participants in the facility/service area evidence-based CDM program(s) will avoid admissions to the hospital or emergency department for the six months following their participation in the program. |
| Baseline | Diabetes Management program 135 persons served , Support groups 73 persons served |
| Intervention Strategy for Achieving Goal | <p>Identify and engage a physician program champion</p> <p>Identify registered dietician or CDE RN specializing in diabetes management to facilitate program</p> <p>Engage home health, and Emergency Department case management for patient enrollment</p> <p>Refer uninsured/underinsured patients to Alliance for Pharmaceutical Access for prescriptions</p> <p>Develop a mechanism to follow-up and track these enrolled patients and for the six months following their participation in the program. (i.e. telephonic support)</p> <p>Identify culturally and linguistically appropriate messaging for this population of diabetic patients.</p> <p>Provide in-service to hospital staff regarding Diabetes Prevention and Management Program.</p> <p>Enroll program participants in CDSMP and Healthy for Life programs.</p> <p>Support in-patient awareness of chronic disease education through case management.</p> <p>Investigate availability of software that can track indicators to follow patients.</p> |
| Community Benefit Category | A1c. Community Health Education: Individual Health Education for uninsured/under insured |

| Congestive Heart Program | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------|-------------------|-------------------|-------------------|-----|----|---|-----|----|----|---|-----|----|----|---|---|----|----|---|-----|
| Hospital CB Priority Areas | <input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Disease Management <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input type="checkbox"/> Maternal 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 checked="" type="checkbox"/> Collaborative Governance | | | | | | | | | | | | | | | | | | | | |
| Link to Community Needs Assessment | Underserved, poor, and broader communities: Disease Management | | | | | | | | | | | | | | | | | | | | |
| Program Description | The Congestive Heart Failure (CHF) program provides education to patients diagnosed with CHF during the hospital stay in addition to providing discharge instructions. Patients enrolled in the program are provided consistent telephonic patient follow-up and education thereby decreasing the number of readmissions to the hospital. This program also serves cardiac patients through education, risk assessment and referrals. | | | | | | | | | | | | | | | | | | | | |
| FY 2011 | | | | | | | | | | | | | | | | | | | | | |
| Goal FY 2011 | Demonstrate a 5% decrease in readmissions within 30 days for participants in the hospital's Congestive Heart Failure program. | | | | | | | | | | | | | | | | | | | | |
| 2011 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Develop levels and associated predictors for each patient enrolled in the program. 2. Provide multi-disciplinary team based pre-discharge planning and intensive pre-discharge patient counseling specific and individualized to avoid readmission followed with at least one post discharge support home visit. 3. Measure/ report cost of the intervention per patient. 4. Provide statistical data on core measures of clients including nutrition, daily weight, & medication regime. | | | | | | | | | | | | | | | | | | | | |
| Baseline | July 2009 – June 2010 there were 90 CHF patients enrolled in the CHF program with a 6.6% readmission rate within 30 days. | | | | | | | | | | | | | | | | | | | | |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Work with sister hospital to develop levels and associated predictors for Central Coast service area since each patient will indicate different levels of needed patient support. 2. Work with case management, medial staff and community resources to provide seamless care from hospital into the community. 3. Work with medical records to determine cost of each CHF enrolled patient. 4. Tracking of core measure by phone follow up and referrals to community education and RD services. | | | | | | | | | | | | | | | | | | | | |
| Result FY 2011 | <p>The Congestive Heart Failure (CHF) program provided education to patients diagnosed with CHF during the hospital stay in addition to providing discharge instructions that have a Dr's order for the program. Patients enrolled in the program are provided consistent telephonic patient follow-up and education thereby decreasing the number of readmissions to the hospital.</p> <table border="1"> <thead> <tr> <th>Quarter/Yr</th> <th># of Participants</th> <th># of Readmissions</th> <th>% of Readmissions</th> </tr> </thead> <tbody> <tr> <td>Q 1</td> <td>46</td> <td>2</td> <td>4.3</td> </tr> <tr> <td>Q2</td> <td>42</td> <td>2</td> <td>4.8</td> </tr> <tr> <td>Q3</td> <td>46</td> <td>0</td> <td>0</td> </tr> <tr> <td>Q4</td> <td>64</td> <td>3</td> <td>4.7</td> </tr> </tbody> </table> | Quarter/Yr | # of Participants | # of Readmissions | % of Readmissions | Q 1 | 46 | 2 | 4.3 | Q2 | 42 | 2 | 4.8 | Q3 | 46 | 0 | 0 | Q4 | 64 | 3 | 4.7 |
| Quarter/Yr | # of Participants | # of Readmissions | % of Readmissions | | | | | | | | | | | | | | | | | | |
| Q 1 | 46 | 2 | 4.3 | | | | | | | | | | | | | | | | | | |
| Q2 | 42 | 2 | 4.8 | | | | | | | | | | | | | | | | | | |
| Q3 | 46 | 0 | 0 | | | | | | | | | | | | | | | | | | |
| Q4 | 64 | 3 | 4.7 | | | | | | | | | | | | | | | | | | |
| Hospital's Contribution / Program Expense | This program serves cardiac patients and CHF clients in the community through education, risk assessment and referrals. Cost \$51,948 | | | | | | | | | | | | | | | | | | | | |
| FY 2012 | | | | | | | | | | | | | | | | | | | | | |
| Goal 2012 | Avoid hospital and emergency department admissions for 6 months among 60% of participants enrolled in the CHF Program. | | | | | | | | | | | | | | | | | | | | |
| 2012 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Enhance the telephone based monitoring program by implementing Philips Telemonitoring to prevent hospital readmissions within 6 months of enrolling in the CHF Program. 2. Identify all patients at high risk for readmission within 6 months of hospital discharge using the Probability of Repeated Readmission tool in Philips software for both telemonitor and telephonic patients. 3. Measure quality of life changes for all participants enrolled in the CHF Program by the completion of program (6 months). | | | | | | | | | | | | | | | | | | | | |
| Baseline | 620 persons served through CHF program | | | | | | | | | | | | | | | | | | | | |
| 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 area. 4. Implement telephonic assessments in Philips software for remaining participants. 5. Continue to collaborate with CHW facilities as well as partners in the community (Community Health Clinic, Public Health Departments) to refer patients to the CHF Program. 6. Track reports for both telemonitor and telephonic participants for outcomes using SHP solutions tool as well as hospital MIDAS reports. | | | | | | | | | | | | | | | | | | | | |

| | |
|-----------------------------------|--|
| | <ol style="list-style-type: none"> 7. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers. 8. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center. 9. Utilize American Heart Association and American College of Cardiology resources and guidelines to continue education regarding heart failure as well as referrals to community based programs. 10. Evaluate participant response the telemonitor and telephonic programs using exit surveys. |
| Community Benefit Category | A3e. Health Care Support Services: Information & Referral |

| Cardiac Wellness | |
|--|---|
| Hospital CB Priority Areas | <input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal 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 checked="" type="checkbox"/> Collaborative Governance |
| Link to Community Needs Assessment | Underserved, poor, and broader communities: Health Promotion/Disease Management |
| Program Description | Cardiovascular disease is the leading cause of death in the United States. Assessment of cardiovascular risk status can identify those medical or lifestyle conditions that may lead to development of the disease. This profile can enable community members to take control of their health and encourage follow-up and treatment of risk factors by their health care provider. |
| FY 2011 | |
| Goal FY 2011 | Decrease heart disease risk for residents in the FHMC service area using the Heart Aware risk assessment, screening and follow-up program, and community education. |
| 2011 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Compare intake assessment and 6-month follow-up data to measure change in cardiac risk average change in BMI, in SBP, number of individuals who quit smoking, number of individuals who increase exercise, change (percent) in average LDL cholesterol. 2. Increase number of women who receive Heart Aware by 10% points over 2010 figures. 3. Provide monthly community education opportunities regarding cardiac disease wellness. |
| Baseline | While San Luis Obispo County met the Healthy People 2010 Objectives for age-adjusted deaths from coronary artery disease, this chronic disease still causes over 24% of deaths in our County. (Community Health Status Report for SLO County 2010) While we do not have county specific data on women, national trends indicate that women are diagnosed later, treated less aggressively, and have worse outcomes with heart disease than do men. Anecdotally, the down-turn in the economy has caused an increase in the number of uninsured individuals. 312 face to face consults |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. For at-risk clients of Heart Aware, provide lipid panel screening, risk factor reduction education, goal setting and referrals for further screening or treatment, as needed. Follow-up at 6-months to track outcomes. 2. Target women in advertising Health Aware, and participate quarterly in education and/or screening opportunities for women/s groups. 3. Provide Cardiac Wellness lecture series, senior health education, and speak to service organization, clubs, and organization about heart health. |
| Result FY 2011 | 598 individuals in SLO County received one-on-one information regarding heart disease risk factors and a heart-healthy lifestyle. 176 point of care Lipid Panel screening tests were done and 35 individuals received follow-up consultation 6 months or more after their initial contact with HeartAware. Of those who took the on-line assessment, 59% were women (up 1% from 2010), and 54% received follow-up consultation (down 2% from 2010). Numerous community outreach lectures, Health Fairs and classes were conducted regarding cardiovascular disease risk |
| Hospital's Contribution / Program Expense | Staff hours: 181 ,Salaries & Fringes: \$10,393, Supplies / Expenses: \$2,912 Total Costs \$13,572 |
| FY 2012 | |
| Goal 2012 | Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area. |
| 2012 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Screen at least 10 people for cardiovascular disease, including free Lipid Panel screening, every other month, for a total of at least 60. 2. Educate at-risk individuals regarding healthy lifestyle to reduce cardiac risk. Follow-up with at-risk individuals at 6 or 12 months to track risk factor reduction in response to lifestyle change. 3. Refer at-risk individuals to a primary care practitioner for retesting and/or treatment. Follow-up at 6 months to track entry to care. 4. Participate in education and outreach activities to the broader community, including at least 2 Health Fairs, and 2 lecture presentations to groups |
| Baseline | 598 persons served |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Assess cardiac risk, including lipid screening at health fairs, free clinics, work-site wellness programs and other venues. 2. Collaborate with other community agencies that serve those at-risk for cardiovascular disease. 3. Educate groups or individuals regarding healthy lifestyle to reduce risk and prevent heart disease. 4. Refer at-risk individuals to a primary care practitioner or clinic for retesting and/or treatment. 5. Follow at-risk clients at 6 months or 1 year to track risk factor reduction with lifestyle change and/or medical treatment of risk factors. |
| Community Benefit Category | A1a. Community Health Education: Lectures/Workshops |

| Cancer Resource Center | |
|--|---|
| Hospital CB Priority Areas | <input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Disease Management <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input type="checkbox"/> Maternal 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 checked="" type="checkbox"/> Collaborative Governance |
| Link to Community Needs Assessment | Underserved, poor, and broader communities: Health Promotion/Disease Prevention |
| Program Description | The Hearst Cancer Resource Center provides information, education and support services for cancer patients and their families. The center is staffed with qualified personnel and collaborates with existing services in the community. The center will be part of a regional approach in concert with the other CHW Central Coast Service Area. |
| FY 2011 | |
| Goal FY 2011 | To increase awareness for early detection and provide information on the importance of cancer screening for the prevention of cancer to FHMC service area. |
| 2011 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Increase attendance by 5% in the "Home Cooking: Familiar Foods for Better Health" Spanish class. 2. Increase awareness on the importance of cancer screening and early detection education by 5% at community health fairs events. 3. Provide lectures on breast cancer and gynecologic cancers in both English and Spanish. 4. A 5% increase in outreach to seniors and poor on the programs and services of the HCRC for education on healthy living and prevention of cancer. |
| Baseline | 7,115 community members served through education, information, and referral, self help and support groups. |
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Collaborate with The Wellness Community, Hospice of SLO County, and SLO County Senior Center to present the 2nd "Home Cooking" for 4 weeks in Spanish. Collect evaluations to determine the outcomes of the program. 2. Partner with FHMC Community Benefits department to sponsor 3 community health fairs. 3. Work with trained Promotoras for outreach to Latino Community. Support collaboration between CHC and HCRC nurse navigator to provide outreach to the population they serve. 4. Provide 3 onsite presentations on HCRC programs to senior centers and /or housing developments. |
| Result FY 2011 | <ol style="list-style-type: none"> 1. Spanish Cooking Class: 40 participants attended a series for Hispanic families to learn how to eat healthy for the prevention of cancer. Added an extra one-on-one consultation day with the Registered Dietitian. 2. Participated in three Hispanic health fairs using Health Educator to distribute cancer prevention and educational information. 295 contacts. Participated in five community health fair events. 350 contacts. Vendor at two senior health fairs. 75 contacts. 3. Offered two lectures on cancer prevention targeting the women population. 120 participants. 4. Offered two different types of programs for the senior population: One on Healing Bowls, a relaxation program offer at HCRC. 11 attended. The second program was a cancer-legal information lecture. 17 participants. 5. Presented seven community educational lectures on cancer education, prevention and wellness. 249 participants. 6. Nurse navigator has assisted seven Spanish speaking patients with the assistance of the CyraCom phone and a certified medical interpreter. 7. HCRC was actively involved with the Cal Poly students on cancer related program. Two events – lecture & Relay for Life - 54 contacts. Hosted tours at HCRC for future dietitians. 49 students participated. |
| Hospital's Contribution / Program Expense | HCRC and FHMC provided in kind space, nutritional services, advertisement, and printing. Expense \$ 219,378 |
| FY 2012 | |
| Goal 2012 | To improve the health and well-being of the underserved in the FHMC service area through education and screening for early detection and the prevention of cancer. |
| 2012 Objective Measure/Indicator of Success | <ol style="list-style-type: none"> 1. Provide 2 lectures by the nurse navigator on prevention and screening of cancer to the Hispanic community. 2. Improve healthy eating habits for the prevention of cancer to Hispanic families by increasing attendance at the cooking series by 5%. 3. Identify 3 outreach venues to increase awareness of the importance of cancer screening, early detection, healthy living, and prevention of cancer to the most vulnerable in the FHMC service area. |
| Baseline | 17,358 community members served through education, information, and referral, self help and support groups |

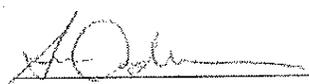
| | |
|---|---|
| Intervention Strategy for Achieving Goal | <ol style="list-style-type: none"> 1. Work in collaboration with the certified medical interpreter. Programs to be held at the SLO Self-Help Housing project in Paso Robles. Follow-up discussions with interpreter to determine outcome of service. In addition, HCRC plans to partner with Dr. Nooristani, who is opening a free clinic for individuals underinsured, by providing bilingual lectures and cancer prevention and screening information. 2. Collaborate with Hospice of San Luis Obispo County and SLO Self-Help Housing to present "Home Cooking: Familiar Foods for Better Health" 4-week class in Spanish. Collect evaluations to determine the outcomes of the program. Promote through flyers, HCRC newsletter and health educators. 3. Partner with FHMC Community Benefits department on numerous SLO county health fairs using bilingual health educators to distribute educational cancer prevention pamphlets and information. Work with the SLO County Promotoras to outreach to the Hispanic community. 4. Provide three onsite presentations at the senior self-help living facilities. Programs to include: Advance Directive in collaboration with FHMC Palliative Care Nurse, HCRC resources and programs lecture and mini-demonstration of a HCRC program. Evaluations will be distributed to determine the outcome of these programs. 5. Partner with local oncologist and dermatologist to provide a skin cancer screening for farmer workers and seniors in the fall of 2011. Forms and follow-up procedures will adhere to the standards of the Dermatologic Society. |
| Community Benefit Category | A1a. Community Education: Lectures/Workshops |

Community Benefit and Economic Value

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

366 French Hospital Medical
Complete Summary - Classified Including Non Community Benefit
For period from 7/1/2010 through 6/30/2011

| | Persons | Total Expense | Offsetting Revenue | Net Benefit | % of Organization Expenses | Revenues |
|--|---------------|-------------------|--------------------|-------------------|----------------------------|-------------|
| <u>Benefits for Living in Poverty</u> | | | | | | |
| Traditional Charity Care | 1,085 | 4,287,272 | 2,340,958 | 1,946,314 | 2.1 | 1.9 |
| Unpaid Cost of Medicaid | 7,209 | 8,425,928 | 3,922,631 | 4,503,297 | 4.8 | 4.5 |
| Means-Tested Programs | 692 | 1,665,345 | 785,268 | 880,077 | 0.9 | 0.9 |
| Community Services | | | | | | |
| Community Benefit Operations | 0 | 35,975 | 0 | 35,975 | 0.0 | 0.0 |
| Community Building Activities | 39 | 23,416 | 0 | 23,416 | 0.0 | 0.0 |
| Community Health Improvement | 8,890 | 301,817 | 0 | 301,817 | 0.3 | 0.3 |
| Financial and In-Kind Contributions | 6,593 | 91,345 | 12,317 | 79,028 | 0.1 | 0.1 |
| Subsidized Health Services | 2,127 | 334,845 | 32,611 | 302,234 | 0.3 | 0.3 |
| Totals for Community Services | 17,649 | 787,398 | 44,928 | 742,470 | 0.8 | 0.7 |
| Totals for Living in Poverty | 26,635 | 15,165,943 | 7,093,785 | 8,072,158 | 8.7 | 8.0 |
| <u>Benefits for Broader</u> | | | | | | |
| Community Services | | | | | | |
| Community Benefit Operations | 0 | 41,957 | 0 | 41,957 | 0.0 | 0.0 |
| Community Health Improvement | 38,782 | 241,582 | 0 | 241,582 | 0.3 | 0.2 |
| Health Professions Education | 16 | 57,224 | 0 | 57,224 | 0.1 | 0.1 |
| Totals for Community Services | 38,798 | 340,763 | 0 | 340,763 | 0.4 | 0.3 |
| Totals for Broader Community | 38,798 | 340,763 | 0 | 340,763 | 0.4 | 0.3 |
| Totals - Community Benefit | 65,433 | 15,506,706 | 7,093,785 | 8,412,921 | 9.1 | 8.4 |
| Unpaid Cost of Medicare | 33,046 | 41,150,149 | 33,402,979 | 7,747,170 | 8.3 | 7.7 |
| Totals with Medicare | 98,479 | 56,656,855 | 40,496,764 | 16,160,091 | 17.4 | 16.1 |
| Totals Including Medicare | 98,479 | 56,656,855 | 40,496,764 | 16,160,091 | 17.4 | 16.1 |


Sue Anderson, CFO Central Coast Service Area Hospitals

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

Policy Overview

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

Eligibility for Patient Financial Assistance:

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

Determination of Financial Need:

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

Patient Financial Assistance Guidelines:

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

Patients whose income is at or below 200% of the FPL are eligible to receive free care;

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

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

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

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

Budgeting and Reporting:

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

Patient financial assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

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

Regulatory Requirements:

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

B. Telling the Story

1. FHMC publishes articles regarding community benefits, community outreach, mission-driven events and community collaborations in our “Points of Excellence” newsletter sent to physicians, community members and leaders, the FHMC Community Board, the FHMC Foundation Board, CHW Corporate Office, CHW Sisters, and employees.
2. A FHMC bi-monthly hospital newsletter, the “In-Service,” highlights a broad range of program activities including hospital, department-specific and individual activities.
3. A FHMC quarterly physician newsletter, the “Physician Folio”, highlights hospital programs and highlights community benefit activities.
4. Press releases, television, radio and newspaper coverage have noted the many programs in which French Hospital is involved. Much of the coverage focuses on the underserved population of San Luis Obispo County
5. All brochures, patient instructions and other information are printed in Spanish. The FHMC website is also translated into Spanish. www.frenchmedicalcenter.org.

THOMPSON/CHW COMMUNITY NEEDS INDEX

Market Name: French Hospital Medical Center

Market 2010 Population: 168,436

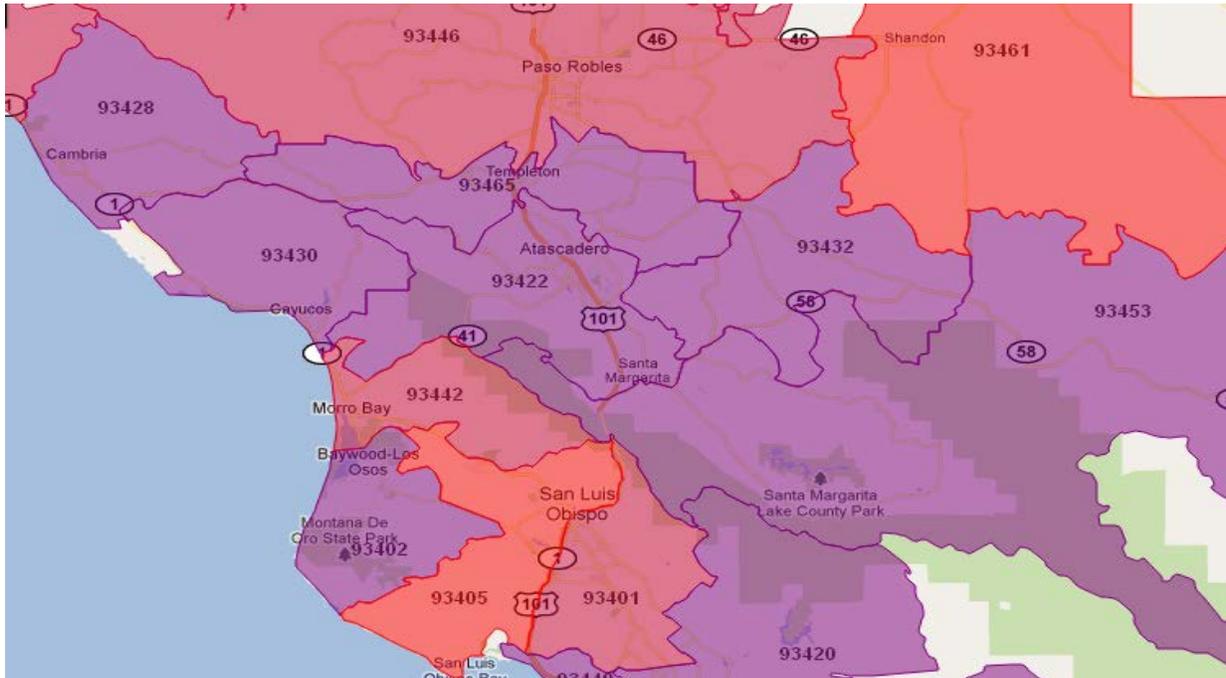
CNI Median Score: 4.8

| ZIP codes | Post Office Box Name | County | CNI Score | Income Ranking | Education Ranking | Cultural Ranking | Insurance Ranking | Housing Ranking | HH Poverty 65+ | Fam Poverty w kids | Fam Poverty F Hd | Prct 25+ wo HS dip | Prct NWhite Hisp | Pop 5+ Ltd Eng | Prct Unemployed | Percent Uninsured | Prct Renting |
|-----------|----------------------|--------|-----------|----------------|-------------------|------------------|-------------------|-----------------|----------------|--------------------|------------------|--------------------|------------------|----------------|-----------------|-------------------|--------------|
| 93401 | San Luis Obispo | SLO | 3.4 | 2 | 1 | 4 | 5 | 5 | 6% | 8% | 21% | 9% | 23% | 2% | 5% | 26% | 51% |
| 93402 | Los Osos | SLO | 2.8 | 2 | 1 | 4 | 3 | 4 | 5% | 9% | 21% | 8% | 20% | 2% | 4% | 14% | 31% |
| 93405 | NW San Luis Obispo | SLO | 4.2 | 2 | 4 | 5 | 5 | 5 | 4% | 5% | 27% | 23% | 40% | 1% | 11% | 36% | 58% |
| 93422 | Atascadero | SLO | 3 | 2 | 1 | 4 | 3 | 5 | 6% | 10% | 25% | 11% | 19% | 1% | 5% | 14% | 33% |
| 93442 | Morro Bay | SLO | 3.8 | 4 | 1 | 4 | 5 | 5 | 8% | 14% | 46% | 10% | 20% | 3% | 4% | 28% | 44% |
| 93446 | Paso Robles | SLO | 3.8 | 3 | 3 | 4 | 4 | 5 | 10% | 13% | 25% | 17% | 32% | 6% | 6% | 18% | 33% |
| 93428 | Cambria | SLO | 2.8 | 2 | 1 | 4 | 3 | 4 | 5% | 13% | 20% | 9% | 21% | 3% | 4% | 16% | 27% |

Attachment A

San Luis Obispo County Zip Codes

French Hospital Medical Center Service Area



| Zip Code | CNI Score | Population | City | County | State |
|----------|-----------|------------|---------------------------------|-----------------|------------|
| 93401 | 3.4 | 28150 | San Luis Obispo | San Luis Obispo | California |
| 93402 | 2.8 | 14017 | Baywood-Los Osos | San Luis Obispo | California |
| 93405 | 4.2 | 31236 | San Luis Obispo County | San Luis Obispo | California |
| 93422 | 3 | 32011 | Atascadero | San Luis Obispo | California |
| 93442 | 3.8 | 10970 | Morro Bay | San Luis Obispo | California |
| 93446 | 3.8 | 45375 | El Paso de Robles (Paso Robles) | San Luis Obispo | California |

Attachment B

French Hospital Medical Center Community Board FY11

John Dunn
Chair of the Board
Retired San Luis Obispo City Administrator

Jim Copeland
Vice Chair
Copeland's Properties

Ann Grant RN, PhD
Secretary
Nurse Educator, Cal State Dominguez Hills

Father Russell Brown
Pastor SLO Old Mission Church

Sister Pius Fahlstrom, OSF
Finance/Budget Analyst/Former CFO

Patricia Gomez
Attorney-at-Law

Alan Iftiniuk
President, French Hospital Medical Center

Ben Kulick
President, Stalfund, LP

Richard J. Macias, MD
Central Coast Pediatrics

Jim Malone, MD
Chief of Staff

Sandee McLaughlin
Executive Dean, Cuesta College

Rabbi Norm Mendel
Rabbi Emeritus, Congregation Beth David

Cornel Morton, PhD
VP Student Affairs Cal Poly

Kerry Pollock
Chief Operating Officer
Morris& Garritano Insurance

Sister Marianne Rasmussen, OSF
Retired Teacher/Administrator

Kevin Rice
Pismo Beach City Manager

Sister Jeanne Rollins, OSF
Senior Adult Ministry – St. Patrick's Parish
Care and Support Services

John Ronca Jr.
Attorney-at-Law

Mark Soll, M.D.
Central Coast Chest Consultants

Bill Thoma
Foundation Board Chair, Thoma Electric

Ke-Ping Tsao, M.D.
Plastic Surgeon

French Hospital Support Staff
Sue Andersen
Service Area CFO

Ken Hritz
Senior Director of Professional Services

Eugene Keller, M.D.
Vice President of Medical Affairs

Megan Maloney
Director of Communications and Mission
Services

Linda Riggle, BSN, MHSL
Chief Nursing Executive

Susan Winsell
Vice President of Human Resources

Attachment C

FHMC Community Benefits Committee FY11

Patricia Gomez
Chair of the Committee

Fr. Russell Brown
San Luis Obispo Mission

Sister Pius Fahlstrom, OSF
Finance/Budget Analyst/Former CFO

Denise Gimbel, RN, MPH
Cardiac Wellness – Program Coordinator

Patricia Herrera, MS, Community Benefits Coordinator - FHMC
Healthcare Education & Disease Prevention – Program Coordinator

Beverly Kirkhart
Hearst Cancer Resource Center – Program Coordinator

Sandee L. McLaughlin
Executive Dean, Cuesta College

Rabbi Norm Mendel
Rabbi Emeritus, Congregation Beth David

Sandra Miller, RD, MS, CDE
Diabetes Prevention & Management – Program Coordinator

Jean Raymond, RN, MSN
Congestive Heart Failure Program – Program Coordinator

Sister Jeanne Rollins, OSF
Senior Adult Ministry – St. Patrick's Parish

Sandy Underwood
Community Benefits Coordinator – MMC

Tamra Winfield, RN
Prenatal & New Parent Education – Program Coordinator

Susan Winsell
Vice President of Human Resources

Attachment D