



French Hospital Medical Center



# **French Hospital Medical Center.**

***Community Benefit Report 2013  
and Implementation Plan 2014***



A message from Alan Iftiniuk, President and Jim Copeland, Board Chair French Hospital Medical Center:

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

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

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

At French Hospital Medical Center we share a commitment to optimize the health of our community. In fiscal year 2013 French Hospital Medical Center provided \$18,254,842 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the French Hospital Medical Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October meeting.

Handwritten signature of Alan Iftiniuk in black ink.

Alan Iftiniuk

President

Handwritten signature of Jim Copeland in black ink.

Jim Copeland

Chair of Board

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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 Dignity Health, formerly Catholic Healthcare West (CHW)<sup>1</sup> 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, and more than 130 volunteers. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics. FHMC has earned a place on the Thomson Reuters list of the 50 Top cardiovascular hospitals in the country, one of only two California hospitals to earn such an honor.

Major Community Benefit activities for fiscal year 2013 focused on increased programming, coalition building within our primary and secondary service areas, and health education for those with disproportionate unmet health related needs (DUHN). FHMC will continue to collaborate with our local partners, Community Health Centers of the Central Coast (CHCCC), Alliance for Pharmaceutical Access (APA), and the SLO Noor Clinic to facilitate a better continuum of care through discharge planning and case management - linking patients with services - with emphasis on access to prescription drugs, transportation, food services, and provider appointments after discharge.

With the acknowledged need to support the development of qualified **healthcare professionals**, French Hospital Medical Center continues to identify and develop a projected priority recruitment plan for healthcare workers. FHMC, as a means to fostering professional development and improve patient care, continues to expand hospital programs, including case management, post acute care coordinators and medical directorships, to coordinate and monitor patient transitions across the continuum of care settings. FHMC will continue its ongoing program of supporting the recruitment of primary care physicians to the area, and promote expansion of existing community health care services, focusing on the needs of the poor.

**Health promotion and disease prevention** were selected as a priority focus to empower community members to assume responsibility for their health. To educate people about various medical conditions, and empower people to make informed choices, the hospital's community education program "Healthy for Life Nutrition" series, and our evidence-based Chronic Disease Self Management program, were offered at multiple community locations within our service area. The hospital also provides a variety of free community health screenings at various locations to promote community health on the Central Coast. Health screenings include a variety of services such as glucose, cholesterol and blood pressure tests, height, weight, Body Mass Index readings, and free skin cancer screenings and flu immunizations. These mobile, free health care screenings increase access to health care to those populations that might be facing multiple barriers to adequate health care. The screenings also increase awareness of the health care resources that are available in the communities of the people in attendance.

**The Diabetes Prevention and Management Program**, which was established to address this named health concern, has as its goal to avoid admissions or readmissions to the hospital or

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

emergency department for 50% of the participants in the hospital's preventive health intervention. The use of the Phillips Telemonitoring Program, which monitors blood glucose levels of discharged patients enrolled in the Diabetes program, has helped in increasing patient compliance. FHMC continues to offer a Diabetes Type I and II support group that meets monthly, offering participants the latest diabetes information and education.

The **Prenatal and New Parent Education Program** provides the only teen prenatal program in San Luis Obispo County. These classes are tailored to the pregnant teens needs and are often held in the community. This year 6 pregnant teens benefited from our program. Our breastfeeding clinic in San Luis Obispo, and lactation counseling at the local Women, Infant, and Child (WIC) clinics has provided 3, 452 lactation consultations for fiscal year 2013.

The **Cardiac Wellness Program** provided education to the community regarding prevention, early detection and treatment of heart disease. 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 established monthly off-site visits for these services at the SLO Noor Clinic, Oak Park Housing Development, and San Luis Obispo Housing Authority Developments.

The **Hearst Cancer Resource Center (HCRC)** continued to provide support and resources to residents of FHMC's service area. The HCRC, located on the FHMC campus, is an excellent resource center that addresses the medical, physical and emotional needs of cancer patients and their families. Since opening its doors in 2008, the HCRC has experienced more than 34,426 visits and contacts from cancer patients, family members, health fairs, and many community organizations.

The **Congestive Heart Failure Program's (CHF)** goal is to demonstrate a decrease in readmissions of participants enrolled in the hospital's preventive health intervention. In 2013, the CHF program had a total of 139 patients served in the FHMC service area. There was a 4.2% hospital readmission rate for those enrolled in the program. This was a .2% decrease from last year. The Congestive Heart Failure Program coordinator works with participants diagnosed with a chronic heart condition to increase their ability to build and maintain their health and quality of life. The use of a telemonitor helps track and transmit any changes in the patients' physical health indicating to the CHF coordinator either an improvement, or decline, in health. This information is vital to reassess the discharge health plan and provide the necessary resources for the patient's continual well being, and decrease the risk of readmissions to the hospital.

FHMC's fiscal year 2013 Community Benefit Report and fiscal year 2014 Community Benefit Implementation Plan documents our commitment to the health and improved quality of life in our community. The total value of community benefit for FY2013 is \$8,530,531 which excludes the unpaid costs of Medicare of \$9,724,311. Including the unpaid cost of Medicare, the total expense for fiscal year 2013 was \$18,254,842.

# Mission Statement

French Hospital Medical Center and Dignity Health are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

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

## Organizational Commitment

### A. Organizational Commitment

The mission of French Hospital Medical Center (FHMC) is built on our vision to serve those most in need. French Hospital Medical Center'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. FHMC's Community Benefit Committee provided leadership through chairing the Community Health Needs Strategic Planning Committee (CHSPC) meeting held on April 16, 2013. The CHSPC members included representatives from the county health department, mental health agencies, drug and alcohol agencies, community clinics, social services agencies, public transportation, and county representatives from the federal Medicaid insurance plan - CenCal. Committee members reflected on the issues, focusing on health disparities and the availability of community resources to address the needs of the community.

1. Both the FHMC Hospital Community Board and the Community Benefit Committee played an instrumental role in providing input and suggestions on who to include as key informants in the Hospital's Community Health Needs Assessment process. In addition, one of the goals of FHMC is to partner with other non-profit organizations in the community, thereby increasing the capacity of meeting the needs identified in the hospital's community health needs assessment report.
  - An example of this is our annual Dignity Health Community Grants funding process in which the priority health needs identified in our Community Health Needs Assessment report is the baseline for funding community partners. The Committee reviews applications for the Dignity Health Community Grant process, and makes recommendations for funding to Dignity Health Corporate based on the community partner programs alignment with FHMC identified needs.
2. The French Hospital Medical Center Community Benefit Committee provides oversight for the Hospital's Community Benefit Programs. The Committee is made up of members of the Hospital Community Board, representatives of the community, members of the hospital's senior management team, and Community Benefit Program Coordinators.
  - The Committee reviews the Community Health Needs Assessment and forwards a final draft for approval to the Hospital Community Board.
  - 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. FHMC senior management approves the Community Benefit annual budget.
  - 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.
3. Rosters of Community Board and Community Benefit Committee members are found at Appendix D

## **B. Non-Quantifiable Benefits**

1. 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 monthly. French's new Integrated Waste Stream Systems program will begin June 1<sup>st</sup> with better data reporting available by September. The goals of the program are 1) streamline waste streams; 2) increase recycling efforts by 10%; and 3) reduce solid waste by 5%. In reviewing the most current data, French Hospital is running under the benchmark of 11 pounds per adjusted patient day (apd) for solid/medical waste combined (10.48). This is even lower than last fiscal year 2012.
  - The facility 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 fiscal year 2012. The medical waste total has been decreased by 67%, which resulted in a savings of more than \$14,000 compared to fiscal year 2012.
  - FHMC continues its successful recycling programs throughout the hospital, to raise awareness and increase participation in our recycling initiatives. FHMC continues to use paper sparingly for meeting agendas, replacing them with an electronic version. The paper copies of FHMC's monthly newsletter have also been reduced by e-mailing the newsletters to those with e-mail capability. All outdated technology, such as computers and printers are safely and environmentally appropriately disposed of. Equipment and materials no longer needed in the hospital are donated to non-profits rather than sent to a landfill.
  - Since June 2010 our battery recycling program has recycled 1822 lbs of batteries.
  - FHMC employees donate clothing to our Caring Closet which provides clothing to patients upon discharge. FHMC employees annually participate in the following drives that help the poor and needy in our communities: Coats for Kids, Stuff the Bus, and the Salvation Army Angel Tree.
  - The commitment of FHMC does not stop with a small group of people volunteering their time to different not-for-profit organizations, but is also reflected in the different collaboration projects with community partners to improve the health of our community. For example - providing free health screening days at low-income housing developments that include diabetes/cholesterol testing, flu shots, blood pressure checks and on occasion free skin cancer screenings by volunteer physicians.
2. There are many examples of non-quantifiable benefits related to the community contributions of the hospital. Working collaboratively with community partners, the hospital provided leadership and advocacy, assisted with local capacity building, and participated in community-wide health planning. Our staff 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. The following are some non-quantifiable services:

- **Alan Iftiniuk, President FHMC** –board member of the following: CenCal Health Board, Hospital Council of Northern and Central California Board, and the American Heart Association – Central Coast Chapter.
- **Dan Farnum, Director of Facilities**- Executive Committee member of SLO County YMCA, SLO City Council Chair Board Member.
- **Patricia Herrera, Community Benefits Coordinator, Committee member**- Member of the following: Latino Outreach Council, HEAL-SLO, ACTION: For Healthy Communities, and Promotores Collaborative of SLO County
- **Jean Raymond Congestive Heart Failure Coordinator, Committee member** - Member of the San Luis Obispo Health Commission, Member of Adult Services Policy Council, Board of Directors Long Term Care Ombudsman Program, and an active member of the Central Coast Coalition for Compassionate Care POLST initiative
- **Sandra Miller, Registered Dietitian, Committee member**- HEAL- SLO, Central Coast MultiSport Club Board Member, and local chapter member, and state board member, of the American Dietetic Association

## Community

Dignity Health hospitals of the Central Coast define the community’s geographic area based on a percentage of hospital discharges and as identified by the Community Needs Index. Although French Hospital Medical Center contracts with over 25 insurers that provide healthcare insurance to this community, an alarming percent of residents in the San Luis Obispo County have little or no health insurance. We rely heavily on our partners, Integrated Health Management Services (IHMS), to assist these patients with health coverage, including government and non government programs.

A. French Hospital Medical Center (FHMC) is located in central San Luis Obispo County. Its primary service area encompasses San Luis Obispo, Atascadero, Morro Bay, Los Osos and Paso Robles, with a secondary service area identified as Pismo Beach, Arroyo Grande, Oceano, Grover Beach and Avila Beach. About 14% of the population is comprised of seniors age 65 and older. Less than one-quarter of the population is 19 years old or younger. Another 63% of the population is between ages 20 and 64. Most residents in the FHMC service area speak English at home, while fewer than 20% speak Spanish at home. The poverty rate in the FHMC service area is less than it is statewide, but about one in every four female heads of household in the area with children are living in poverty. In Los Osos and Paso Robles, that number jumps to more than 30%. About one-tenth of the people residing in the FHMC service do not have high school diplomas and one-third of residents have a bachelor’s degree or higher. San Luis Obispo City has been called “The happiest city in the United States” but even this city has not escaped the effects of a downward economy. Poverty increases the risk of many conditions, including poor nutrition, low birth weight, cognitive and developmental delays, unaffordable and inaccessible health care, decreased mental well-being, poor academic achievement, unemployment, and inadequate housing. Death rates for people below the poverty level are much higher than those above it. Low socioeconomic status is also associated with higher risks

of infectious diseases, accidents and homicides. 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% are MediCal eligible, and 11.9% of children live in poverty. The approximate number of uninsured individuals in San Luis Obispo County is estimated by CHIS (2009 California Health Interview Survey) to be 15.1%.

- B.** The population of FHMC's primary service area is approximately 169,938, with the greatest population being San Luis Obispo City and Paso Robles, at 27,949 and 44,379, respectively. Demographics at a glance provided by The Nielsen Company and 2012 Thomson Reuters data base:
1. Population (SLO County): 242,493
  2. Diversity %
    - Caucasian 70.5%
    - Hispanic 21.0%
    - Asian 3.4%
    - African American 2.0%
    - American Indian/Alaska Native 0.5%
    - 2+ races 2.4%
    - Others .2%
  3. Average income: \$74,235
  4. Uninsured: 16.1%
  5. No HS diploma: 11.3%
  6. Renters: 35.8%
  7. CNI Score: 3.4
  8. Medicaid Patients: 11.6%
  9. Other Area Hospital: Arroyo Grande Community Hospital, Sierra Vista Regional Medical Center and Twin Cities Hospital
- C.** The service area of French Hospital Medical Center has been designated as a Medically Underserved Area (MUA) and as a medically Underserved Population (MUP). The Community Health Centers of the Central Coast have six primary care health centers in the service area including a dental clinic in Templeton. All have Federal Qualify Health Center (FQHC) status.

## **Community Benefit Planning Process**

### **A. Community Health Needs Assessment Process**

In their community health needs assessment, French Hospital Medical Center included the voices of the people who live in their service areas and who represent the organizations and agencies that serve the hospital's population. Community Benefit staff determined that conducting primary qualitative research would be the best way to achieve this goal. The Dignity Health Central Coast Service area thus engaged Massachusetts-based Helene Fuchs Associates and the California-based STRIDE program at Cal Poly State University, San Luis Obispo. The research process began with Dignity Health staff working with Cal Poly's STRIDE program faculty and staff to design a qualitative study that would include focus groups with patients who use Dignity Health services, and whose zip codes correlated with the most neediest neighborhoods according to the CNI index, key informant interviews with representatives of

area agencies and organization, and hospital providers. Helene Fuchs Associates completed a Community Health Needs Assessment for French Hospital Medical Center in March 2012.

1. Dignity Health's Arroyo Grande Community Hospital and French Hospital Medical Center service area decided to use purposive expert sampling to identify key informants. Purposive expert sampling is useful when a study requires the opinions and thoughts of people who have a high level of knowledge in an area. Hospital staff members selected agency partners and key stakeholders as key informants who had special knowledge or expertise of the community. A total of 35 people participated in the focus groups. Two focus groups were conducted in Spanish with a total of 20 participants, and two focus groups were conducted in English with a total of 15 participants. A total of 9 key informants were interviewed. Helene Fuchs (HF) Associates compiled, organized, and analyzed the primary and secondary data. The research associates were graduate students and alumni of Tufts University's Friedman School of Nutrition Science and Policy, alumni and graduate students from the Tufts University Master of Public Health Program, and alumni of Simmons College Graduate School of Health Sciences and School of Management
2. Below is a summary including primary and chronic disease needs and health issues of the uninsured person. The key findings of the Community Health Needs tend to overlap each other into the same category. The findings of the needs assessment were the following:
  - Economic Disadvantage:** The primary research findings indicate that many residents in the FHMC service area are struggling to meet the basic needs of their families. The challenge of meeting one's basic needs means that families are unable to improve their lives in other ways, like taking parenting or language classes. Poverty is particularly high among women.
  - Access to Healthcare:** Access to healthcare was a major issue for both key informants and focus group participants. Secondary data findings confirm that this is a problem area. Key informants reported that there are numerous potential barriers to access, including health insurance status and delayed care, among others. Key informants and focus group participants indicated that residents often avoid seeking preventive care because they simply cannot afford it.
  - Emergency Department Utilization:** A key informant said that people avoid visits with primary care providers because they can't afford to pay for them, but that these same people can end up in the ED because they avoided seeking care earlier. It also is not unusual for people to go to the ED when healthcare is delayed or otherwise unavailable.
  - Navigating the System:** While some focus group participants acknowledged finding ways to "work the system," others find it challenging to navigate the system, understand what services are available to them, and determine how to access those services.
  - Clinical Conditions:** Obesity, Diabetes, Heart Disease, Stroke, Hypertension, Oral Health, and Mental Health were among the conditions mentioned by the participants of the focus groups. Lack of awareness, education, and support systems were some of the issues that the voiced.
  - Coordination and Continuity of Care and Social Services:** Insufficient coordination and continuity of care frequently were brought up as problems that leave people confused and at-risk. One English-speaking focus group participant said patients often are left to their own devices. People are concerned about the lack of continuity of care and the potential consequences.

**Services for the Elderly:** Focus group participants and key informants are concerned about the senior population. They feel that because people are living longer, the senior population is growing and experiencing more health and social problems.

**Diet and Nutrition:** Focus group participants and key informants talked about nutrition and poor eating habits in the FHMC service area and expressed a need for more nutrition education.

3. This assessment summary is on the website of French Hospital Medical Center. A copy can also be obtained by contacting the administrative offices of any of the three organizations.

## **B. Assets Assessment Process**

An inventory of community assets indicates that there are community resources that address the hospital community benefit priority areas of French Hospital Medical Center are described below.

1. Access to primary healthcare services is addressed through the primary care health centers that are located in the hospital service areas. The French Health Center, a Dignity Health Facility, located on the FHMC campus, offers primary care services. Community Health Centers of the Central Coast has six primary care health centers throughout the FHMC service area; all are Federally Qualified Health Centers including the primary care clinic at the Prado Homeless Day Center. SLO Noor Clinic is a free primary care adult clinic. Alliance for Pharmaceutical Access provides disease management to their clients by providing counseling services to assist in obtaining free medications. FHMC's Congestive Heart Failure program provides case management services and offers free telemonitors to CHF patients to assure patient compliance after discharge. FHMC's Hearst Cancer Resource Center offers cancer patients resources, expertise and support services needed to manage a cancer diagnosis. FHMC's Healthy for Life Nutrition series and Chronic Self Disease Management workshops offer free education on proper nutrition, and skills on how to better manage ones chronic illness. FHMC offers free monthly Diabetes support groups for patients with diabetes Types I and II. To address Health Promotion and Disease Prevention, First 5 and Community Health Centers of the Central Coast offer free classes to school age children on oral health. Childhood obesity is the focus of the Healthy Eating Active Living–San Luis Obispo coalition of which FHMC is a member. San Luis Obispo County Public Health Tobacco Control Program offers free smoking cessation classes. Cal Poly STRIDE Health Ambassadors collaborate with FHMC at health fair events, and Cal Poly interns volunteer in the FHMC Cardiac Rehabilitation department. FHMC offers their Cardiac Wellness program at offsite locations providing free lipid screening and risk assessments. Both French Hospital Medical Center and Sierra Vista Regional Medical Center offer a variety of community classes such as teen prenatal classes, breastfeeding, and infant CPR. French Hospital Medical Center provides English and Spanish lactation consultations at their breastfeeding clinic and local WIC clinics. FHMC offers a free monthly breastfeeding support group, and the Warmline, a breastfeeding information “hotline” to the community.
2. A number of community needs exist in the service areas of Dignity Health's three Central Coast hospitals. French Hospital Medical Center, Arroyo Grande Community Hospital, and Marian Regional Medical Center may realize efficiencies by working together to address the following common unmet community needs:
  - Access to Healthcare/ insurance
  - Emergency Room Utilization

Mental Health  
Clinical Conditions  
Oral health  
Transportation  
Cultural Awareness

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

### **C. Developing the Hospital's Implementation Plan**

1. The process for French Hospital Medical Center's Implementation Strategy was developed based on the community health needs assessment and findings, review of the most recent Community Benefit Report and Implementation Plan, the hospital's existing community benefit activities, and collaboration with local community agencies. FHMC's Community Benefit Committee provided leadership by chairing the Community Health Needs Strategic Planning Committee (CHSPC) meeting held on April 16, 2013. The CHSPC members included representatives from the county health department, mental health agencies, drug and alcohol agencies, community clinics, social services agencies, public transportation, and county representatives from the federal Medicaid insurance plan- CenCal. After a roundtable discussion, it was evident there were many more services offered in the San Luis Obispo County than the hospitals realized. Committee members reflected on the issues, focusing on health disparities and the availability of community resources to address the need. Committee members were given an opportunity to rank the top seven identified community health needs. The prioritization process identified four priority issues for the community:
  - Access to Healthcare/Insurance
  - Emergency Room Utilization
  - Mental Health
  - Clinical Conditions
2. The factors that were considered for this process were high utilization rates of the Emergency Room and the target population. Review of the Venn diagrams created for the CHNA's for French Hospital Medical Center and Arroyo Grande Community Hospital showed where there was agreement among the findings from data collected through focus groups, key informant interviews and secondary data collection. Results indicated seven common community health needs:
  - Access to Healthcare/ insurance
  - Emergency Room Utilization
  - Mental Health
  - Clinical Conditions
  - Oral health
  - Transportation
  - Cultural Awareness

An inventory of existing programs demonstrated that some programs exist that match community health needs. A summary of this analysis was created for use by the Community Health Needs Strategic Planning Committee.

FHMC, along with Arroyo Grande Community Hospital and Marian Regional Medical Center, will continue to work as the Dignity Health Central Coast Service Area to address the needs of the Central Coast in the most efficient matter. FHMC will continue to partner with community-based organizations, community health clinics and other community partners providing services and activities such as health fairs, free health screening events, and health education programs to promote, educate, and help bridge the gap between services and the underserved. As a result of the robust discussion among the community partners attending the CHSPC meeting, several possible solution strategies were identified.

3. The Community Health Needs Strategic Planning Committee has selected four initiatives to address:

**Access to Healthcare** : Expansion of clinic hours (evenings and weekends), communication campaigns to promote existing programs, investigating public transportation options near healthcare facilities and discharge planning/case management for patients being discharged from the hospital or emergency department. French Hospital Medical Center staff will join the existing Affordable Care Act coalition of SLO County to collaborate with other SLO County agencies to participate in a community approach to addressing some of these issues.

**Emergency Room Utilization**: By reviewing department reports, FHMC can analyze the patient visits to the Emergency Room, by the hour of the day, and the day of the week, and readmissions to the Emergency Room and/or hospital. While this analysis can help in understanding the patterns of ER Utilization, people will continue to use the Emergency Room in the absence of insurance coverage, and when there is limited access to community-based primary care. Referrals to the free SLO Noor Medical clinic will be one option for those that are uninsured.

**Mental Health**: Mental Health is a significant concern in SLO County. The county Public Health Department operates outpatient clinics for mental health and substance abuse patients and an inpatient Psychiatric Health Facility. Services provided by Transition Mental Health Inc. include: provision of housing for mentally ill, a 24 hour hotline, crisis intervention programs, case managers, and a homeless outreach team. These services and how to access them will be communicated in a more thorough manner to the FHMC providers and staff, as well as to family members and friends of persons with mental illness.

**Clinical Conditions** such as obesity, diabetes and poor dietary habits, are addressed in FHMC's Community Benefit Plan by offering nutrition classes in both English and Spanish, and the evidence-based Stanford Chronic Disease Self Management Program, which has shown decrease in ER usage by those that enrolled in the program. FHMC's Diabetes Program, accredited by the American Diabetes Association, offers one-on-one counseling sessions on nutrition, as well as glucose monitoring. Support groups for diabetes types I and II are offered to the community weekly. Many residents in the FHMC service area do not know how to navigate the system for needed service; they are unaware of existing services that might provide preventive care. A media and communication campaign was suggested both internally and externally to promote available services. This could enhance the limited continuity of care between providers in the community. Bilingual education should be provided for all programs since the Latino population is one of the target populations.

4. The three zip code areas with the most need identified in the French Hospital Medical Center primary service area are North San Luis Obispo (93405), Morro Bay (93442) and Paso Robles (93446) as determined by the Dignity Health Community Needs Index. These

three locations have the greatest need, so FHMC and the Community Health Needs Assessment Strategic Planning Committee will focus primarily on these zip codes.

5. French Hospital Medical Center will also focus on building community capacity by strengthening our partnerships among community-based organizations. By working together to identify, adopt, and develop programs to address these common areas of need, each of the hospitals may save valuable resources. However, it is important to be mindful of the population that each hospital serves and tailor programs to meet the needs of each hospital's unique population. This may mean modifying programs to suit cultural and/or language differences.
6. Based on the comparison of each hospital's assessment reports, French cannot directly affect the following community health needs but support through partnership and collaboration.  
**Oral Health** is addressed by the following community resources: Community Health Centers of the Central Coast offers dental services for both children and adults, SLO Noor Free Dental Clinic for adults; Tolosa Dental, CHDP, WIC, and DART address dental education, screenings and dental services.  
**Cultural Awareness** is a health need that can be addressed through other identified needs such as: Access to Healthcare, Emergency Room Utilization, Mental Health and Clinical Conditions. The key findings related to cultural awareness are: language barrier, awareness of existing services, affordability of care, inadequate use of preventive care, navigating the system and services for the elderly.  
**Transportation** is a key factor in addressing the identified community health needs, such as access to healthcare care, and many clinical conditions such as diabetes, nutrition, and asthma. Presently, FHMC offers free transportation vouchers to discharged patients who need them. Transportation will be incorporated into the implementation strategies of the Access to Healthcare and Clinical Conditions subcommittees.

#### **D. Planning for the Uninsured/Underinsured Patient Population**

1. FHMC follows the Dignity Health 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 Dignity Health Summary of Patient Financial Assistance Policy, Attachment )
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](http://www.frenchmedicalcenter.org) admitting staff educates all patients about the payment assistance policies.
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. Business Office 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 in advertisements that it turns no one away regardless of his/her ability to pay, if applicable.

# 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 2013/14. Based on findings in the Community Health Needs Assessment data and statistics 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.

For FY 2014 French Hospital Medical Center will implement/enhance programs as indicated by the priority Focus Areas. Survey data statistics, data in the Community Need Index, and hospital utilization data indicate three Priority Focus Areas for the fiscal year 2014. Programs intended to be operating in 2014 are noted by \*. Programs were developed in response to the current Community Health Needs Assessment and are guided by the five core principles.

## Priority Area 1: Access to Primary Healthcare Services

Charity Care for uninsured/underinsured and low income residents\*

Alliance for Pharmaceutical Access\*

Transportation vouchers for discharged patients\*

## Priority Area 2: Health Promotion / Disease Prevention

Healthy for Life Nutrition Lecture Workshop\*

Maternal Outreach\*

Community Blood Pressure Checks\*

Lipid/Glucose Screenings\*

## Priority Area 3: Disease Management

Congestive Heart Failure Program \*

Diabetes Prevention and Management \*

Hearst Cancer Resource Center Services\*

Healthy Living: Your Life Take Care\*

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Hospital Leadership team, the Community Board and Dignity Health receive quarterly updates on program performance and news.

# PROGRAM DIGESTS

<b>Healthcare Education and Disease Prevention</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input checked="" type="checkbox"/> Maternal Health
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Clinical conditions
<b>Program Description</b>	Provide San Luis Obispo county with opportunities to become proactive in their health by providing health- related education events in the French Hospital Medical Center (FHMC) service area.
FY 2013	
<b>Goal FY 2013</b>	Promote the chronic disease self-management program, childbirth teen education, lactation consultations, and related health prevention lectures and screenings to FHMC service area.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. The Chronic Disease Self-Management (CDSMP) program will decrease the number of visits to the ED room by 5% among the participants within 6 months from completion date of hospital's preventive health intervention.</li> <li>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 completion date of program.</li> <li>3. Increase attendance by 10% in both our Healthy for Life and Chronic Disease Self-Management Program.</li> <li>4. Increase community benefit prenatal classes and support group such as the Baby Hour and monthly number of births by 10 %.</li> <li>5. Increase number of teens or other disadvantaged women supported during their child birthing process by 10 %.</li> </ol>
<b>Baseline</b>	Number of people served through community education 1,912 screenings 1,039, Maternal Outreach for Moms (MOM): 1,583 persons served
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Promote CDSMP and HFL workshops using social media and other printed media outlets.</li> <li>2. Implement telephonic follow up of participants in the CDSMP and HFL programs at 3 and 6 months intervals after participants' completion date from the program.</li> <li>3. Collaborate and promote classes and birthing at French through OBGYN/CNM offices, local agencies and groups.</li> <li>4. Collaborate with TAPP to support teens going through the child birthing process as well as agencies working with homeless women, women in shelters and women in rehab programs</li> </ol>
<b>Result FY 2013</b>	<ol style="list-style-type: none"> <li>1. A total of 15 CDSMP program graduates completed their since 6 month follow up and reported neither ER usage nor hospitalizations.</li> <li>2. Thirty one of the graduates of the Healthy for Life (HFL) nutrition series reported a 5% increase in their consumption of fruits and vegetables.</li> <li>3. There was an overall 8% increase in attendance in both our HFL and CDSMP programs</li> <li>4. Childbirth education classes taught 1,969 students in FY 2013. Taught 1,621 students in FY 2012. Overall that is a 21% increase!</li> <li>5. Number of births for FY 2013 was 590, averaging 49 deliveries a month. Births for FY 2012 were 640, averaging 53 deliveries a month. Overall we had a 7.8%</li> </ol>

	decrease. 6. Teen childbirth classes for FY 2013 only 6 students attended class. In FY 2012 we taught 34 students. This is a decrease of 82%.
<b>Hospital's Contribution / Program Expense</b>	Hospital has provided in-kind space, nutrition services, advertising, printing, supplies for health fairs and screenings: \$ 83,232. Hospital provided the in kind advertisement and space for the childbirth classes and breastfeeding support group: \$ 243,991
<b>FY 2014</b>	
<b>Goal 2014</b>	Promote the chronic disease self-management program, childbirth teen education, doula program, and related health prevention lectures and screenings to FHMC service area
<b>2014 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. The Chronic Disease Self-Management (CDSMP) program will decrease the number of visits to the ED room by 5% among the participants within 3 months from completion date of hospital's preventive health intervention.</li> <li>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 completion date of program.</li> <li>3. Increase attendance by 10% in both our Healthy for Life and Chronic Disease Self-Management Program.</li> </ol>
<b>Baseline</b>	Number of people attending Healthy for Life nutrition program- 33, Chronic Disease Self-Management programs-27
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Promote CDSMP and HFL workshops using social media and other printed media outlets.</li> <li>2. 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.</li> <li>3. Train Promotoras in providing HFL workshops in Cambria, Paso Robles, and San Luis Obispo.</li> </ol>
<b>Community Benefit Category</b>	A1a. Community Health Education: Lectures/Workshops & C5. Women's and Children Service

<b>Hearst Cancer Resource Center</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Health
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Clinical Conditions
<b>Program Description</b>	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 hospitals in the Dignity Health Central Coast Service Area.
FY 2013	
<b>Goal FY 2013</b>	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.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Improve healthy eating habits for the prevention of cancer to Hispanic families by increasing attendance at the cooking series by 10%.</li> <li>2. Provide 3 outreach programs 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.</li> <li>3. Offer a skin cancer screening to the Latino population of the FHMC service area. Increase attendance by 10%. (22 individuals)</li> </ol>
<b>Baseline</b>	7,623 community members served through education, information, and referral, self help and support groups
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Collaborate with Hospice of San Luis Obispo County and The Wellness Kitchen to present "Home Cooking: Familiar Foods for Better Health" 4-week class in Spanish. Collect evaluations to determine the outcomes of the program.</li> <li>2. Promote through flyers, Latino support groups, churches and health educators.</li> <li>3. Partner with FHMC Community Benefits department on numerous SLO county health fairs using bi-lingual health educators to distribute educational cancer prevention pamphlets and information. Work with the SLO County Promotoras to outreach to the Hispanic community.</li> <li>4. Provide three onsite presentations at the senior self-help living facilities. Programs to include: Advance Directive in collaboration with FHMC CHF Nurse, Medicare Seminar partnership with HICAP and mini-demonstration of a HCRC programs. Evaluations will be distributed to determine the outcome of these programs.</li> <li>5. Partner with local oncologist and dermatologist to provide a skin cancer screening for Latino farmer workers in the fall of 2013. Forms and follow-up procedures will adhere to the standards of the Dermatologic Society.</li> </ol>
<b>Result FY 2013</b>	<ol style="list-style-type: none"> <li>1. Collaborated with The Wellness Kitchen to present "Home Cooking: Familiar Foods for Better Health" 4-week class in Spanish. 21 individuals attended. Unfortunately this is a decrease in attendance due to a schedule conflict with the Hispanic exercise class. However, on a positive note (as a result of this program) HCRC will offer in FY 2014, in collaboration with the CHC Childcare Provider program, a nutritional snack cooking series for the young Latino population.</li> <li>2. Registered dietitian assisted 172 cancer patients on the importance of good nutrition during and after cancer treatments.</li> <li>3. Participated in six offsite presentations which included the SLO Housing Authority Health Fair, two Health+Wealth+Estate Planning, Breast Cancer</li> </ol>

	<p>Awareness Fair, Atascadero State Hospital Employee Health Fair, and Wellness Health Exp. Information and presentations were given on HCRC programs and services. Total contacts 494.</p> <ol style="list-style-type: none"> <li>4. Sponsored six community educational programs which included Clinical Trials, Integrative Therapies in Breast Cancer, Nutrition Matters, Nurturing Your Health Women’s Health series, Spirituality and Cancer, Women’s Day Celebration. Total attendees 313.</li> <li>5. Partner with local oncologist and dermatologist to provide a free skin cancer screening for Latino population – residences at the Oak Park facility in Paso Robles. Eighteen individuals were screened with no suspicious spots or referrals.</li> </ol>
<b>Hospital’s Contribution / Program Expense</b>	HCRC and FHMC provided in kind space, nutritional services, advertisement, and printing. Expense: \$ 219,899
<b>FY 2014</b>	
<b>Goal 2014</b>	Improve the health and well-being of the underserved in the FHMC service area through education and screening for early detection and prevention of cancer.
<b>2014 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. To bring awareness of healthy eating for the prevention of cancer with the Latino population through increasing attendance of the Spanish Cooking series by 5%.</li> <li>2. Provide three outreach programs 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.</li> <li>3. Increase attendance to the skin cancer screening of the Latino population in the FHMC service area by 10%.</li> </ol>
<b>Baseline</b>	21 participants attended the Spanish Cooking series, 18 individuals were screened for skin cancer, 494 participants attended Cancer related/ prevention workshops
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>4. Collaboration with CAPSLO Child Care Resources Connection for a Latino Childcare Provider three-part lecture series and demonstration on cooking nutritious food for the younger Latino population. Work with the program coordinator in identifying the distribution of a healthy snack for children’s lunches.</li> <li>5. Collaborate with The Wellness Kitchen to present “Home Cooking: Familiar Foods for Better Health” a four-part lecture and demonstration series presented in Spanish. Collect evaluations to determine the outcomes of the program. Marketing and promotion will be focused on the various Latino organizations, clubs and housing associations.</li> <li>6. Partner with FHMC Community Benefits department on numerous SLO county health fairs using bi-lingual health educators to distribute educational cancer prevention pamphlets and information. Work with the SLO County Promotoras to outreach to the Hispanic community.</li> <li>7. Provide three offsite presentations in collaboration with SLO Housing Authority for the underserved senior population. Programs to include: Advance Directive in collaboration with FHMC CHF Nurse, Medicare Seminar partnership with HICAP and healthy-life style lecture for the prevention of cancer.</li> <li>8. Partner with local oncologist and dermatologist to provide a skin cancer screening for Latinos and the underserved population. Forms and follow-up procedures will adhere to the standards of the Dermatologic Society.</li> </ol>
<b>Community Benefit Category</b>	A1a. Community Health Education: Lectures/Workshops

<b>Cardiac Wellness</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Health
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Clinical Conditions
<b>Program Description</b>	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.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Screen at least 10 people for cardiovascular disease, including free Lipid Panel screening, every other month, for a total of at least 75.</li> <li>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.</li> <li>3. Refer at-risk individuals to a primary care practitioner for retesting and/or treatment.</li> <li>4. Participate in education and outreach activities including at least 2 Health Fairs, and 2 lecture presentations to groups.</li> <li>5. Target women for education and screening.</li> <li>6. Offer free screening CT Calcium Score tests for uninsured.</li> </ol>
<b>Baseline</b>	344 persons served
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Assess cardiac risk, including lipid screening at health fairs, free clinics, work-site wellness programs and other venues.</li> <li>2. Collaborate with other community agencies that serve those at-risk for cardiovascular disease.</li> <li>3. Educate groups or individuals regarding healthy lifestyle to reduce risk and prevent heart disease.</li> <li>4. Refer at-risk individuals to a primary care practitioner or clinic for retesting and/or treatment.</li> <li>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.</li> <li>6. Offer one educational presentation specifically regarding women and heart disease.</li> <li>7. Offer 12 free CT Calcium Score tests to uninsured clients whose MDs request this test.</li> </ol>
<b>Result FY 2013</b>	<ol style="list-style-type: none"> <li>1. 310 individuals screened for cardiovascular disease. 240 Lipid Panel screening tests done.</li> <li>2. 240 individuals educated regarding healthy lifestyle to reduce cardiac risk. Follow-up at 6 or 12 months with 10 individuals.</li> <li>3. 100% of at-risk individuals referred back to their primary care practitioner for retesting and/or treatment. If the client did not have a PCP, they were urged to initiate this relationship, and given resources to find a PCP, including Dignity Health's Find a Physician link and phone number, and/or contact information for CHC and SLO Noor Clinics.</li> </ol>

	<ol style="list-style-type: none"> <li>4. Participated in 6 Health Fairs and 3 lecture presentations.</li> <li>5. Women targeted for screening and education via Cal Poly Sorority and Cuesta College.</li> <li>6. Free CT Calcium Score tests not offered for uninsured after consultation with Medical Director.</li> </ol>
<b>Hospital's Contribution / Program Expense</b>	Hospital provided in kind space, nutritional services, advertising, and printing. Expense: \$ 13,628.
<b>FY 2014</b>	
<b>Goal 2014</b>	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area
<b>2014 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Screen at least 10 people for cardiovascular disease, including free Lipid Panel screening, every other month, for a total of at least 60.</li> <li>2. Educate 50 at-risk individuals regarding healthy lifestyle to reduce cardiac risk. Follow-up with 6 at-risk individuals at 6 or 12 months to track risk factor reduction in response to lifestyle change.</li> <li>3. Participate in education and outreach activities including at least 2 Health Fairs, and 2 lecture presentations to groups.</li> <li>4. Use promotoras to target 10 Hispanic women per quarter for heart disease risk screening.</li> </ol>
<b>Baseline</b>	240 free lipid screening provided, 19 follow ups done, 265 participants attending a cardiac wellness lecture.
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Assess cardiac risk, including lipid screening at health fairs, free clinics, work-site wellness programs and other venues.</li> <li>2. Collaborate with other community agencies that serve those at-risk for cardiovascular disease.</li> <li>3. Educate groups or individuals regarding healthy lifestyle to reduce risk and prevent heart disease.</li> <li>4. Refer at-risk individuals to a primary care practitioner or clinic for retesting and/or treatment.</li> <li>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.</li> <li>6. Offer one educational presentation specifically regarding women and heart disease.</li> <li>7. Train promotoras to use HeartAware cardiac risk assessment tool for heart disease risk screening</li> </ol>
<b>Community Benefit Category</b>	A1a. Community Health Education: Lectures/Workshops

<b>Congestive Heart Program</b>	
<b>Hospital CB Priority Areas</b>	<input 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
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Clinical Conditions
<b>Program Description</b>	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.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	Avoid hospital and ER admissions for 3 months among 80% of participants enrolled in the CHF Program.
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Identify all patients with a CHF diagnosis at high risk for readmission.</li> <li>2. Maintain the telephone based monitoring and Philips Home Monitoring Programs to prevent readmissions within 3 months of enrolling.</li> <li>3. Measure program satisfaction with a Satisfaction Survey.</li> <li>4. Enhance access to care with use of Meditech.</li> </ol>
<b>Baseline</b>	At the end of FY 2012 there were 139 participants in the CHF Program with a 4.4% readmission rate.
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Continue to offer the CHF Program to all inpatients with a diagnosis of heart failure.</li> <li>2. Provide hospital inpatients evidence based education regarding heart failure.</li> <li>3. Maintain Philips telemonitoring program for 50 patients of the Central Coast service area.</li> <li>4. Work with computer support to capture important data for telephonic assessments participants.</li> <li>5. Continue to collaborate with Dignity Health facilities as well as partners in the community (Community Health Clinic, Public Health Departments) to refer patients to the CHF Program.</li> <li>6. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers.</li> <li>7. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center.</li> <li>8. Utilize American Heart Association and American College of Cardiology resources and guidelines to continue education regarding heart failure as well as referrals to community based programs.</li> </ol>

<b>Result FY 2013</b>	Quarter/Yr	# of participants	# of readmission	% of readmission	program expense	
	Q1 9/12	131	10	7.6%	\$35,999	
	Q2 12/12	140	6	4.2%	\$29,796	
	Q3 03/13	122	7	5.7%	\$36,039	
	Q4 06/13	140	6	4.2%	\$26,392	
	<ol style="list-style-type: none"> <li>1. There was an average of 15 participants in the Philips Home Monitoring program this quarter. The trends reports were sent to CHF coordinator every morning by computer indicating any changes in the patient health. For example if the weight of the patient increased it might mean an increase in salt intake by the patient, CHF coordinator would then contact patient to adjust dietary intake.</li> <li>2. Telephonic calls were made to patient for 3 months after being discharged from the hospital to record if patient was being compliant and staying within the core measure parameters to avoid readmission.</li> <li>3. Patient satisfaction scores for all 3 hospitals: French Hospital Medical Center, Arroyo Grande Community Hospital, and Marian Regional Medical Center:</li> </ol>					
	Telehealth Patient Satisfaction Survey – 8 weeks					
		Definitely Not	I don't think so	Maybe	Yes, I think so	Yes, Definitely
	Telehealth equipment was easy to use	2.0%	1.0%	1.0%	19.2%	76.8%
	I would recommend Telehealth	0.0%	2.0%	2.0%	25.3%	70.7%
	1. Patient Satisfaction Survey Data for the period 8/11/12 – 7/13/2013					
<b>Hospital's Contribution / Program Expense</b>	This program serves cardiac patients and CHF clients in the community through education, risk assessment and referrals. Expense: \$ 123,509.					
<b>FY 2014</b>						
<b>Goal 2014</b>	Avoid hospital and emergency department admissions for 6 months among 80% of participants enrolled in the Congestive Heart Failure (CHF) Program.					
<b>2014 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Identify 100% of patients hospitalized at French Hospital Medical Center with a diagnosis of CHF and at risk for readmissions.</li> <li>2. Provide evidence-based health education to 100% of participants enrolled in the CHF program.</li> <li>3. Maintain Philips telemonitoring program for 50 patients in the Central Coast Service area.</li> <li>4. Returned satisfaction surveys on the questions “your overall evaluation of program” will be “very good” or “excellent”.</li> <li>5. Avoid hospital and emergency department admissions for 3 months among 80% of the enrolled participants in the CHF program.</li> </ol>					
<b>Baseline</b>	15 telemonitors on average were placed in patient's home for 30 days, 149 patients served in FY2013					
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Offer the CHF program to all inpatients with a diagnosis of CHF</li> <li>2. Implement telephonic assessment utilizing the newly constructed dignity health data-base with the ultimate goal of integrating it into Cerner.</li> <li>3. Track data-base and Midas reports for both the telemonitored and telephonic participants for outcomes and make program adjustments based on data derived.</li> <li>4. Collaborate with Dignity Health Facilities, Community Health Center, CDMSP, local skilled nursing facilities and cardiologist's offices.</li> <li>5. Partner with Dignity Health Home Health for referrals to the CHF program and</li> </ol>					

	collaborate on treatment plans with home health case managers. 6. Refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access and other identified community partners.
<b>Community Benefit Category</b>	A3e. Health Care Support Services: Information & Referral

<b>Diabetes Prevention and Management</b>																										
<b>Hospital CB Priority Areas</b>	<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																									
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance																									
<b>Link to Community Needs Assessment</b>	Clinical Conditions																									
<b>Program Description</b>	Provide a comprehensive evidence-based diabetes management program providing education with registered dietitian and/or nurse specialized in diabetes management. The program will improve behavior and self management practices of diabetic patients: enhance and improve the access and delivery of effective preventive health care services.																									
<b>FY 2013</b>																										
<b>Goal FY 2013</b>	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education.																									
<b>2013 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Establish a system for identifying patients with frequent re use of the emergency room for glycemic control issues.</li> <li>2. Identify resources and tools needed to meet these patients' needs and develop a plan for providing care.</li> <li>3. Pilot the use of the Phillips Monitoring Program blood glucose capabilities for patients in the CHF program who have diabetes.</li> <li>4. Utilize the nutrition department and diabetic educator to reach out and educate these patients and collaborate with CHF program lead on identifying needs for intervention.</li> <li>5. Continue with the diabetes support group and increase enrollment by 2%.</li> </ol>																									
<b>Baseline</b>	Diabetes Support Group 81 No data for Phillips Monitoring Program this will be new																									
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Identifying high risk patients that frequent the ER and determine the best process for following these patients after ER visit.</li> <li>2. Collaborate with current CHF coordinator to develop a system for identifying CHF patients with diabetes and referral to the nutrition department and diabetic educator.</li> <li>3. Modify the tool kit developed in 2012 to be used with the Phillips system.</li> <li>4. Pilot the use of the system with these patients for tracking blood sugar results and providing self management telephonic support.</li> <li>5. Track results such as: Patient Satisfaction, MD filling out glucose goals, re-admittance or ER visit for glycemic control issues. Diabetes Association best Practice guidelines and educational tools will be use.</li> </ol>																									
<b>Result FY 2013</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Quarter/Yr</th> <th style="text-align: center;"># of participants</th> <th style="text-align: center;"># of readmission</th> <th style="text-align: center;">% of readmission</th> <th style="text-align: right;">program expense</th> </tr> </thead> <tbody> <tr> <td>Q1/2013</td> <td style="text-align: center;">3</td> <td style="text-align: center;">8</td> <td style="text-align: center;">0%</td> <td style="text-align: right;">\$10,061</td> </tr> <tr> <td>Q2/2013</td> <td style="text-align: center;">9</td> <td style="text-align: center;">9</td> <td style="text-align: center;">11%</td> <td style="text-align: right;">\$359</td> </tr> <tr> <td>Q3/2013</td> <td style="text-align: center;">9</td> <td style="text-align: center;">0</td> <td style="text-align: center;">0%</td> <td style="text-align: right;">\$233</td> </tr> <tr> <td>Q4/2013</td> <td style="text-align: center;">21</td> <td style="text-align: center;">0</td> <td style="text-align: center;">0%</td> <td style="text-align: right;">\$231</td> </tr> </tbody> </table>	Quarter/Yr	# of participants	# of readmission	% of readmission	program expense	Q1/2013	3	8	0%	\$10,061	Q2/2013	9	9	11%	\$359	Q3/2013	9	0	0%	\$233	Q4/2013	21	0	0%	\$231
Quarter/Yr	# of participants	# of readmission	% of readmission	program expense																						
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<b>FY 2014</b>																										
<b>Goal 2014</b>	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education.																									

<b>2014 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Increase outreach and support by 2% to diabetics who are at high risk secondary to lack of primary care access and disease self management skills.</li> <li>2. Increase community opportunities by 2% for chronic disease self management via support groups and community lectures.</li> </ol>
<b>Baseline</b>	Diabetes Support Group- 93 Patients on telemonitors-2
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Identify high risk diabetic patients enrolled in the CHF program for both AG and French and follow up using Phillips education tools and monitoring system.</li> <li>2. Identify high risk patients from inpatient population at French Hospital via referrals from patient care coordinator.</li> <li>3. Service high risk diabetics without access to primary care at the Noor clinic.</li> <li>4. Utilize the nutrition department and diabetic educator to educate and provide support for these patients.</li> <li>5. Continue with the diabetes support group and increase enrollment by 2%.</li> <li>6. Offer one community diabetes education class series.</li> <li>7. Investigate developing support group for young adults.</li> <li>8. Develop a discharge packet for high risk diabetics providing low literacy education on survival care and resources in the area. Discharge packet would be targeted for all three facilities in the Central Coast and direct patients to appropriate outpatient resources and the support group.</li> <li>9. Follow identified patients for up to 3 months Track results such as: Patient Satisfaction, MD filling out glucose goals, re-admittance or ER visit for glycemic control issues. Diabetes Association best Practice guidelines and educational tools will be used.</li> </ol>
<b>Community Benefit Category</b>	A1c. Community Health Education: Individual Health Education for uninsured/under insured

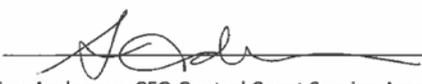
This implementation strategy specifies community health needs that the Hospital has determined to meet, in whole or in part, and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become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

# Community Benefit and Economic Value

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

8/20/2013  
 366 French Hospital Medical  
 Complete Summary - Classified Including Non Community Benefit  
 For period from 7/1/2012 through 6/30/2013

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<b>Benefits for Poor</b>						
Financial Assistance	3,147	837,686	0	837,686	0.9	0.8
Medicaid	6,214	15,750,758	10,491,739	5,259,019	5.4	5.2
Means-Tested Programs	840	1,684,925	442,823	1,242,102	1.3	1.2
<b>Community Services</b>						
Community Benefit Operations	17	59,478	0	59,478	0.1	0.1
Community Health Improvement	12,796	461,602	0	461,602	0.5	0.5
Financial and In-Kind Contributions	877	162,102	20,473	141,629	0.1	0.1
Subsidized Health Services	3,451	168,121	0	168,121	0.2	0.2
<b>Totals for Community Services</b>	<b>17,141</b>	<b>851,303</b>	<b>20,473</b>	<b>830,830</b>	<b>0.9</b>	<b>0.8</b>
<b>Totals for Poor</b>	<b>27,342</b>	<b>19,124,672</b>	<b>10,955,035</b>	<b>8,169,637</b>	<b>8.4</b>	<b>8.0</b>
<b>Benefits for Broader</b>						
<b>Community Services</b>						
Community Benefit Operations	0	22,470	0	22,470	0.0	0.0
Community Health Improvement	9,260	269,329	0	269,329	0.3	0.3
Health Professions Education	18	69,095	0	69,095	0.1	0.1
<b>Totals for Community Services</b>	<b>9,278</b>	<b>360,894</b>	<b>0</b>	<b>360,894</b>	<b>0.4</b>	<b>0.4</b>
<b>Totals for Broader Community</b>	<b>9,278</b>	<b>360,894</b>	<b>0</b>	<b>360,894</b>	<b>0.4</b>	<b>0.4</b>
<b>Totals - Community Benefit</b>	<b>36,620</b>	<b>19,485,566</b>	<b>10,955,035</b>	<b>8,530,531</b>	<b>8.8</b>	<b>8.4</b>
<b>Unpaid Cost of Medicare</b>	<b>30,381</b>	<b>44,449,956</b>	<b>34,725,645</b>	<b>9,724,311</b>	<b>10.0</b>	<b>9.6</b>
<b>Totals with Medicare</b>	<b>67,001</b>	<b>63,935,522</b>	<b>45,680,680</b>	<b>18,254,842</b>	<b>18.8</b>	<b>17.9</b>
<b>Grand Totals</b>	<b>67,001</b>	<b>63,935,522</b>	<b>45,680,680</b>	<b>18,254,842</b>	<b>18.8</b>	<b>17.9</b>

  
 Sue Anderson, CFO Central Coast Service Area, Dignity Health, Date

## **B. Telling the Story**

1. FHMC publishes articles regarding community benefits, community outreach, mission-driven events and community collaborations in our “Making a Difference” newsletter sent to physicians, community members and leaders, the FHMC Community Board, the FHMC Foundation Board, Dignity Health Corporate Office, and employees.
2. Press releases, television, radio and newspaper coverage have noted the many programs in which FHMC is involved. Much of the coverage focuses on the underserved population of San Luis Obispo County.
3. All brochures, patient instructions and other information are printed in Spanish. The FHMC website is also translated into Spanish. [www.frenchmedicalcenter.org](http://www.frenchmedicalcenter.org).
4. FHMC Community Health Needs Assessment, FHMC Community Benefit fiscal year 2013 and FHMC Implementation Plan fiscal year 2014 can be found online at [www.frenchmedicalcenter.org](http://www.frenchmedicalcenter.org) and on the Dignity Health website at [www.dignityhelath.org](http://www.dignityhelath.org).

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

Policy Overview:

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

Eligibility for Patient Payment Assistance:

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

Determination of Financial Need:

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

Patient Payment Assistance Guidelines:

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

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;

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

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

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

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

Budgeting and Reporting:

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

Relationship to Collection Policies:

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

Regulatory Requirements:

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

Attachment A

# THOMPSON/DIGNITY HEALTH COMMUNITY NEEDS INDEX

Market Name: French Hospital Medical Center

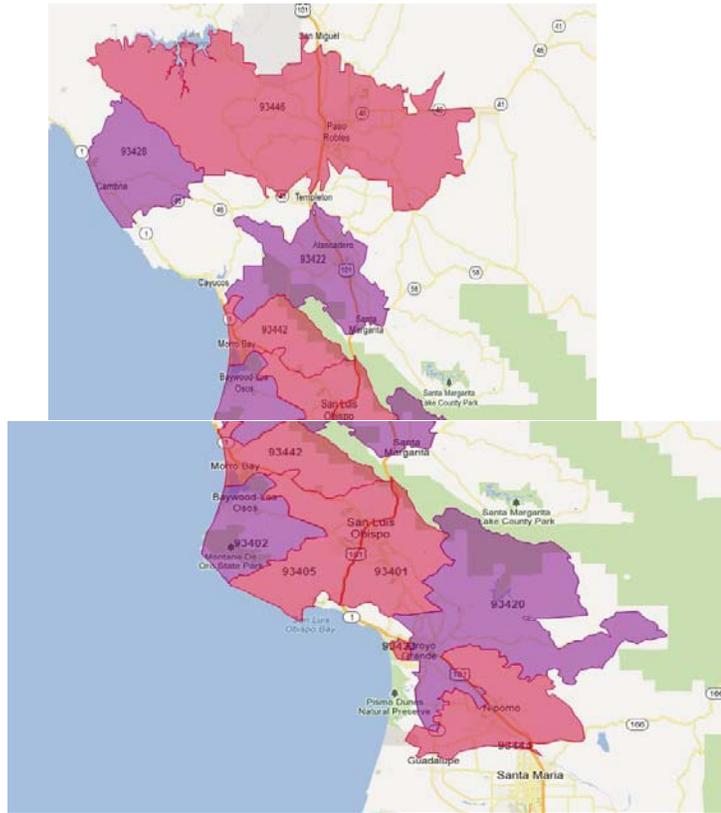
Market 2011 Population: 233,399

CNI Median Score: 3.4

Zip Code	STATE	COUNTY	City	2011 Population	2011 CNI	2010 CNI	% HH in poverty, HoH 65+	% families w/kids < 18 in poverty	% families single mother w/kids < 18 in poverty	Income Quintile	% age > 5 w/no English	% pop. minority	Cultural Quintile	% pop. > 25 w/no HS diploma	Education Quintile	% pop. in labor force unemployed	% pop. No health insurance	Insurance Quintile	% HH renting	Housing Quintile	Income Barrier	Cultural Barrier	Education Barrier	Insurance Barrier	Housing Barrier
93401	CA	SLO	San Luis Obispo	27,949	3.4	3.4	5.9%	8.0%	21.0%	2	1.7%	23.7%	4	7.4%	1	6.9%	24.6%	5	51.7%	5	23.2%	23.8%	7.4%	25.6%	51.7%
93402	CA	SLO	Los Osos	13,886	2.8	2.8	4.6%	9.0%	20.7%	2	2.4%	21.5%	4	6.9%	1	5.0%	14.6%	3	32.8%	4	23.0%	21.6%	6.9%	15.5%	32.8%
93405	CA	SLO	N. San Luis Obispo	31,183	3.8	3.8	3.9%	5.0%	26.6%	2	0.9%	40.7%	5	9.5%	2	13.8%	36.6%	5	59.3%	5	26.8%	40.6%	9.5%	39.1%	59.3%
93420	CA	SLO	Arroyo Grande	28,603	3	3	5.4%	6.8%	18.7%	2	1.3%	19.0%	4	10.6%	2	5.6%	14.3%	3	28.7%	4	20.5%	19.0%	10.6%	15.3%	28.7%
93422	CA	SLO	Atascadero	32,403	3.2	3.2	6.0%	9.9%	24.6%	2	0.6%	19.3%	4	10.2%	2	5.7%	14.6%	3	33.9%	5	27.2%	19.3%	10.2%	15.7%	33.9%
93428	CA	SLO	Cambria	6,717	2.8	3	5.3%	12.5%	19.8%	2	3.6%	22.6%	4	7.8%	1	5.0%	14.5%	3	28.3%	4	23.6%	22.9%	7.8%	15.3%	28.3%
93433	CA	SLO	Grover Beach	12,844	3.6	3.6	9.3%	10.5%	19.7%	2	4.8%	33.9%	4	15.6%	3	7.2%	19.0%	4	50.6%	5	23.7%	34.2%	15.6%	20.3%	50.6%
93442	CA	SLO	Morro Bay	10,842	4	4	8.1%	14.2%	45.9%	4	3.1%	20.5%	4	8.6%	2	5.3%	27.0%	5	45.7%	5	48.5%	20.7%	8.6%	27.3%	45.7%
93444	CA	SLO	Nipomo	18,894	3.4	3.2	5.9%	7.7%	24.3%	2	6.7%	40.4%	5	18.7%	4	7.8%	11.4%	3	24.2%	3	26.1%	40.9%	18.7%	13.2%	24.2%
93446	CA	SLO	Paso Robles	44,379	3.8	3.8	9.5%	13.2%	24.6%	3	5.9%	33.4%	4	15.3%	3	7.6%	17.2%	4	33.5%	5	29.1%	33.8%	15.3%	18.7%	33.5%

Attachment B

## French Hospital Medical Center CNI Map



	<b>Lowest Need</b>						<b>Highest Need</b>		
	<b>1 - 1.7 Lowest</b>		<b>1.8 - 2.5 Lower</b>		<b>2.6 - 3.3 Mid</b>		<b>3.4 - 4.1 Higher</b>		<b>4.2 - 5 Highest</b>

<b>CNI</b>						
<span style="color: red;">■</span>	<span style="color: purple;">■</span>	<span style="color: red;">■</span>	<span style="color: purple;">■</span>	<span style="color: red;">■</span>	<span style="color: purple;">■</span>	<span style="color: red;">■</span>
<u>Zip Code</u>	<u>Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>	
93401	3.4	27,949	San Luis Obispo	San Luis Obispo	California	
93402	2.8	13,886	Baywood-Los Osos	San Luis Obispo	California	
93405	3.8	31,183	N. San Luis Obispo	San Luis Obispo	California	
93420	3.0	28,603	Arroyo Grande	San Luis Obispo	California	
93422	3.2	32,403	Atascadero	San Luis Obispo	California	
93433	3.6	12,844	Grover Beach	San Luis Obispo	California	
93444	3.4	18,894	Nipomo	San Luis Obispo	California	
93442	4.0	10,842	Morro Bay	San Luis Obispo	California	
93446	3.8	44,379	El Paso de Robles (Paso Robles)	San Luis Obispo	California	
93428	2.8	6,717	Cambria	San Luis Obispo	California	

**CNI Median Score: 3.4**

Attachment C

## French Hospital Medical Center Community Board Fiscal Year 2013

Jim Copeland  
**Chair of the Board**  
Copeland's Properties

Kevin M. Rice  
**Vice –Chair of the Board**  
Retired Pismo Beach City Manager

Patricia Gomez  
**Secretary**  
Attorney-at-Law

Father Russell Brown  
Pastor SLO Old Mission Church

Michael DeWitt Clayton, MD  
Urology Associates

Robert Doria, MD  
Coastal Cardiology

Sandy Dunn  
Foundation Board Chair

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

Sister Linda Gonzales  
Retired Teacher/Administrator

Alan Iftiniuk  
President, French Hospital Medical Center

Ben Kulick  
President, Stalfund, LP

Jim Lokey  
Retired Executive Banker

Sandee McLaughlin  
VP Student Services and College Centers,  
Cuesta College

Rabbi Norman Mendel  
Rabbi Emeritus, Congregation Beth David

Kerry Morris  
COO, Morris & Garritano Insurance

Cornel Morton, PhD  
Senior Advisor to the President for Outreach

Sister Marianne Rasmussen, OSF  
Retired Teacher/Administrator

J Trees Ritter, DO  
Chief of Staff

John Ronca Jr.  
Attorney-at-Law

Wayne Simon  
Attorney-at-Law

Mark Soll, M.D.  
Central Coast Chest Consultants

Antonia Torrey, RN, PhD  
Nurse Educator, Cuesta College

Dee Torres  
Director, EOC Homeless Services

Ke-Ping Tsao, MD  
Plastic Surgeon

### **Hospital Staff:**

Sue Andersen  
VP Finance for the Central Coast

Eugene Keller, MD  
VP Quality for the Central Coast and FHMC  
VPMA

Carla Adams  
FHMC COO/CNE

Attachment D

**FHMC Community Benefits Committee  
Fiscal Year 2013**

Patricia Gomez  
Attorney-at-Law  
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 Norman Mendel  
Rabbi Emeritus, Congregation Beth David

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

Debby Nicklas  
Vice President, Philanthropy and Mission Services

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

JoAnn Costa  
Facility Privacy and Compliance Officer and Mission Integration Director  
Central Coast Service Area

Sandy Underwood  
Senior Community Education Coordinator – MRMC  
Central Coast Service Area

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

Kathleen Sullivan  
Vice President- Post Acute Care Services  
Central Coast Service Area

Attachment E