



French Hospital Medical Center

Community Benefit Report 2014
Community Benefit Implementation Plan 2015

A message from Alan Iftiniuk, President, and Kevin M. Rice, Community Board Chair, for Dignity Health French Hospital Medical,

The **Hello Humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At French Hospital Medical Center we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501(r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 10 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report their communities benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities and are proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

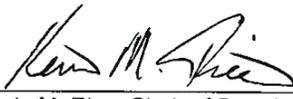
In fiscal year 2014 French Hospital Medical Center provided \$7,539,369 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$18,630,851.

Dignity Health's French Hospital Medical Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their September 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 805-542-6268.

(Signatures)



Alan Iftiniuk, President, President

Kevin M. Rice, Chair of Board

TABLE OF CONTENTS

Executive Summary	4
Mission Statement	
Dignity Health Mission Statement.....	6
Organizational Commitment	
Organizational Commitment	7
Non-Quantifiable Benefit	7
Community	
Definition of Community	9
Description of the Community	9
Community Demographics	9
Community Benefit Planning Process	
Community Health Needs Assessment Process.....	10
Assets Assessment Process	10
Developing the Hospital's Implementation Plan (Community Benefit Report and Plan).....	11
Planning for the Uninsured/Underinsured Patient Population.....	12
Plan Report and Update including Measurable Objectives and Timeframes	
Summary of Key Programs and Initiatives – FY 2015.....	13
Description of Key Programs and Initiatives (Program Digests)	13
Community Benefit and Economic Value	
Report – Classified Summary of Un-sponsored Community Benefit Expense	25
Telling the Story.....	26
Attachments	
A. Summary of Patient Payment Assistance Policy	27
B. French Hospital Medical Center CNI Map	29
C. French Hospital Medical Center Community Board.....	30
D. French Hospital Medical Center Community Benefit Committee	31

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 in 2004. The facility has 103 licensed beds, and the campus is approximately 15 acres in size. FHMC has a staff of more than 500, and professional relationships with more than 330 local physicians, and more than 130 volunteers. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics. This year FHMC became the home to the Central's Coast's first and only cardiac hybrid suite, a space where interventional radiologists, cardiologist, and cardiovascular surgeons can work side-by-side in the same room at the same time. The George Hoag Family Advanced Hybrid Surgical Suite delivers the latest in high-tech imaging, computer, and diagnostic equipment and newly developed surgical capabilities to a traditional cardiovascular catheterization lab. The Osteoporosis Resource Center also opened this year which offers a range of comprehensive services focusing on the evaluation and management of patients with osteoporosis, as well as a number of free community services and educational programs.

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

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 an evidence-based Chronic Disease Self Management program, were offered at multiple community locations within the 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 people in attendance about health care resources that are available in the communities. The Prenatal and New Parent Education Program continue to provide free community classes to first time mothers and their families. Our breastfeeding clinic in San Luis Obispo and lactation counseling at the local Women, Infant, and Child (WIC) clinics has provided 4,326 lactation consultations for fiscal year 2014.

The **Diabetes Prevention and Management Program** continues to offer free Diabetes Type I and II support groups which meet monthly, offering participants the latest diabetes information and education. This year the program enhanced their education by providing their Diabetics Conversations series to care givers and their clients in group home settings. One agency was Options that benefited greatly from this series was Options, a nonprofit organization dedicated to helping people with disabilities.. The goal was to provide educational tools for caregivers to use in the group homes. Low literacy visuals were developed and interactive techniques were demonstrated to help engage the clients. Discussions focused on how to get the clients to eat better, test more, and to explain medications work. The series also focused on preventing blood sugar excursions to avoid ER visits.

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 San Luis Obispo Noor Clinic, Oak Park Housing Development, and San Luis Obispo Housing Authority Developments.

The **Congestive Heart Failure Program (CHF)** continues to bridge the medical and educational needs of patients living with heart failure through a collaborative effort between the hospital, home health and the physicians' offices. This program is successful in decreasing the severity of the illness for most program participants and in minimizing readmission of patients. The use of tele-health and tele-monitors to build a support of remote health service delivery, based on reliable, easy-to-use, integrated technology that supports equitable access for patients and efficiency for clinicians. This support 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.

The **French Hospital Medical Center Community Grants Program** is an important way to fulfill our mission through creative partnerships. Each year, non-profit organizations apply for grants of up to \$25,000 based on French Hospital Medical Center initiatives, core community benefits principles, and community health needs. This year FHMC gave a total of \$48,051 in community grants. Organizations receiving grants from French Hospital Medical Center during the 2014 fiscal year included: Applied Pharmaceutical Access (APA), Cancer Well Fit Inc., Coast Caregiver Resource Center, Community Counseling Center, SLO County Child Abuse Prevention Center: Promotoras Collaborative, SLO Noor foundation and Women's Shelter of SLO County.

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 primarily on the needs of the poor.

FHMC's fiscal year 2014 Community Benefit Report and fiscal year 2015 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 FY2014 is \$7,539,369 which excludes the unpaid costs of Medicare of \$11,091,482. Including the unpaid cost of Medicare, the total expense for fiscal year 2014 was \$18,630,851.

MISSION STATEMENT

A. FRENCH HOSPITAL MEDICAL CENTER

Dignity Health 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.

B. HELLO HUMANKINDNESS

As Dignity Health turns the page in our history, our core mission, vision, and values remain untouched, unwavering, and as true as ever. We step into our future with a strength that comes from our past. Today, we build on this foundation to give our name meaning in an ever-changing world. Our message comes from our values: Dignity, Collaboration, Justice, Stewardship and Excellence. Hello humankindness is a movement in the making. Dignity Health's commitment to healing through humankindness is what makes us different from other health care brands. But turning a belief into a movement will take every single employee, physician and volunteer. We truly believe that, together, our humanity and kindness create something that this profession—and the world at large—needs. Our shared humanity is what wakes us in the morning. Our shared kindness is what we give without hesitation, without thought or ever asking for in return. Humankindness isn't an ideal; it's our guiding light, it's the fire within. Lloyd Dean, President and CEO of Dignity Health hosted the Central Coast Service Area kick off for Hello humankindness at Cal Poly University on April 1, 2014. The central coast service area hosted the first Hello Humankindness Retreat on June 18, 2014. This retreat was an exciting and interactive session designed to share more information about Hello humankindness

ORGANIZATIONAL COMMITMENT

A. Hospital's Organizational Commitment

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.
 - 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.
2. Rosters of Community Board and Community Benefit Committee members are found at Appendix C.

B. Non-Quantifiable Benefits

1. There are many examples of non-quantifiable benefits related to the community contribution of French Hospital Medical Center. Working collaboratively with community partners, the hospital provided leadership and advocacy, stewardship of resources, assisted with local capacity building, and participated in community-wide health planning. The following are some non-quantifiable services:
 - **Ecology**-The newly combined Environmental Action Committee and Mission Integration committee meets monthly and supports many environmental "green projects" including recycling electronic waste, fluorescent tubes, cooking oil, paper, batteries, writing instruments and plastic. With these efforts it is estimated that FHMC has kept over 49.14 tons of recycle products out of the landfill. In FY 2014 alone, 98,296 pounds of product were recycling with a cost saving of \$11,945.86. With the remodeling of our facilities we are able to recycle many of our old furnishing. This year three large counter tops and cabinets were donated to the Coastal Christian Schools for their classrooms. This year the Mission Integration donated and planted a fruit tree at the Prado day homeless shelter in honor of Earth Day 2014.

- **Stewardship**-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 hospital also provides in kind medical supply donations to Reaching for the Stars and Camp Hapitok which are camps for children with special needs.
- **Community Building Activities**-French Hospital Medical Center engages in a variety of essential community building activities as a means to further the mission of advocacy, partnership, and collaboration. Activities during FY2014 included executive, system leadership and staff involvement in community boards such as: Cencal Health Board, Hospital Council of Northern and Central California Board, American Association, YMCA of SLO County, San Luis Obispo Health Commission, Adult Services Policy Council, Long term Ombudsman program, Healthy Eating Active Living (HEAL-SLO), Latino Outreach Council, ACTION: For Healthy Communities, and Promotoras Collaborative of SLO County.

COMMUNITY

A. Definition of Community

1. 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.
2. 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. There were a total of 274,804 people in San Luis Obispo County in 2012. The majority of residents 70.5% identified as White, followed by 21% as Hispanic/Latino, and 3.4% as Asian. Thirty-one percent were between the ages of 35 and 59 years old. Seniors over the age of 60 are the fastest growing group in the county at 24% in 2012, an increase from 19% in 2006. Eighty-one percent only spoke English in their household, 15.4% spoke Spanish, 1.9% spoke Asian and Pacific Islander language, 1.9% spoke other Indo-European language and .3% spoke other language in their household. 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%. According to Department for Human and Health Services Federal Register Poverty Guidelines 2006-2013, in 2012, there were 12,605 households in San Luis Obispo County living in poverty (12% of all households). San Luis Obispo County saw an increase in the percentage of children living below the federal poverty level from 9% in 2006 to 15% in 2012. 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.
3. The demographics of French Hospital Medical Center's service area are more clearly defined below as identified in the 2012 Census data and which are reported on the Schedule H 990.
 - Population: 242,493
 - Diversity %: Caucasian 70.5% | Hispanic 21% | Asian 3.4% | African American 2% | American Indian/Alaska Native 0.5% | 2+ races 2.4% | Other 0.2%
 - Average Income: \$74,235
 - Uninsured: 16.1%
 - Unemployment: 5%
 - No HS Diploma: 11.3%
 - Renters: 35.8%
 - CNI Score: 3.6
 - Medicaid Patients: 11.6%
 - Other Area Hospitals: Arroyo Grande Community Hospital, Sierra Vista Regional Medical Center, and Twin Cities Hospital
4. 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

1. In our community health needs assessment, French Hospital Medical Center conducted primary qualitative research and included the voices of the people who live in our service areas and who represent the organizations and agencies that serve the hospital's population.
 - 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.
2. 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
3. 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
4. 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
 - Access to Healthcare
 - Emergency Department Utilization
 - Navigating the System
 - Clinic Conditions
 - Coordination and Continuity of Care and Social Services
 - Services for the Elderly
 - Diet and Nutrition
5. This assessment summary is on the website of French Hospital Medical Center as well as on the Dignity Health Website: www.frenchmedicacenter.org and www.dignityhealth.org . A copy can also be obtained by contacting the administrative office of FHMC.

B. Assets Assessment

1. An inventory of community assets indicates that there are community resources that address the hospital community benefit priority areas of French Hospital Medical Center.
2. 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 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 tele-monitors 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 breastfeeding, baby hour,, 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.

C. Developing the Hospital's Implementation Plan (Community Benefit Report and 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
3. The 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 FHMC has partnered with Alliance for Pharmaceutical Assess (APA) to not only facilitate our patients in obtaining their medications for free or at low cost but also as a certified state agency for Covered California to enroll those that need health insurance. The use of Promotoras (Health Outreach Workers) has increase awareness and attendance among the Latino community in our nutrition, chronic disease management programs, free screenings clinics and health fairs.
4. The four zip code areas with the most need identified in the French Hospital Medical Center primary service area are North San Luis Obispo (93405 & 93401), Morro Bay (93442) and Paso Robles (93446) as determined by the Dignity Health Community Needs Index. Four locations have the greatest need, which indicate a high percentage of residents living below the federal poverty level as well as having no health insurance. FHMC and the Community Health Needs

Assessment Strategic Planning Committee will focus primarily on these zip codes.(CNI zip code map attachment B)

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. Our Readmission Team continual use of RRAT (Readmission Reduction Assessment Tool) which is a tool used across the system to identify patients who are high risk for readmission. It is an assessment done on admission to and is used to alert appropriate staff so that interventions to prevent readmissions can be implemented Currently, FHMC nursing and case management staff are closely tracking all readmissions and, as best as possible, identifying the primary cause. The FHMC nursing staff and case management staff work closely with the Patient Care Coordinators to develop processes with the hope will improve communication across the continuum of care. Cost analysis of our discharged patients, our community benefit programs, and making sure that our patients have access enrolling in the Covered California insurance and the items mention earlier will continue to help contain the growth of community health care costs. To meet the needs for all patients to have a medical home, there is a RN Patient Care Coordinator program in place. The Patient Care Coordinator initiative focuses the hospital's care transitions work with the goal of assuring all evidence based interventions are completed in order to effect a safe and effective transition of the patient back to the community. Currently case managers, social workers and physicians can refer patients to the French Health Center and Community Health Center Clinics; both of which serve as medical homes. Inpatient discharges from French Hospital are being seen consistently when referred to either of these two resources within 72 hours. A Call Center has been contracted to assist unassigned patients with finding a primary care physician/medical home. The phone number for assistance and an available community physicians' roster appear is posted on the website.
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 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 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

- A. Below are major initiatives and key community-based programs operated or substantially supported by French Hospital Medical Center in 2014/15. Based on findings in the Community Health Needs Assessment data and statistics and hospital utilization data, FHMC has selected five 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.
- B. For FY 2015 French Hospital Medical Center will implement/enhance programs that address the priority focus areas that were derived from survey data statistics, data in the Community Need Index, and hospital utilization data. These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Executive Leadership, Community Board and Dignity Health receive regular program updates. Noted below are the programs.
- **Priority Area 1: Access to Healthcare Services**
 - Charity Care for uninsured/underinsured and low income residents
 - Alliance for Pharmaceutical Access
 - Transportation vouchers for discharged patients
 - Patient Care Coordinator Initiative
 - **Priority Area 2: Emergency Room Utilization**
 - Alliance for Pharmaceutical Access
 - FHMC Patient Care Coordinators
 - **Priority Area 3: Clinical Conditions**
 - Healthy for Life Nutrition Lecture Workshop
 - Maternal Outreach
 - Community Blood Pressure Checks
 - Lipid/Glucose Screenings
 - Congestive Heart Failure Program
 - Diabetes Prevention and Management
 - Hearst Cancer Resource Center Services
 - Healthy Living: Your Life Take Care
 - **Priority Area 4: Mental Health**
 - Dignity Health Community Grants process sent Letters of Intent to local community agencies that support clients with mental health issues.
 - Work with community based organizations that provide mental health services by providing facility use: in kind printing for Motivational Interviewing Training offer on February 20, 2013, workshops, and /or brochures.
- C. **PROGRAM DIGEST:** The following pages include Program Digests for key programs that address one or more of the Initiatives listed above.
- Chronic Disease Self-Management Program (CDSMP), (formerly Health Care Education & Disease Prevention)
 - Hearst Cancer Resource Center
 - Cardiac Wellness
 - Heart Failure Program (formerly Congestive Heart Failure Program)
 - Dignity Health Community Grants

Chronic Disease Self-Management Program (CDSMP)

Formerly Health Care Education & Disease Prevention

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Health care Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
Program Emphasis	Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Clinical Conditions ,Emergency Room Utilization and ,Access to Primary Healthcare Services
Program Description	A six session Chronic Disease Self Management Workshop that teaches participants to understand their chronic condition and how to respond to it by becoming a skilled self-manager on a continuing basis.
FY 2014	
Goal FY 2014	Promote the chronic disease self-management program, childbirth teen education, doula program, and related health prevention lectures and screenings to FHMC service area
2014 Objective Measure/Indicator of Success	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. 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. 3. Increase attendance by 10% in both our Healthy for Life and Chronic Disease Self- Management Program.
Baseline	Number of people attending Healthy for Life nutrition program- 33, Chronic Disease Self-Management programs-27
Intervention Strategy for Achieving Goal	1. Promote CDSMP and HFL workshops using social media and other printed media outlets. 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 3. Train Promotoras in providing HFL workshops in Cambria, Paso Robles, and San Luis Obispo
Result FY 2014	1. A total of 12 CDSMP program graduates completed their since 6 month follow up and reported neither ER usage nor hospitalizations. 2. A total of twenty eight of the graduates of the Healthy for Life (HFL) nutrition series reported a 5% increase in their consumption of fruits and vegetables. 3. There was a 7 % increase in attendance in our HFL and a 1% decrease in attendance in CDSMP programs due to lack of Spanish speaking lay instructor to conduct a workshop in Spanish and cancellation of workshops due to low attendance. 4. Our Healthy for Life expanded to include Youth nutrition series at afterschool programs in the Paso Robles are. One hundred and thirty seven children went through out Healthy for Life children's program. 5. Four Promotoras were trained to teach HFL classes and where schedule to co-teach with the community benefit coordinator.
Hospital's Contribution / Program Expense	Hospital has provided in-kind space, nutrition services, advertising, printing, supplies for health fairs and screenings:\$ 99,992.
FY 2015	
Goal 2015	The evidence-based chronic disease self management programs (CDSMP) offered to the community, will offer the participants in the program empowerment skills to better self-care through enhanced self-efficacy.
2015 Objective Measure/Indicator of Success	1. The Chronic disease self-management program will decrease the number the number of visits to the Emergency room by 5% among the program participants within 90 days from completion date of the workshop. 2. Increase attendance by 30% in the Chronic disease self –management workshops. 3. Thirty percent of the chronic disease self management program participants will identify 2 coping techniques they are using at 90 days after completion date of the workshop.
Baseline	Chronic Disease Self-Management programs participants-12
Intervention Strategy for Achieving Goal	1. Train lay leaders in both English and Spanish to increase the number of workshops offered. 2. Implement telephonic follow up of graduated participants of Chronic disease self management program at 90 days of completion of workshop. 3. Offer 4 Chronic Disease Self Management Program workshops in the FHMC service area.
Community Benefit Category	A1a- Community Health Education: Lectures/Workshops

Hearst Cancer Resource Center	
Hospital CB Priority Areas	<input type="checkbox"/> Access to Primary Health care Services <input type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Clinical Conditions
Program Description	The Hearst Cancer Resource Center provides no cost information, education, and support services for cancer patients and their families. The center is staffed with qualified personal and collaborates with existing services.
FY 2014	
Goal FY 2014	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.
2014 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 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%. 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. Increase attendance to the skin cancer screening of the Latino population in the FHMC service area by 10%.
Baseline	21 participants attended the Spanish Cooking series, 18 individuals were screened for skin cancer, 494 participants attended Cancer related/ prevention workshops
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 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. 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. 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. 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. 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.
Result FY 2014	<ol style="list-style-type: none"> Collaboration with CAPSLO Child Care Resources Connection and The Wellness Kitchen for a Latino Childcare Provider three-part lecture series and demonstration on cooking nutritious food for the younger Latino population. Total of 97 attended the workshops from Nipomo to Paso Robles. (93444, 93446, 93420, 93422, 93433). Our goal of 5% was reached. Register dietitian assisted 127 cancer patients on the importance of good nutrition during and after cancer treatments. Participated in thirteen offsite health fairs and events ranging from Cancer Wellness Fair, French Hospital Medical Center's "Nurture Your Health" series, SLO County Employee Health Fair to San Luis Obispo's Health and Wellness Expo. Cancer prevention and information was distributed at all offsite events. Total contacts - 624. (93401, 93420, 93422, 93428, 93433, 93446, 93449) Sponsored seven community educational programs which included Clinical Trials, Nutrition Matters, Nurturing Your Health Women's Health series, Managing Grief & Loss, Palliative Care Lecture, Self-Hypnosis Lecture & Women's Day Celebration. Total attendees 133. (93401, 93420, 93422, 93428, 93433, 93446, 93449) Skin Cancer Screening for the Senior and Latino population in conjunction with the SLO Housing Authority. Two physicians (local oncologist and a dermatologist) were assisted by one certified medical interpreter and a nurse navigator. Eighteen individuals were screened with no suspicious spots or referrals. (93401)
Hospital's Contribution / Program Expense	Hearst Cancer Resource Center and FHMC provided in kind space, nutritional services, advertisement, and printing. Expense: \$351,509.

FY 2015	
Goal 2015	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.
2015 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. To bring awareness of a culturally-appropriate healthy diet for the prevention of cancer in the Latino population through increasing attendance of the Spanish Cooking series by 5%. 2. Develop an increased awareness of transportation resources in the FHMC service area by 5% of the 2015 fiscal year. 3. Increase attendance to the skin cancer screening of the Latino population in the FHMC service area by 10%. 4. Launch a breast cancer outreach and navigation program to increase awareness of breast health, screening and navigation services to the uninsured and underinsured Spanish speaking population by 25%.
Baseline	16 participants attended the Spanish Cooking series, 18 individuals were screened for skin cancer, 412 participants attended Cancer related/ prevention workshops
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Collaboration with CAPSLO Child Care Resources Connection for a Latino Childcare Provider three-part lecture series and demonstration on healthy recipes to educate the younger Latino population and childcare provider. Work with the program coordinator in identifying the distribution of a healthy snack for children's lunches. 2. In collaboration with San Luis Obispo Mission and The Wellness Kitchen to present "Home Cooking: Familiar Foods for Better Health" a lecture and demonstration series presented in Spanish targeting the uninsured and underinsured Hispanic population. Collect evaluations to determine the outcomes of the program. Marketing and promotion will be focused on the various Latino organizations, clubs and housing associations. 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 offsite presentations in collaboration with SLO Housing Authority for the underserved senior population. Programs to include: Advance Directive, Medicare Seminar partnership presented by HICAP and healthy movement lecture for the prevention of cancer. 5. To provide a listing of free transportation resources available to the underserved population for access to their healthcare needs. Distribute this list to Noor Foundation and other non-profit groups working with the underserved population. 6. Implement a gas card program to support individuals whose financial resources limit access to healthcare services. 7. Offer a series of transportation lectures with San Luis Regional Rideshare & the various special transportation resources/agencies. 8. Partner with local oncologist and dermatologist to provide a skin cancer screening for Latinos and the underserved population. In collaboration with Self-Help Housing in north county. Forms and follow-up procedures will adhere to the standards of the Dermatologic Society. 9. Through a grant the breast cancer outreach and navigation program will entail a three-pronged approach to address the needs of Hispanic Women this includes: 1. Hiring a bilingual Lay Patient Navigator. 2. Bilingual pamphlets on healthy lifestyle for the prevention of cancer. 3. Free mammography clinics and diagnostic testing for low income Hispanic women.
Community Benefit Category	A1a.- Community Health Education: Lectures/Workshops

Cardiac Wellness

Cardiac Wellness	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Health care Services <input type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Clinical Conditions and Access to Primary Healthcare Services
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 2014	
Goal FY 2014	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area
2014 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 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. 3. Participate in education and outreach activities including at least 2 Health Fairs, and 2 lecture presentations to groups. Use promotoras to target 10 Hispanic women per quarter for heart disease risk screening.
Baseline	240 free lipid screening provided, 19 follow ups done, 265 participants attending a cardiac wellness lecture.
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. 6. Offer one educational presentation specifically regarding women and heart disease. 7. Train promotoras to use HeartAware cardiac risk assessment tool for heart disease risk screening
Result FY 2014	<ol style="list-style-type: none"> 1. 240 individuals learned about their risk for heart disease by doing the on-line risk assessment. 217 got personalized, individual counseling, and 184 had a free lipid panel screening test to further assess risk. 2. 29 individuals received 6 or 12 month reassessment and consultation to track risk reduction in response to change. 3. Participated in education and outreach at 5 Health Fairs and offered lecture presentations to two groups. 4. Because of logistics, we were unable to collaborate with the promotoras to target mono-lingual Spanish speaking women. We will try again in FY15.
Hospital's Contribution / Program Expense	Hospital provided in kind space, nutritional services, advertising, and printing. Expense: \$ 9,195.

FY 2015	
Goal 2015	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area
2015 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 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. 3. Participate in education and outreach activities including at least 2 Health Fairs, and 2 lecture presentations to groups. 4. Use promotoras to target 10 Hispanic women per quarter for heart disease risk screening.
Baseline	331 free lipid screening provided, 74 follow ups done, 200 participants attending a cardiac wellness lecture.
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. 6. Offer one educational presentation specifically regarding women and heart disease. 7. Partner with FHMC Community Benefits department on numerous SLO county health fairs using bi-lingual health educators to assess cardiovascular risk factors and dispense prevention pamphlets and information. Work with the SLO County Promotoras to outreach to the Hispanic community.
Community Benefit Category	A1a.- Community Health Education: Lectures/Workshops

Heart Failure Program Formerly Congestive Heart Failure

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Health care Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health																									
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance																									
Link to Community Needs Assessment	Access to Primary Healthcare Services, Clinical Conditions, and Emergency Room Utilization																									
Program Description	The Heart Failure 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 2014																										
Goal FY 2014	Avoid hospital and ER admissions for 3 months among 80% of participants enrolled in the CHF Program.																									
2014 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> Identify all patients with a CHF diagnosis at high risk for readmission. Maintain the telephone based monitoring and Philips Home Monitoring Programs to prevent readmissions within 3 months of enrolling. Measure program satisfaction with a Satisfaction Survey. Enhance access to care with use of Meditech.																									
Baseline	At the end of FY 2013 there were 139 participants in the CHF Program with a 4.4% readmission rate.																									
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Continue to offer the CHF Program to all inpatients with a diagnosis of heart failure. Provide hospital inpatients evidence based education regarding heart failure. Maintain Philips tele-monitoring program for 50 patients of the Central Coast service area. Work with computer support to capture important data for telephonic assessments participants. 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. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center. 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. 																									
Result FY 2014	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Quarter</th> <th># of Participants</th> <th># of Readmission</th> <th>% of Readmission</th> <th>Program Expense</th> </tr> </thead> <tbody> <tr> <td>Q1 9/13</td> <td>157</td> <td>10</td> <td>6.4%</td> <td>\$31,282</td> </tr> <tr> <td>Q2 12/13</td> <td>173</td> <td>11</td> <td>6.4%</td> <td>\$29,261</td> </tr> <tr> <td>Q3 03/14</td> <td>179</td> <td>15</td> <td>8.4%</td> <td>\$31,673</td> </tr> <tr> <td>*Q4 06/14</td> <td>175</td> <td>4</td> <td>2.3%</td> <td>\$28,732</td> </tr> </tbody> </table> <ol style="list-style-type: none"> The CHF program staff offered CHF program to all hospital in-patients admitted with CHF by utilizing BNP reports, hospital censes reports, patient discharge reports and hospital referrals. The CHF program staff implemented telephonic assessment by collaborating with Cerner & IT staff to integrate case management with Cerner. We are currently utilizing case management data base and continue to work with Cerner to integrate patient information. The CHF program staff tracked data base and Midas reports for both the tele-monitored and telephonic participants for outcomes and made program adjustments based on data derived. The CHF program staff collaborated with Dignity Health Facilities, Community Health Centers, CDMSp, local skilled nursing facilities and cardiologist office to achieve improved outcomes. The CHF program staff partnered with Dignity Health Home Health nursing staff and collaborated with hospital staff to work in partnership on treatment plan. The CHF program staff continues to refer patients who are underserved and cannot afford their medications to Alliance for Pharmaceutical Access and other community support resources <p>* Reflects a change in statistical reporting on readmissions that are only related to heart failure problems vs all cause readmissions.</p>	Quarter	# of Participants	# of Readmission	% of Readmission	Program Expense	Q1 9/13	157	10	6.4%	\$31,282	Q2 12/13	173	11	6.4%	\$29,261	Q3 03/14	179	15	8.4%	\$31,673	*Q4 06/14	175	4	2.3%	\$28,732
Quarter	# of Participants	# of Readmission	% of Readmission	Program Expense																						
Q1 9/13	157	10	6.4%	\$31,282																						
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Q3 03/14	179	15	8.4%	\$31,673																						
*Q4 06/14	175	4	2.3%	\$28,732																						
Hospital's Contribution / Program Expense	This program serves cardiac patients and CHF clients in the community through education, risk assessment and referrals. Expense:\$128,899.																									

FY 2015	
Goal 2015	Avoid hospital and emergency department admissions for all participants with heart failure enrolled in the program for fiscal year 2015
2015 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. 80% of participants enrolled in the program will verbalize they take their heart failure medications as prescribed. 2. 80% of participants enrolled in the program will self-report that they conduct daily weigh in 7 days a week. 3. Participants identified for tele-monitoring will be placed on a Philips monitor within 4 days
Baseline	At the end of FY 2014 there were 171 participants in the CHF Program with a 2.3% readmission rate.
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. All patients will be queried regarding med compliance at each patient encounter 2. All patients will be queried regarding daily weight at each patient encounter 3. Provide evidence-based health education to 100% of participants enrolled in the CHF program. 4. Work with Case Management design team to design tool to capture patient response regarding wt & meds 5. Utilize redesigned standard tele-monitor protocol orders to communicate to patient's medical provider that their patient has been provided with scale, BP machine and pulse oximeter.
Community Benefit Category	A3e-Health Care Support Services

Dignity Health Community Grants Program

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Health care Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input checked="" type="checkbox"/> Mental Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Access to Primary Healthcare Services, Emergency Room Utilization , Clinical Conditions, and Mental Health
Program Description	This is a grant program designed to give needed funds to community organizations or agencies that are a 501(c)3 and are providing services to underserved populations to improve the quality of their lives. Focus of the grant is identified by the needs described in the community health needs assessment.
FY 2014	
Goal FY 2014	Distribute grant funds to organizations in the FHMC service area to those agencies meeting the grant requirements that align with the Community Health Needs Assessment and whose proposal is approved by the Community Benefit Committee and the System Office
2014 Objective Measure/Indicator of Success	100% of the proposals approved will address one or more the health needs identified in the community health needs assessment
Baseline	Quarterly reports have shown that 100% of the funded organizations' programs demonstrated fulfilling on or more of the community health needs identified in the community health needs assessment as well as sustainability of the program
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Community Benefits Committee reviews the Community Health Needs assessment and agrees to use the same 4 prioritized health needs as the focus for the grant process. 2. Notification of the Dignity Health Community Grants Program will be done through PSA in local newspapers, community calendars, and letters of intent invitation will be mailed to appropriate organizations. 3. The Community Benefits Committee members carefully reviewed 14 letters of intent; requested funds totaled over \$100,000. Seven organizations were invited to complete a full proposal. Proposals were reviewed by the Community Benefits Committee and then recommendations were sent to Dignity Health system office for final approval.
Result FY 2014	<p>\$48,051 in grant money awarded to the community for the purpose of improving the quality of life of the residents of San Luis Obispo County.</p> <p>Agencies receiving grant funds were:</p> <ol style="list-style-type: none"> 1. Alliance for Pharmaceutical Access. Inc (APA) -\$10,000 to provide direct services and continue to expand its model of providing access to prescription medications for chronic medical conditions to targeted populations (the in-insured, under-insured, seniors in the "donut-hole" of coverage, the homeless, low- and very -low income, the newly unemployed or under-employed and other disenfranchised communities) of the San Luis Obispo area. 2. Cancer Well-fit-\$7,000 to provide a supervised exercise/wellness program for first year cancer survivors. 3. Coast Caregiver Resource Center (CCRC)-\$7,000"This project will address the health and well-being of family/friend caregivers of older adults and of adults of any age with cognitive impairment by providing assessment, respite, counseling and group support to unpaid caregivers in greatest economic and social need. 4. Community Counseling Center (CCC) of San Luis Obispo County, Inc.-\$5495 Professional affordable therapy for low income and medically uninsured individuals, couples, and families. 5. San Luis Obispo County Child Abuse Prevention Council (SLO-CAP): Promotoras Collaborative of SLO County-\$8,000 members of the Promotoras Collaborative will work with the Central San Luis Obispo Lead Promotora and North County Lead Promotora in a cooperative setting to deliver ongoing healthcare education outreach to underserved populations such as people living in poverty, Latinos and single mothers living in the City of San Luis Obispo, Los Osos, Morro Bay, Atascadero, Paso Robles, Cambria, San Miguel communities. 6. SLO Noor Foundation- \$10,000 aligning with our focus on preventative health, 2013 goals are to increase number of patients served, continue laboratory and diagnostic screenings (free of charge) for patients as part of our existing primary care medical program, and to begin offering a currently missing ""spoke"" in our circle of care: oral health exams/treatments to further optimize overall patient health. 7. Women's Shelter Project- \$3,000 to pay for needed mental health counseling services for Latina victims at the agency's San Luis Obispo and Grover Beach counseling centers.
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and, \$48,051 in grant money awarded to the community for the purpose of improving the quality of life of the residents of San Luis Obispo County.

FY 2015	
Goal 2015	Distribute grant funds to organizations in the FHMC service area to those agencies meeting the "Accountable Care Community" grant requirements that align with the Community Health Needs Assessment and whose proposal is approved by the Community Benefit Committee and the System Office
2015 Objective Measure/Indicator of Success	100% of the proposals approved will address one or more of the health needs identified in the community health needs assessment
Baseline	Quarterly reports have shown that 100% of the funded organizations' programs demonstrated fulfilling on or more of the community health needs identified in the community health needs assessment as well as sustainability of the program
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Offer a Dignity Health Community Grants Workshop providing new strategies for the application process of funding only Accountable Care Communities 2. Offer workshop in a location conducive for all three Central Coast Service Area hospitals. 3. Community Benefit Committee members carefully review Letters of Intent. 4. Invite organizations to complete a full proposal. 5. Proposals will be reviewed by the Community Benefit Committee 6. Recommendations for funding will be sent to Dignity Health's System Office for final approval. 7. Central Coast Service Area agencies funded with Dignity Health Community Grants are requested to provide a quarterly Sustainability Report on the status of their program. 8. Community Benefit Committee reviews quarterly reports for adherence to proposal and funding 9. Provide feedback to funded agencies from the Community Benefit Committee
Community Benefit Category	E2-Cash and In-Kind Contributions

Diabetes Prevention and Management	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Health care Services <input checked="" type="checkbox"/> Emergency Room Utilization <input checked="" type="checkbox"/> Clinical Conditions <input type="checkbox"/> Mental Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Access to Primary Healthcare Services, Emergency Room Utilization , Clinical Conditions,
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 improve behavior and self-management practices of diabetic patients: enhance and improve the access and delivery of effective preventive health care service
FY 2014	
Goal FY 2014	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
2014 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 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. Increase community opportunities by 2% for chronic disease self-management via support groups and community lectures.
Baseline	Diabetes Support Group- 93 Patients on telemonitors-2
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 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. Identify high risk patients from inpatient population at French Hospital via referrals from patient care coordinator. Service high risk diabetics without access to primary care at the Noor clinic. Utilize the nutrition department and diabetic educator to educate and provide support for these patients. Continue with the diabetes support group and increase enrollment by 2%. Offer one community diabetes education class series. Investigate developing support group for young adults. 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. 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.
Result FY 2014	Program was successful as 0 participants reported visiting ER for uncontrolled hyperglycemia. Increased outreach to diabetics via: 3 sets of series classes plus one refresher class (a total of 10 classes) open to the community via French Hospital, SLO Housing Authority and OPTIONS of SLO; held support group monthly. Provided service to diabetics at the Noor clinic and used nutrition dept to follow up with patients who requested support. Survival care discharge packet was created and is now distributed. Philips education tools and monitoring system was not successful in identifying high risk diabetic patients.
Hospital's Contribution / Program Expense	Hospital provided in kind space, nutritional services, advertising, and printing. Expense: \$3,179.
FY 2015	
Goal 2015	Increase diabetes self management skills in the targeted population by providing diabetes self-management education and support groups
2015 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> Increase diabetes support group and series classes participation by 10%. 85% of the participants reported no ER visit during a follow up call at 3 months after completing the series. 95% of diabetes class series participants indicated on a post survey that they enjoyed the series and it was beneficial for their diabetes management 95% of support group participants indicated after 12 months on a survey that they enjoyed the support group and it was beneficial for their diabetes management.
Baseline	Diabetes Support Groups- 69 Patients on telemonitors-0 Diabetes Conversation class-55 OPTIONS series-20
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Identify high risk patients from inpatient population at French Hospital via referrals from patient care coordinator Partner with the Noor clinic to encourage patients to attend community classes and support group Offer four community diabetes education class series (Diabetes Association best practice guidelines and educational tools will be used.) Implement 3 month follow up calls on diabetes class series participants Implement post surveys on both diabetes support group and class series participate
Community Benefit Category	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 be more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

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

9/12/2014
366 French Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2013 through 6/30/2014

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
Benefits for Poor						
Financial Assistance	2,131	791,020	0	791,020	0.8	0.8
Medicaid	6,286	10,669,590	5,398,463	5,271,127	5.4	5.1
Means-Tested Programs	154	628,517	147,957	480,560	0.5	0.5
Community Services						
Community Benefit Operations	1	69,865	0	69,865	0.1	0.1
Community Building Activities	9	12,414	0	12,414	0.0	0.0
Community Health Improvement Services	13,079	237,959	0	237,959	0.2	0.2
Financial and In-Kind Contributions	263	139,534	22,070	117,464	0.1	0.1
Subsidized Health Services	4,326	99,792	83,501	16,291	0.0	0.0
Totals for Community Services	17,678	559,564	105,571	453,993	0.5	0.4
Totals for Poor	26,249	12,648,691	5,651,991	6,996,700	7.1	6.8
Benefits for Broader Community						
Community Services						
Community Benefit Operations	0	30,014	0	30,014	0.0	0.0
Community Health Improvement Services	7,350	331,268	0	331,268	0.3	0.3
Health Professions Education	25	181,387	0	181,387	0.2	0.2
Totals for Community Services	7,375	542,669	0	542,669	0.6	0.5
Totals for Broader Community	7,375	542,669	0	542,669	0.6	0.5
Totals - Community Benefit	33,624	13,191,360	5,651,991	7,539,369	7.7	7.3
Medicare	29,751	47,635,643	36,544,161	11,091,482	11.3	10.8
Totals with Medicare	63,375	60,827,003	42,196,152	18,630,851	18.9	18.2


Sue Andersen
Chief Financial Officer
Dignity Health Central Coast Service Area

Note: Calculations were derived using a cost accounting system.

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. Central Coast Service Area e-blast are sent on a weekly bases to all staff at Arroyo Grande Community hospital, French Hospital Medical center, and Marian Regional Medical center which highlights staff involvement in their work but also in their community
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 and on the Dignity Health website at 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.
- 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.

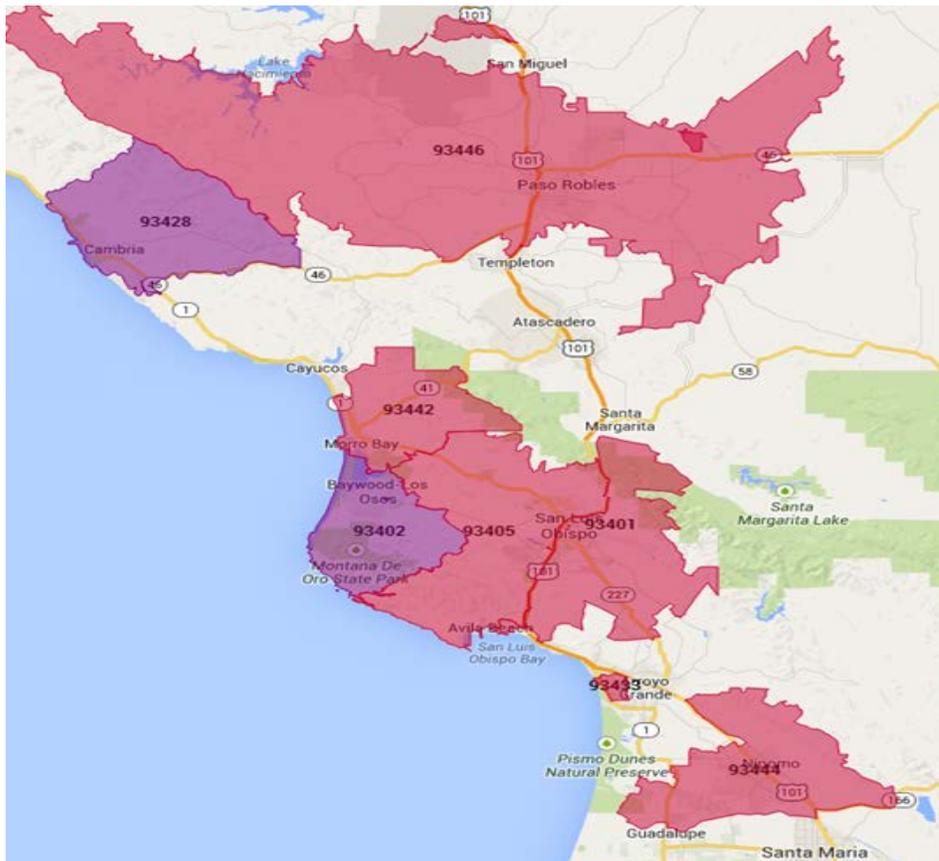
Attachment A

FRENCH HOSPITAL MEDICAL CENTER

Lowest Need

Highest Need

1 - 1.7 Lowest	1.8 - 2.5 2nd Lowest	2.6 - 3.3 Mid	3.4 - 4.1 2nd Highest	4.2 - 5 Highest
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CNI MEDIAN SCORE: 3.6

Zip Code	CNI Score	Population	City	County	State
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	San Luis Obispo County	San Luis Obispo	California
93428	2.8	6,717	Cambria	San Luis Obispo	California
93433	3.6	12,844	Grover Beach	San Luis Obispo	California
93442	4	10,842	Morro Bay	San Luis Obispo	California
93444	3.4	18,894	San Luis Obispo County	San Luis Obispo	California
93446	3.8	44,379	El Paso de Robles	San Luis Obispo	California

Attachment B

French Hospital Medical Center Community Board FY 2014

Kevin M. Rice, Colonel, USA (Ret.)
Chair of the Board
Retired Pismo Beach City Manager

Patricia Gomez
Vice –Chair of the Board
Attorney-at-Law

Sandee McLaughlin
Secretary
Assistant Superintendent/VP of Student Services,
Cuesta College

Father Russell Brown
Pastor, SLO Old Mission Church

Michael DeWitt Clayton, MD
Urology Associates

Jim Copeland
Copeland's Properties

Armando Corella
Former Paso Robles Housing Authority Director

Robert Doria, MD
Coastal Cardiology

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

Sister Linda Gonzales
Retired Teacher/Administrator

Alan Iftiniuk
President, French Hospital Medical Center

Ben Kulick
Owner, Stalwork, Inc. Construction + Design
Stalfund, LP

Jim Lokey
Retired Executive Banker

Rabbi Norm Mendel
Rabbi Emeritus, Congregation Beth David

Kerry Morris
COO, Morris & Garritano Insurance

Cornel Morton, PhD
Senior Advisor to the President for Outreach,
CPSU, SLO

Pierre Rademaker
Foundation Board Chair
Rademaker Design

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

Leopold Selker, PhD, MBA
Research Scholar in Residence, CPSU, SLO

Antonia Torrey, RN, PhD
Nurse Educator, Cuesta College

Dee Torres
Director, EOC Homeless Services

Ke-Ping Tsao, MD
Plastic Surgeon

Attachment C

FHMC Community Benefits Committee FY14

Patricia Gomez
Attorney-at-Law
Chair of the Committee

Fr. Russell Brown
San Luis Obispo Mission

Armando Corella
FHMC Community Board Member

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

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

Heidi Summers, MN, RN
Senior Director, Mission Integration and Education
Central Coast Service Area

Sandy Underwood
Senior Community Education Coordinator – Central Coast Service Area

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

Kathleen Sullivan, PhD, RN
Vice President - Central Coast Service Area

Attachment D