



**French Hospital Medical Center
Community Benefit Report 2012
Community Benefit Implementation Plan 2013**



1911 Johnson Avenue
San Luis Obispo, CA 93401
direct 805.543.5353
fax 805.543.5708
frenchmedicalcenter.org

A message from Chief Executive Officer, French Hospital Medical Center and Board Chair

At French Hospital Medical Center we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$13,334,561 in charity care, community benefits, and unreimbursed patient care.

At French Hospital Medical Center we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy the French Hospital Medical Center Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 18, 2012.

Alan Iftiniuk

President, French Hospital Medical Center

Jim Copeland

Community Board Chair

TABLE OF CONTENTS

Executive Summary	Page 4
Mission Statement	
Dignity Health Mission Statement	Page 6
Organizational Commitment	
Hospital's Organizational Commitment	Page 6
Non-quantifiable Benefits	Page 7
Community	
Definition of Community	Page 8
Description of the Community	Page 9
Community Demographics	Page 10
Community Benefit Planning Process	
Community Health Needs Assessment Process	Page 10
Assets Assessments Process	Page 12
Developing the Hospital's Implementation Plan	Page 13
Planning for the Uninsured/Underinsured Patient Population	Page 15
Plan Report and Update including Measurable Objectives & Timeframes	Page 16
Summary of Key Programs and Initiatives – FY 2012	Page 16
Description of Key Programs and Initiatives	Page 18
Community Benefit and Economic Value	
Classified Summary of Quantifiable Community Benefit Expenses	Page 29
Telling the Story	Page 30
Attachments	
Summary of Patient Financial Assistance Policy (Attachment A)	Page 31
Dignity Health Reporting Sheet for Community Need Index (Attachment B)	Page 34
French Hospital Medical Center Service Area Map (Attachment C)	Page 35
Hospital Community Board Roster 2011-2012 (Attachment D)	Page 36
Community Benefit Committee Roster (Attachment E)	Page 37
Attachment F	Page 38

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)¹ in 2004. Though the facility has 112 licensed beds, 68 are currently available and the campus is approximately 15 acres in size. FHMC has a staff of more than 520 and professional relationships with more than 314 local physicians. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics.

Major Community Benefit activities for FY2012 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).

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. Partnering with Allan Hancock College and Cuesta College, FHMC contributes money annually to provide for instructors and other program support. These arrangements allow the hospital to provide clinical training experiences for students in a variety of health science fields of study, thereby providing the hospital with improved recruitment capacity. FHMC, as a means to foster professional development and improve patient care, continues to expand hospital programs, including case management, post acute care coordinators and medical directorships to coordinate and monitor patient transitions across the continuum of care settings. 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 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 programs: Healthy for Life Nutrition series and our evidence-based Chronic Disease Self Management program were offered at multiple community sites within our service area. Another health promotion technique the hospital provided were health screenings which are excellent teaching strategies for awareness and prevention at community events which include blood pressure, height, weight, lipid panel, blood glucose checks, Flu, and Pertussis vaccinations.

The Diabetes Prevention and Management Program became the second Long Term Improvement Plan (LTIP) focus this year. The goal of this program is to avoid admissions to the hospital or emergency department for 50% of the participants in the hospital's preventive health intervention. The program consisted of implementing the Diabetes Conversation Program, an evidence-based program from the American Dietetic Association, which includes ideas on lifestyle modification, such as diet and exercise, testing blood sugars, and education regarding managing diabetes. FHMC has continued to offer a Diabetes II support group that meets monthly offering participants the latest

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

diabetes information and education. A Diabetes I monthly support group has also been developed.

The **Prenatal and New Parent Education Program** provided education in English and Spanish to mothers, pregnant teens, and their partners regarding prenatal preparation, birth classes and family support classes. Our breastfeeding clinic in San Luis Obispo and lactation counseling at the local WIC (Women, Infant, and Child) clinics has provided 2,054 lactation consultations for FY 2012.

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

The Hearst Cancer Resource Center (HCRC) continued to provide support and resources to residents of FHMC's service area. The HCRC located on FHMC campus is an excellent resource center that addresses the medical, physical and emotional needs of cancer patients and their families. Since opening its doors in 2008, HCRC has experienced more than 29,200 visits and contacts from cancer patients, family members, health fairs, and many community organizations.

Congestive Heart Failure Program (CHF) is one of our Long Term Improvement Plan (LTIP) whose goal is to demonstrate a decrease in readmissions of participants in the hospital's preventive health intervention. In 2012 the CHF program had a total of 620 patient contacts in the community. There was a 4.4% hospital readmission rate for those enrolled in the program. The goal of the Congestive Heart Failure Patient Navigation Program is to increase the ability of people in our community who are diagnosed with a chronic heart condition to build and maintain their health and quality of life. This year's enhancement was the deployment of telemonitors to patients. The telemonitor tracks and transmits any changes in the patients' physical health which would indicate either improvement or decline in recovery to the CHF coordinator. 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 FY2011 Community Benefit Report and FY2012 Community Benefit Plan document our commitment to the health and improved quality of life in our community. The total value of community benefit for FY2012 is \$6,585,732 which excludes the unpaid costs of Medicare of \$7,084,765. Including the unpaid cost of Medicare, the total expense for FY2012 was \$13,670,497.

MISSION STATEMENT

A. Mission Statement

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

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

ORGANIZATIONAL COMMITMENT

A. Description of the hospital's organizational commitment:

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

3. The Community Benefit Committee is structured as follows:
 - The Community Benefit Committee Chair. The Committee will nominate and appoint a representative to Chair the Community Benefit Committee, the nominee will be a member of the Hospital Community Board.
 - The Vice President of Human Resources for the Central Coast Service Area
 - Senior Community Benefits Coordinator for the Central Coast Service Area
 - FHMC Community Benefits Coordinator
 - Community Benefit Program Coordinators
 - Additional (maximum of 5) Community Board Members
 - Rosters of Community Board and Community Benefit Committee members are found at Appendix D and E

- B. There are many examples of non-quantifiable benefits related to the community contribution of the hospital. Working collaboratively with community partners, the hospital provided leadership and advocacy, assisted with local capacity building, and participated in community wide health planning. The following are some non-quantifiable services
 1. Our executive senior management team is actively involved in community non-profit and community organizations on a volunteer basis. Their leadership helps to develop partnerships in the community to address the needs of the underserved.

Alan Iftiniuk, President FHMC –board member of the following: Cen Cal Health Board, Hospital Council of Northern and Central California Board, and the American Heart Association – Central Coast Chapter.

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

Debbly Nicklas, Foundation Executive Director – San Luis Obispo Rotary member; Chamber of Commerce Issues and Evaluation Committee member.

Dan Farnum, Director of Facilities- Executive Committee member of SLO County YMCA, SLO City Chair Board Member.

Patricia Herrera, Community Benefits Coordinator, Committee member- Member of the following: Latino Outreach Council, HEAL-SLO, ACTION: For Healthy Communities, SLO Benefits-ARCH, Community Service Alliance, 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
 2. Employees donated their time to raise money and awareness of the American Heart Association Heart Walk, Go Red for Women Day, and Breast Cancer Awareness Denim Day.

3. FHMC employees donate clothing to our Caring Closet which provides clothing to patients upon discharge.
4. 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. In May, the Committee heard a presentation on the new Integrated Waste Steam Systems program which will start on June 1st. Better data reporting will be 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 2011.
 - a. The facility set and met its goal to reduce total waste from 525,700/apd to 499,700/apd. Highlights of this goal include a 38% decrease in solid waste which is a savings of more than \$12,000 from FY11. The medical waste total has been decreases by 67% which resulted in a savings of more than \$14,000 compared to FY11;
 - b. FHMC continues to implement successful recycling programs throughout the hospital, in non-clinical and clinical departments, to raise awareness and increase participation in our recycling initiatives. FHMC continues to use sparingly, paper agendas for meetings, replacing them with electronic versions. The paper copies of FHMC's monthly newsletter have also been reduced by emailing the newsletters to those with email capability. All outdated technology, such as computers and printers are safely and environmentally disposed of. Equipment and materials no longer needed in the hospital are donated to non-profits rather than to a landfill.
 - c. Since June 2010 to June 2012 our battery recycling program has recycled 1522 lbs of batteries.
5. French Hospital Medical Center has offered both financial and in-kind printing services to the newly opened SLO Noor Free medical clinic to expand the access to health care to those in greatest need.
6. The Hearts Cancer Resource Center provided a Free Skin Cancer Screening at a low housing development in Paso Robles. Two volunteer physicians screened 30 residents.

COMMUNITY

- A. Definition of community-French Hospital Medical Center defines its community as located in central San Luis Obispo County along the central coast. Sierra Vista Medical Center, a Tenet owned facility shares essentially the same service area as FHMC. Twin Cities Hospital, another Tenet owned facility mainly serves the community in northern San Luis Obispo County. The primary service area for FHMC is San Luis Obispo, Morro Bay, Los Osos, Atascadero and Paso Robles, with the secondary service area identified as Arroyo Grande, Pismo Beach, Grover Beach, Oceano, and Avila Beach. (See map Attachment B) FHMC offers community outreach to this secondary service area as needed, partnering with sister hospital Arroyo Grande Community Hospital.

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

Culture and Language

- Languages spoken in the San Luis Obispo County: 85% of residents of San Luis Obispo County speak English at home, 15% of residents speak Spanish at home.
- The FHMC service area has a population of approximately 169,983. About 14.8% 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.
- Indigenous farm workers from the states of Oaxaca and Guerrero are currently the fastest growing population in the northern part of San Luis Obispo County.

Economic Indicators

- San Luis Obispo County's population has an estimated per capita family income of \$71,165, slightly higher than state and national per capita income levels.
- The Federal Poverty Level (FPL) for one person is currently \$10,890 annually and for two is \$14,710. In San Luis Obispo County 13.6% of residents live in poverty, 11% medical eligible, and 11.9% of children live in poverty.
- Approximately one in every four female heads of household living with children in the area are living in poverty.
- As of December 2011, per the California Employment Development Department, the unemployment rate in San Luis Obispo was 8.8% compared to California at 10.9%.
- The approximate number of uninsured individuals in San Luis Obispo County is estimated by CHIS (2009 California Health Interview Survey) to be 15.1%.

Housing status

- According to the ACTION for Healthy Communities 2010 survey 1 in 4 San Luis Obispo county residents said they used more than one-half of their income on housing and utilities. The average monthly cost for a two bedroom rental was \$1,230 in 2010, up from \$975 in 2004.
- According to the San Luis Obispo County 2011 Homeless Enumeration there are approximately 3,774 homeless persons in the San Luis Obispo County and 49% of those homeless are children.
- The Community Need Index (CNI) developed by Dignity Health and Thomson-Reuters formerly Solucient is a tool that pinpoints communities in service areas with the greatest barriers to health care access. It uses socio-demographic information data to provide an "at a glance" view of disproportionate unmet health care needs (DUHN) in a given geographic area. See Appendix B

Education and Literacy Indicators

- Education level is often interrelated with health status. According to the National Center for Education, the better educated a person is, the more likely that person is to report being in very good or excellent health, regardless of income.
 - 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.
- C. The population of FHMC's primary service area is approximately 167,359 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:
- Population (SLO County): 233,399
 - Diversity: Caucasian 70.3%, Hispanic 21%, Asian 3.4%, African American 2.1%, Other 3.2%
 - Average income: \$71,165
 - Uninsured: 19.25%
 - No HS diploma: 11.5%
 - Renters: 35.1%
 - CNI Score: 3.4
 - Medicaid Patients: 10.84%
 - Other Area Hospital: Arroyo Grande Community Hospital, Sierra Vista Hospital and Twin Cities Hospital
- D. 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 including a dental clinic in Templeton. All have Federal Qualify Health Center (FQHC) status.

COMMUNITY BENEFIT PLANNING PROCESS

A. Community Health Needs Assessment Process

The Affordable Care Act issued a new law that affects the community health needs assessment. The requirement is that every not-for-profit hospital must conduct a health needs assessment in accordance with the following criteria:

- at least once every three years – 1st must be completed by end of tax year beginning after March 23, 2012,
- include input from persons who represent the broad interests of the community, and
- include input from persons having public health knowledge or expertise.

We must also make the assessment widely available to the public and adopt a written implementation strategy to address identified community needs.

French Hospital Medical Center's community health needs assessment was conducted during the current tax year, and will be made publicly available by January 2013. French Hospital Medical Center's Implementation Strategy report will be posted no later than March 23, 2013.

In the areas that overlap, each central coast hospital's report identified findings and recommendations based on that particular service area. The Community

Health Needs Assessment (CHNA) report for each hospital provides a more in depth explanation for Next Steps. The next step in completing this process is to set up a working committee meeting to brainstorm strategies for implementation of programs to address the top identified priorities. While implementations strategies will be reflected in the FY2013/2014 Community Benefit Plan Report and Implementation Plan, French Hospital Medical Center will utilize some of this primary research, supported by secondary data which indicates the prevalence of several medical conditions occurring in the community. There are a number of barriers to healthcare that while they may appear disparate, have the same outcome: hindering vulnerable populations from obtaining care. The qualitative and secondary data findings indicate that the rates of uninsured and underinsured in the area are major barriers to care. Around 15% of San Luis Obispo residents reported being uninsured.

A summary of community needs is provided below. The section tells the story by comparing and contrasting primary data with the secondary data gathered from publicly available reports.

1. Inappropriate use of the **Emergency Department** is common in the FHMC service area and frequently is the result of several of the conclusions reached above. People use emergency services inappropriately for various reasons, one of which is a lack of insurance that would enable them to see a primary care provider. People also use emergency services because they are tired of waiting to get a clinic appointment or they are unable to visit a clinic during regular business hours. Also, people use emergency services when care is otherwise unavailable in the area (e.g., lack of detoxification centers).
2. Preventing **obesity** and reducing the current prevalence of overweight and obese individuals in FHMC's service area is a community need, as obesity is associated with increased incidence of multiple serious health conditions. A majority of SLO County adults are overweight or obese (about 60%) and the number of adults who are considered overweight increased by more than 10% from 2007 to 2009. One-third of SLO County youth are overweight or obese.
3. Secondary data show that people who have **diabetes** in SLO County are not receiving treatment that adheres to guidelines established by the American Diabetes Association. The number of diabetes patients reporting that a provider had never checked their feet for sores or ordered an HgA1C test has been increasing. Some of the increase found in the secondary data may be artificial, as some patients may not know which blood tests are being performed, or they may forget the names of the tests. But the fact that one in every five SLO County adults who has diabetes is not being monitored regularly should be cause for concern if FHMC hopes to achieve its diabetes-related goals.
4. While addressing poor dietary habits is important to improving the health of residents in the FHMC service area, participants also identified **oral health** as an area of need, and oral health has been shown to impact overall health. Low-income residents have inadequate access to dental care. Study participants are particularly concerned about children who are not receiving dental care. In fact, 14% of SLO County children have never even visited a dentist.

5. Primary research participants reported that their communities have gaps in **mental health** services. The primary research revealed that the FHMC service area has a need for a detoxification center and for additional mental healthcare providers. Qualitative evidence indicates that the wait to see a psychiatrist can be months-long and residents reported needing mental healthcare in the past but not receiving it. Emergency Department staff members lack awareness about how to treat people who present to the ED with severe psychiatric conditions and these patients have difficulty navigating the system. Mental illness remains stigmatized and at least one anti-stigma campaign exists in the FHMC service area.
6. **Language** is another barrier to care in the FHMC service area both at the hospital and at community agencies. People are dissatisfied with the limited availability of interpreters and with what they perceive as poor quality interpretation. They would like more interpreters and they would like interpreters to appear in-person, rather than providing services by telephone. By “poor quality,” participants meant that interpreters only interpret *part* of what the provider is saying to the patient and *part* of what the patient is saying to the provider. They want what is being said to be interpreted fully. In addition, they need to have medication instructions provided in their primary language, as instructions currently are provided in English, so some people do not know how to take their medicine.
7. **Transportation** is a major barrier to access healthcare in the FHMC service area for several reasons. First, the cost of gasoline can be prohibitive for those who own vehicles. For those who do not own vehicles, options are few and public transportation has not proven to be very useful in removing barriers to healthcare. Even the cost of bus fare can be unaffordable for some. The public bus system also has hours of operation that often do not enable people to get to clinic appointments on time. In addition, not all healthcare facilities and social service agencies in the area are covered by available bus routes. Using Dignity Health’s Community Needs Index (CNI), zip code area of 93446 (Paso Robles), 93405(San Luis Obispo) and 93442 (Morro Bay) are neighborhoods with Disproportionate Unmet Health Needs (DUHN).

B. Assets Assessment

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

Access to Primary Healthcare Services

- The Community Health Centers of the Central Coast have six primary care health centers throughout the FHMC service area all Federal Qualified Health Centers.
- The Community Health Centers of the Central Coast provide a primary care mobile clinic at the Prado Homeless Day Center.
- In an effort to reduce unnecessary emergency room visits that can include long waiting room times, many CenCal primary care providers in San Luis Obispo County have extended their office hours to 6pm to see patients.

- French Hospital Medical Center is an active member of the SLO-Benefits-ARCH committee which has as its main focus the ability to expedite the SSI application process among the disabled and homeless populations.

Disease Management

- French Hospital Medical Center will continue to use the 12 home tele-station monitors to educate patients throughout the service area living with heart failure and in the monitoring and reporting of critical vital signs such as blood pressure, pulse oximetry and weight. Telephone support will also continue to be offered to the community by doctor's referral.
- French Hospital Medical Center provides English and Spanish evidence-based chronic disease self management workshops developed by Stanford University School of Medicine. Healthy for Life Nutrition Lecture Series is also offered at no cost to all community members.
- French Hospital Medical Center offers monthly support groups for Diabetes I and II to the community for free.

Health Promotion/Disease Prevention

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

Maternal Health

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

C. Developing the Hospital's Implementation Plan

1. The community benefit planning process considers the fiscal year 2012 program outcomes serving as a springboard for the continuation of most current programs. There are a number of checks and balances set to ensure Dignity Health values are integrated into programs and services: (a) strategic planning has impact on factors of involvement for specific program implementation; (b) the Community Benefits Committee reviews outreach

- programs on a quarterly basis comparing goals to objective measures and outcomes of each program and ensuring commitment to the strategic plan; (c) Hospital and Foundation board members participate and provide strategic influence to the Community Benefit Committee while the Hospital Board reviews community outreach programs through monthly board meetings and; (d) the community needs and assets assessment process provides a data analysis that directors and coordinators can use for program improvement and continuation of their respective programs.
2. Factors considered in planning for outreach programs include analysis of the high utilization rate of the hospital's emergency room by those uninsured or underinsured and the severity of their health problems. In the last six years, French Hospital Medical Center has seen an increase in the number of uninsured residents and residents covered by Medi-Cal. This trend is driven by a variety of factors, including an increased demand for healthcare services to treat chronic conditions - conditions that if treated through primary care services in the community would likely not result in a hospitalization or need for emergency care. To effectively impact the increase in charity care and Medi-Cal expense, French Hospital Medical Center has established a plan to address these issues internally while providing quality healthcare service to this population.
 - a. Partner with physicians and share ambulatory care sensitive condition admission/ readmission data;
 - b. Collaborate on improved healthcare education and referral plan addressing those patients within our control;
 - c. Identify physician/Staff champion within service area to promote disease management initiative;
 - d. Identify the availability of community partners that will collaborate with us in providing disease prevention education programs that target cost-effective prevention.

A number of community needs exist in the service area 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 as we work together in FY2013/2014.:

- Access to Healthcare/Insurance
- ER Utilization
- Chronic Disease
- Mental Health
- 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.

3. The recommendations above are not ranked. A next step is for French Hospital Medical Center, along with Marian Regional Medical Center, Arroyo Grande Community Hospital, community partners, and others to determine which issues to address first. There are resources available that may assist French Hospital Medical Center's strategic planning committee in determining which needs to address first and how best to allocate resources. Implementation strategies, identified target areas and populations, how the major needs were prioritized, a description of what FHMC will do to address Community Needs and the subsequent Action Plan will be completed and part of French Hospital Medical Center's CHNA and Implementation Strategies Report by March 23, 2013.
4. Based on the comparison of each hospital's assessment reports the following are two areas that our hospital cannot directly affect but we support in this manner.

Mental Health –Through our Dignity Health Community Grants process some of the community proposals submitted are requesting funds addressing the mental health problem in our community. The Community Benefit Program coordinators collaborate often with local with Mental Health agencies in community forum to increase awareness of the resources. In kind printing for workshop and/or brochures and use of hospital facilities for community events are also offered by French Hospital Medical Center.

Oral Health- Through our Dignity Health Community Grants process some of the community proposals submitted are requesting funds addressing the oral health problem in our community. Hospital administration donates to SLO NOOR (a local free clinic) to support dental care in the service area.

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 educate all patients about the payment assistance policies and have been trained when it is appropriate to give payment assistance information and applications to patients.
3. FHMC keeps the public informed about the hospital's Financial Assistance/ Charity Care policy by providing signage and brochures in both English and Spanish. Dignity Health has assigned a name to describe these efforts: The FAIR cause Project; Financial – Assistance – Implementation – Review. Business Office staff and admitting/registration staff are provided training and scripting information about payment assistance to be given to patients during

- the registration process. Letters are sent to self-pay patients informing them of the program. Lobby and waiting areas have brochures and information available to patients as well. In addition, FHMC states that it turns no-one away regardless of his/her ability to pay in advertisements, if applicable.
4. FHMC has contracted with an outside vendor to work with patients as a Financial Counselor. This counselor will help link them to the various financial assistance programs available through the federal, state, local government programs and if they qualify through FHMC's payment assistance program. In FY 2011/2012 there were 1663 people who benefited from this program.

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 2011/12. Based on our findings in our assessment data statistics, related data in the Community Needs Index and hospital utilization data, FHMC has selected six key programs that provide significant efforts and resources guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs:** Seeks to accommodate the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention:** Addresses the underlying causes of a persistent health problem.
- **Seamless Continuum of Care:** Emphasizes evidence-based approaches by establishing operational linkages (i.e., coordination and redesign of care modalities) between clinical services and community health improvement activities.
- **Build Community Capacity:** Targets charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance:** Engages diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

For FY 2013 French Hospital Medical Center will implement/enhance program organized by the priority Focus Areas. Survey data statistics, data in the Community Need Index and hospital utilization data indicate three Priority Focus Areas for the FY2013. Programs intended to be operating in 2013 are noted by *. Programs were developed in response to the current Community Health Needs Assessment and are guided by the five core values.

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*
Kohl's nutrition education grant*
Lipid/Glucose Screenings*

Priority Area 3: Disease Management

Congestive Heart Failure Program – Long term improvement program*
Diabetes Prevention and Management – Long term improvement program*
Hearst Cancer Resource Center Services*
Healthy Living: Your Life Take Care*

Healthcare Education and Disease Prevention

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Underserved, poor, and broader communities: Health Promotion/Disease Prevention
Program Description	Provide San Luis Obispo population with opportunities to become proactive in their health by providing health- related education events in the French Hospital Medical Center (FHMC) service area.
FY 2012	
Goal FY 2012	Promote the chronic disease self-management program, related prevention lectures and screenings to FHMC service area. Promote Childbirth Education Classes to decrease fears, increase understanding and promote healthy choices during the childbirth process as a solid foundation to begin their families.
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. The Chronic Disease Self-Management program will decrease the number of visits to the ED room by 5% among the participants within 6 months from graduating date of hospital's preventive health intervention. 2. The Health for Life Nutrition lecture series will increase consumption of vegetables and fruits among the program participants by 5% within 6 months of graduating date of program. 3. Annual health fairs will show a 30% increase in screening ensuring each participant is provided a referral to a primary care provider and /or assistance to access to care focusing on the underserved and uninsured. 4. Increase collaboration with other local agencies to enrich class curriculums and to increase a greater understanding of resources available in our county. 5. Collaborate with TAPP in providing and organizing on site Teen Childbirth Classes twice a year. 6. Increase breastfeeding support.
Baseline	Number of people served through community education 4,443 screenings 1,711, MOM: 2010/2011 3,369 persons served
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Increase enrollment of participants by 10% in the CDSMP and HFL workshops . 2. Implement telephonic follow up of participants in the CDSMP and HFL programs at 3 and 6 months intervals after participants' graduation date form the program. 3. Partner with other community based organizations to sponsor 3 annual health fairs/screenings events 4. Increase collaboration with other agencies and resources by 10%. 5. Increase the number of pregnant teens participating in childbirth education classes by 10%. 6. Increase the number of women in the weekly Baby Hour by 10%, as well as use of French Breastfeeding Clinic (BFC) by 10%.

Result FY 2012	<ol style="list-style-type: none"> Partnerships were formed with CAP-SLO, SLO Public Health Clinic, and CRLA to implement CDSMP and HFL programs. No increase in attendance. Attendance stayed the same in our CDSMP and HFL programs this was due to the decrease in instructors. Only 3 month follow-up was completed due to graduation dates of workshops pass FY date. Participants in both English and Spanish CDSMP programs reported no ED visits at 3 month follow up time frame. Participants in HFL program noted a 15% increase in fruit and vegetable consumption and increase in physical activity. Three health fairs were completed two in Paso Robles and one in San Luis Obispo there was a 15% increased in referrals. Health screenings were done to individuals and upon assessment if the individual do not have a medical home for follow up they were referred to the nearest Community Health Center or to the Free SLO Noor clinic. Collaborated with 2 new community partners: Child Injury Prevention Coalition and Beginnings to increase awareness and enrollment in our community benefit prenatal classes. There was a 1.1% increase in pregnant teens participating in childbirth classes. There was a 1.2% increase in attendance in the weekly baby hour and attendances remain the same at Breastfeeding Clinic.
Hospital's Contribution / Program Expense	Hospital has provided in-kind space, nutrition services, advertising, printing, supplies for health fairs and screenings. \$ 60,182. Hospital provided the in kind advertisement and space for the childbirth classes and breastfeeding support group. \$ 183,786
FY 2013	
Goal 2013	Promote the chronic disease self-management program, childbirth teen education, lactation consultations, and related health prevention lectures and screenings to FHMC service area.
2013 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> The Chronic Disease Self-Management program will decrease the number of visits to the ED room by 5% among the participants within 6 months from graduating date of hospital's preventive health intervention. The Health for Life Nutrition lecture series will increase consumption of vegetables and fruits among the program participants by 5% within 6 months of graduating date of program. Increase attendance by 10% in both our Healthy for life and chronic self disease management programs. Increase community benefit prenatal classless and support group such as the Baby Hour and monthly number of births by 10 %. Increase number of teens or other disadvantaged women supported during their child birthing process by 10 %.
Baseline	Number of people served through community education 1,912 screenings 1,039, MOM: 1,583 persons served
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Promote CDSMP and HFL workshops using social media and other printed media outlets. 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. Collaborate and promote classes and birthing at French through OBGYN/CNM offices, local agencies and groups. 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
Community Benefit Category	A1a. Community Health Education: Lectures/Workshops & C5. Women's and Children Service

Congestive Heart Program																					
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Disease Management <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input type="checkbox"/> Maternal Health																				
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance																				
Link to Community Needs Assessment	Underserved, poor, and broader communities: Disease Management																				
Program Description	The Congestive Heart Failure (CHF) program provides education to patients diagnosed with CHF during the hospital stay in addition to providing discharge instructions. Patients enrolled in the program are provided consistent telephonic patient follow-up and education thereby decreasing the number of readmissions to the hospital. This program also serves cardiac patients through education, risk assessment and referrals.																				
FY 2012																					
Goal FY 2012	Avoid hospital and emergency department admissions for 6 months among 60% of participants enrolled in the CHF Program.																				
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Enhance the telephone based monitoring program by implementing Philips Telemonitoring to prevent hospital readmissions within 6 months of enrolling in the CHF Program. 2. Identify all patients at high risk for readmission within 6 months of hospital discharge using the Probability of Repeated Readmission tool in Philips software for both telemonitor and telephonic patients. 3. Measure quality of life changes for all participants enrolled in the CHF Program by the completion of program (6 months). 																				
Baseline	620 patient contacts documented through CHF program																				
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Continue to offer the CHF Program to all inpatients with a diagnosis of heart failure. 2. Provide hospital inpatients evidence based education regarding heart failure. 3. Implement Philips telemonitoring pilot program for 50 patients of the Central Coast service area. 4. Implement telephonic assessments in Philips software for remaining participants. 5. Continue to collaborate with CHW facilities as well as partners in the community (Community Health Clinic, Public Health Departments) to refer patients to the CHF Program. 6. Track reports for both telemonitor and telephonic participants for outcomes using SHP solutions tool as well as hospital MIDAS reports. 7. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers. 8. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center. 9. Utilize American Heart Association and American College of Cardiology resources and guidelines to continue education regarding heart failure as well as referrals to community based programs. 10. Evaluate participant response the telemonitor and telephonic programs using exit surveys. 																				
Result FY 2012	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Quarter/Yr</th> <th># of Participants</th> <th># of Readmissions</th> <th>% of Readmissions</th> </tr> </thead> <tbody> <tr> <td>Q 1/12</td> <td style="text-align: center;">87</td> <td style="text-align: center;">4</td> <td style="text-align: center;">4.6</td> </tr> <tr> <td>Q2 /2</td> <td style="text-align: center;">90</td> <td style="text-align: center;">6</td> <td style="text-align: center;">6.7</td> </tr> <tr> <td>Q3/12</td> <td style="text-align: center;">109</td> <td style="text-align: center;">5</td> <td style="text-align: center;">4.6</td> </tr> <tr> <td>Q4 /12</td> <td style="text-align: center;">139</td> <td style="text-align: center;">6</td> <td style="text-align: center;">4.4</td> </tr> </tbody> </table> <ol style="list-style-type: none"> 1. The average of participants receiving a telemonitors for 6 month was 16. Track 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 and discuss medication management. 2. 2. Telephonic calls were made to hospitalized patient and patients referred by doctors after 72 hours of being discharged to record if patient is being compliant and staying within the core measure parameters to avoid readmission. 	Quarter/Yr	# of Participants	# of Readmissions	% of Readmissions	Q 1/12	87	4	4.6	Q2 /2	90	6	6.7	Q3/12	109	5	4.6	Q4 /12	139	6	4.4
Quarter/Yr	# of Participants	# of Readmissions	% of Readmissions																		
Q 1/12	87	4	4.6																		
Q2 /2	90	6	6.7																		
Q3/12	109	5	4.6																		
Q4 /12	139	6	4.4																		
Hospital's Contribution / Program Expense	This program serves cardiac patients and CHF clients in the community through education, risk assessment and referrals. Cost \$ 115,445																				

FY 2013	
Goal 2013	Avoid hospital and ER admissions for 3 months among 80% of participants enrolled in the CHF Program
2013 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Identify all patients with a CHF diagnosis at high risk for readmission 2. Maintain the telephone based monitoring and Philips Home Monitoring Programs to prevent readmissions within 3 months of enrolling. 3. Measure program satisfaction with a Satisfaction Survey 4. Enhance access to care with use of Meditech
Baseline	At the end of FY 2012 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"> 1. Continue to offer the CHF Program to all inpatients with a diagnosis of heart failure. 2. Provide hospital inpatients evidence based education regarding heart failure. 3. Maintain Philips telemonitoring program for 50 patients of the Central Coast service area. 4. Work with computer support to capture important data for telephonic assessments participants. 5. Continue to collaborate with CHW facilities as well as partners in the community (Community Health Clinic, Public Health Departments) to refer patients to the CHF Program. 6. Partner with Marian Home Care for referrals to the CHF Program and collaborate on treatment plans with the home health case managers. 7. Continue to refer underserved patients who cannot afford their medication to the Alliance for Pharmaceutical Access Program at Marian Medical Center. 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.
Community Benefit Category	A3e. Health Care Support Services: Information & Referral

Cardiac Wellness	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Underserved, poor, and broader communities: Health Promotion/Disease Management
Program Description	Cardiovascular disease is the leading cause of death in the United States. The Heartaware Program 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 2012	
Goal FY 2012	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Screen at least 10 people for cardiovascular disease, including free Lipid Panel screening, every other month, for a total of at least 60. 2. Educate at-risk individuals regarding healthy lifestyle to reduce cardiac risk. Follow-up with at-risk individuals at 6 or 12 months to track risk factor reduction in response to lifestyle change. 3. Refer at-risk individuals to a primary care practitioner for retesting and/or treatment. Follow-up at 6 months to track entry to care. 4. Participate in education and outreach activities to the broader community, including at least 2 Health Fairs, and 2 lecture presentations to groups
Baseline	598 persons served
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Assess cardiac risk, including lipid screening at health fairs, free clinics, work-site wellness programs and other venues. 2. Collaborate with other community agencies that serve those at-risk for cardiovascular disease. 3. Educate groups or individuals regarding healthy lifestyle to reduce risk and prevent heart disease. 4. Refer at-risk individuals to a primary care practitioner or clinic for retesting and/or treatment. 5. Follow at-risk clients at 6 months or 1 year to track risk factor reduction with lifestyle change and/or medical treatment of risk factors
Result FY 2012	<ol style="list-style-type: none"> 1. Collaboration with community partners resulted in education and outreach at five health fairs (Health Expo in SLO, Winter Fiesta in Oceano, Atascadero State Hospital Employee Health Fairs, and 2 Paso Robles health fairs. 2. Provided 354 at risk assessment in which 165 deemed at risk and were offered a free lipid panels surpasses the initial goal of 60 free lipid panels, 67% were to women. Three resulted in elevated lipid and were referred back to their doctor or the free Noor clinic. 3. Seven follow up were completed at the 6 month interval, one resulted normal lipid levels. 4. 4. Monthly free lipid panel testing and risk assessment are being offered at the free Noor clinic.
Hospital's Contribution / Program Expense	Hospital provided in kind space, nutritional services, advertising, and printing. Expense \$ 10,228

FY 2013	
Goal 2013	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area
2013 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 75. 2. Educate at-risk individuals regarding healthy lifestyle to reduce cardiac risk. Follow-up with at-risk individuals at 6 or 12 months to track risk factor reduction in response to lifestyle change. 3. Refer at-risk individuals to a primary care practitioner for retesting and/or treatment. 4. Participate in education and outreach activities including at least 2 Health Fairs, and 2 lecture presentations to groups. 5. Target women for education and screening. 6. Offer free screening CT Calcium Score tests for uninsured.
Baseline	344 persons served
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Assess cardiac risk, including lipid screening at health fairs, free clinics, work-site wellness programs and other venues. 2. Collaborate with other community agencies that serve those at-risk for cardiovascular disease. 3. Educate groups or individuals regarding healthy lifestyle to reduce risk and prevent heart disease. 4. Refer at-risk individuals to a primary care practitioner or clinic for retesting and/or treatment. 5. Follow at-risk clients at 6 months or 1 year to track risk factor reduction with lifestyle change and/or medical treatment of risk factors. 6. Offer one educational presentation specifically regarding women and heart disease. 7. Offer 12 free CT Calcium Score tests to uninsured clients whose MDs request this test.
Community Benefit Category	A2d. Community Health Education: Lectures/Workshops

LTIP: Diabetes Prevention and Management																					
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Health																				
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance																				
Link to Community Needs Assessment	Underserved, poor, and broader communities: Access to Primary Healthcare, Disease Management																				
Program Description	Provide a comprehensive evidence-based diabetes management program providing education with registered dietitian and/or nurse specialized in diabetes management. The program will in prove behavior and self management practices of diabetic patients: enhance and improve the access and delivery of effective preventive health care services.																				
FY 2012																					
Goal FY 2012	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education.																				
2012 Objective Measure/Indicator of Success	Participants in the facility/service area evidence-based CDM program(s) will avoid admissions to the hospital or emergency department for the six months following their participation in the program.																				
Baseline	Diabetes Management program 56 persons served , Support groups 81 persons served																				
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Identify and engage a physician program champion 2. Identify registered dietician or CDE RN specializing in diabetes management to facilitate program 3. Engage home health, and Emergency Department case management for patient enrollment 4. Refer uninsured/underinsured patients to Alliance for Pharmaceutical Access for prescriptions 5. Develop a mechanism to follow-up and track these enrolled patients and for the six months following their participation in the program. (i.e. telephonic support) 6. Identify culturally and linguistically appropriate messaging for this population of diabetic patients. 7. Provide in-service to hospital staff regarding Diabetes Prevention and Management Program. 8. Enroll program participants in CDSMP and Healthy for Life programs. 9. Support in-patient awareness of chronic disease education through case management. 10. Investigate availability of software that can track indicators to follow patients. 																				
Result FY 2012	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education. <table border="1"> <thead> <tr> <th>Quarter/Yr</th> <th># of participants</th> <th># of readmissions</th> <th>% of readmissions</th> </tr> </thead> <tbody> <tr> <td>Q1/12</td> <td>6</td> <td>0</td> <td>0</td> </tr> <tr> <td>Q2/12</td> <td>29</td> <td>0</td> <td>0</td> </tr> <tr> <td>Q3/12</td> <td>31</td> <td>0</td> <td>0</td> </tr> <tr> <td>Q4/12</td> <td>6</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Quarter/Yr	# of participants	# of readmissions	% of readmissions	Q1/12	6	0	0	Q2/12	29	0	0	Q3/12	31	0	0	Q4/12	6	0	0
Quarter/Yr	# of participants	# of readmissions	% of readmissions																		
Q1/12	6	0	0																		
Q2/12	29	0	0																		
Q3/12	31	0	0																		
Q4/12	6	0	0																		
Hospital's Contribution / Program Expense	Hospital provided n kind space, nutritional services, advertising, and printing. Expense \$ 9,397																				
FY 2013																					
Goal 2013	Avoid Emergency Room visits for uncontrolled hyperglycemia among the targeted population by incorporating health system navigation, concise diabetes self-management skills and health-related education.																				
2013 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Establish a system for identifying patients with frequent re use of the emergency room for glycemetic control issues. 2. Identify resources and tools needed to meet these patients needs and develop a plan for providing care 3. Pilot the use of the Phillips Monitoring Program blood glucose capabilities for patients in the CHF program who have diabetes. 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 5. Continue with the diabetes support group and increase enrollment by 2% 																				

Baseline	Diabetes Support Group 81 No data for Phillips Monitoring Program this will be new
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Identifying high risk patients that frequent the ER and determine the best process for following these patients after ER visit. 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. 3. Modify the tool kit developed in 2012 to be used with the Phillips system 4. Pilot the use of the system with these patients for tracking blood sugar results and providing self management telephonic support. 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.
Community Benefit Category	A1c. Community Health Education: Individual Health Education for uninsured/under insured

Cancer Resource Center

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Primary Healthcare Services <input checked="" type="checkbox"/> Health Promotion/ Disease Prevention <input checked="" type="checkbox"/> Disease Management <input type="checkbox"/> Maternal Health
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Underserved, poor, and broader communities: Health Promotion/Disease Prevention
Program Description	The Hearst Cancer Resource Center provides information, education and support services for cancer patients and their families. The center is staffed with qualified personnel and collaborates with existing services in the community. The center will be part of a regional approach in concert with the other CHW Central Coast Service Area.
FY 2012	
Goal FY 2012	To improve the health and well-being of the underserved in the FHMC service area through education and screening for early detection and the prevention of cancer.
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Provide 2 lectures by the nurse navigator on prevention and screening of cancer to the Hispanic community. 2. Improve healthy eating habits for the prevention of cancer to Hispanic families by increasing attendance at the cooking series by 5%. 3. Identify 3 outreach venues to increase awareness of the importance of cancer screening, early detection, healthy living, and prevention of cancer to the most vulnerable in the FHMC service area.
Baseline	17,358 community members served through education, information, and referral, self help and support groups
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Work in collaboration with the certified medical interpreter. Programs to be held at the SLO Self-Help Housing project in Paso Robles. Follow-up discussions with interpreter to determine outcome of service. In addition, HCRC plans to partner with Dr. Nooristani, who is opening a free clinic for individuals underinsured, by providing bilingual lectures and cancer prevention and screening information. 2. Collaborate with Hospice of San Luis Obispo County and SLO Self-Help Housing to present "Home Cooking: Familiar Foods for Better Health" 4-week class in Spanish. Collect evaluations to determine the outcomes of the program. Promote through flyers, HCRC newsletter and health educators. 3. Partner with FHMC Community Benefits department on numerous SLO county health fairs using bi-lingual health educators to distribute educational cancer prevention pamphlets and information. Work with the SLO County Promotoras to outreach to the Hispanic community. 4. Provide three onsite presentations at the senior self-help living facilities. Programs to include: Advance Directive in collaboration with FHMC Palliative Care Nurse, HCRC resources and programs lecture and mini-demonstration of a HCRC program. Evaluations will be distributed to determine the outcome of these programs. 5. Partner with local oncologist and dermatologist to provide a skin cancer screening for farmer workers and seniors in the fall of 2011. Forms and follow-up procedures will adhere to the standards of the Dermatologic Society
Result FY 2012	<ol style="list-style-type: none"> 1. Nurse Navigator assisted 12 Spanish speaking cancer patients and also assisted approximately 70 underinsured or uninsured cancer patients with the process of navigating the financial burdens of their cancer treatment. 2. Collaborate with Hospice of San Luis Obispo County and the Wellness Kitchen to present "Home Cooking: Familiar Foods for Better Health." 59 Spanish speaking participants attended and learned how to eat healthy for the prevention of cancer. 3. Provided three offsite presentations at the senior self-help living facilities which include: Advance Directive presented by FHMC/CHF nurse and two presentations on HCRC information and program demonstration. 4. Partnered with local dermatologist and oncologist for a free skin cancer screening for the underinsured and uninsured Hispanic workers and seniors. Held at Canyon Creek Apartments in Paso Robles. Twenty individuals were screened. 2 referrals for further exam were made, with both results benign. 5. HCRC organized and coordinated the "Survivors' Tent" at the San Luis Obispo Relay for Life 2012. HCRC collect, from the community, donated items for survivor gift bags which were distributed to all cancer survivors in attendance. In addition HCRC coordinated scheduled activities held in the "Survivors' Tent" ranging from massage, energy balancing, and various art projects, to free refreshing ice tea. 60 participated and their feedback was positive and appreciative.
Hospital's Contribution / Program Expense	HCRC and FHMC provided in kind space, nutritional services, advertisement, and printing. Expense \$ 199,417

FY 2013	
Goal 2013	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.
2013 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Improve healthy eating habits for the prevention of cancer to Hispanic families by increasing attendance at the cooking series by 10%. 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. 3. Offer a skin cancer screening to the Latino population of the FHMC service area. Increase attendance by 10%. (22 individual)
Baseline	7,623 community members served through education, information, and referral, self help and support groups
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Collaborate with 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. Promote through flyers, Latino support groups, churches and health educators. 2. 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. 3. 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. 4. 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.
Community Benefit Category	A1a. Community Education: Lectures/Workshops

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

Community Benefit and Economic Value

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

9/26/2012
 366 French Hospital Medical
 Complete Summary - Classified Including Non Community Benefit (Medicare)
 For period from 7/1/2011 through 6/30/2012

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
Benefits for Poor						
Financial Assistance	1,663	661,071	0	661,071	0.7	0.7
Medicaid	6,509	10,417,914	6,222,602	4,195,312	4.5	4.2
Means-Tested Programs	581	1,397,928	662,425	735,503	0.8	0.7
Community Services						
Community Benefit Operations	0	65,519	0	65,519	0.1	0.1
Community Health Improvement	8,122	388,300	0	388,300	0.4	0.4
Financial and In-Kind Contributions	7,107	105,610	24,036	81,574	0.1	0.1
Subsidized Health Services	2,054	161,412	20,855	140,557	0.2	0.1
Totals for Community Services	17,283	720,841	44,891	675,950	0.7	0.7
Totals for Poor	26,036	13,197,754	6,929,918	6,267,836	6.8	6.2
Benefits for Broader						
Community Services						
Community Benefit Operations	0	43,044	0	43,044	0.0	0.0
Community Health Improvement	8,105	204,900	0	204,900	0.2	0.2
Health Professions Education	0	69,952	0	69,952	0.1	0.1
Totals for Community Services	8,105	317,896	0	317,896	0.3	0.3
Totals for Broader Community	8,105	317,896	0	317,896	0.3	0.3
Totals - Community Benefit	34,141	13,515,650	6,929,918	6,585,732	7.1	6.5
Unpaid Cost of Medicare	23,848	32,221,891	25,137,126	7,084,765	7.6	7.0
Totals with Medicare	57,989	45,737,541	32,067,044	13,670,497	14.7	13.6
Totals Including Medicare	57,989	45,737,541	32,067,044	13,670,497	14.7	13.6


9/25/12
 Sue Anderson CFO, Central Coast Service Area Dignity Health Hospital, Date

B. Telling the Story

1. FHMC publishes articles regarding community benefits, community outreach, mission-driven events and community collaborations in our “Points of Excellence” newsletter sent to physicians, community members and leaders, the FHMC Community Board, the FHMC Foundation Board, CHW Corporate Office, CHW Sisters, and employees.
2. A FHMC bi-monthly hospital newsletter, the “In-Service,” highlights a broad range of program activities including hospital, department-specific and individual activities.
3. A FHMC quarterly physician newsletter, the “Physician Folio”, highlights hospital programs and highlights community benefit activities.
4. Press releases, television, radio and newspaper coverage have noted the many programs in which French Hospital is involved. Much of the coverage focuses on the underserved population of San Luis Obispo County
5. All brochures, patient instructions and other information are printed in Spanish. The FHMC website is also translated into Spanish.
www.frenchmedicalcenter.org.
6. FHMC Community Benefit Report FY 2012 and FHMC Community Needs Assessment Report 2012 can be found on line at
www.frenchmedicalcenter.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

THOMPSON/CHW COMMUNITY NEEDS INDEX

Market Name: French Hospital Medical Center

Market 2011 Population: 233,399

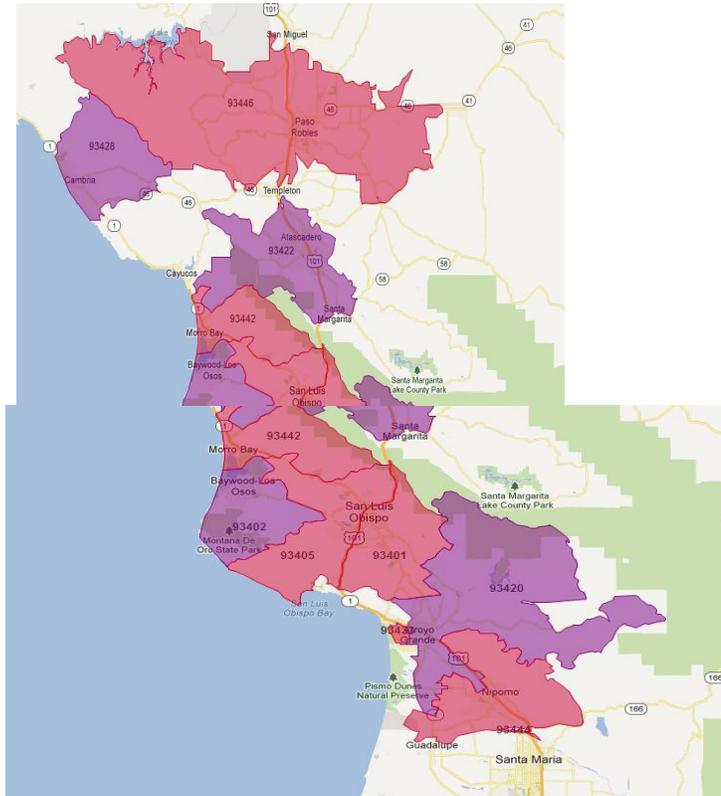
CNI Median Score: 3.4

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

San Luis Obispo County Zip Codes

French Hospital Medical Center Primary & Secondary Service Area



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

	<u>Zip Code</u>	<u>CNI 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

FY 12

Jim Copeland
Chair of the Board
Copeland's Properties

Ann Grant RN, PhD
Vice Chair
Nurse Educator, Cal State Dominguez Hills

Kevin Rice
Secretary
Pismo Beach City Manager

Father Russell Brown
Pastor SLO Old Mission Church

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

Patricia Gomez
Attorney-at-Law

Alan Iftiniuk
President, French Hospital Medical Center

Ben Kulick
President, Stalfund, LP

Richard J. Macias, MD
Central Coast Pediatrics

J Trees Ritter, OD
Chief of Staff

Sandee McLaughlin
Executive Dean, Cuesta College

Rabbi Norm Mendel
Rabbi Emeritus, Congregation Beth David

Cornel Morton, PhD
Senior Advisor to the President for Outreach

Kerry Pollock
Chief Operating Officer
Morris & Garritano Insurance

Sister Marianne Rasmussen, OSF
Retired Teacher/Administrator

John Dunn
Retired San Luis Obispo City Administrator

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

John Ronca Jr.
Attorney-at-Law

Mark Soll, M.D.
Central Coast Chest Consultants

Sandy Dunn
Foundation Board Chair

Ke-Ping Tsao, M.D.
Plastic Surgeon

French Hospital Support Staff

Sue Andersen
Service Area CFO

Ken Hritz
Vice President of Professional Services

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

Megan Maloney
Director of Communications and Mission
Services

Linda Riggle, BSN, MHSL
Chief Nursing Executive

Susan Cedar
Vice President of Human Resources

Attachment D

FHMC Community Benefits Committee FY12

Patricia Gomez
Chair of the Committee

Fr. Russell Brown
San Luis Obispo Mission

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

Denise Gimbel, RN, MPH
Cardiac Wellness – Program Coordinator

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

Beverly Kirkhart
Hearst Cancer Resource Center – Program Coordinator

Sandee L. McLaughlin
Executive Dean, Cuesta College

Rabbi Norm Mendel
Rabbi Emeritus, Congregation Beth David

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

Ami Padilla
Director of Education and Community Benefits

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

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

Sandy Underwood
Community Benefits Coordinator – MMC

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

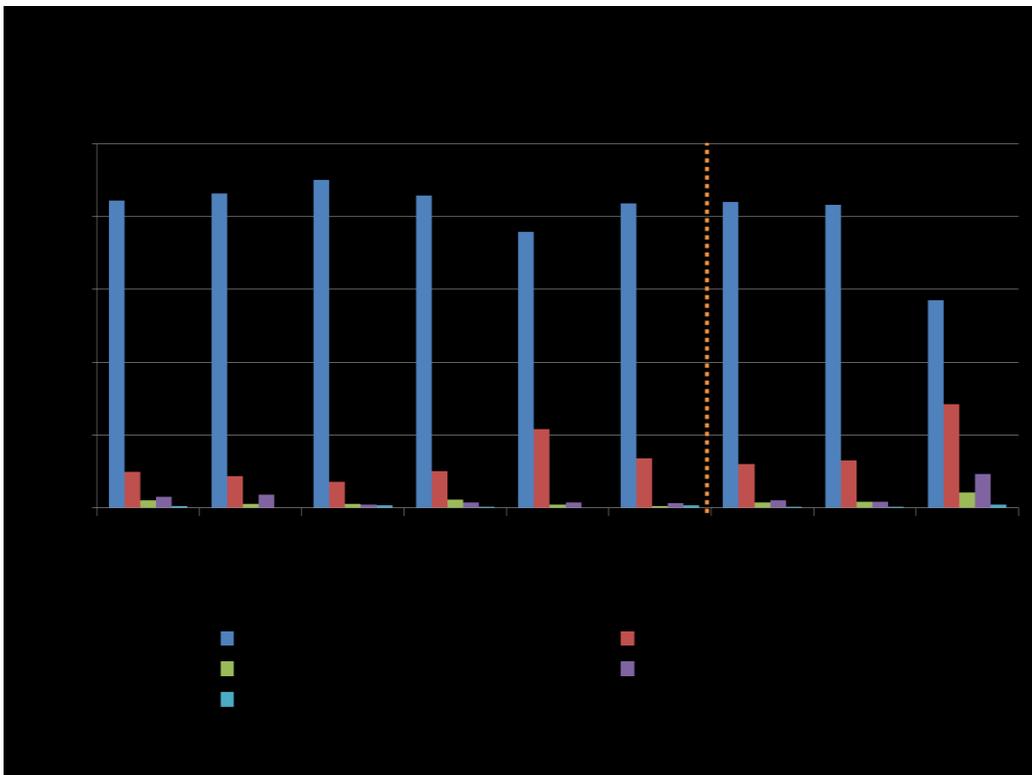
Susan Cedar
Vice President of Human Resources

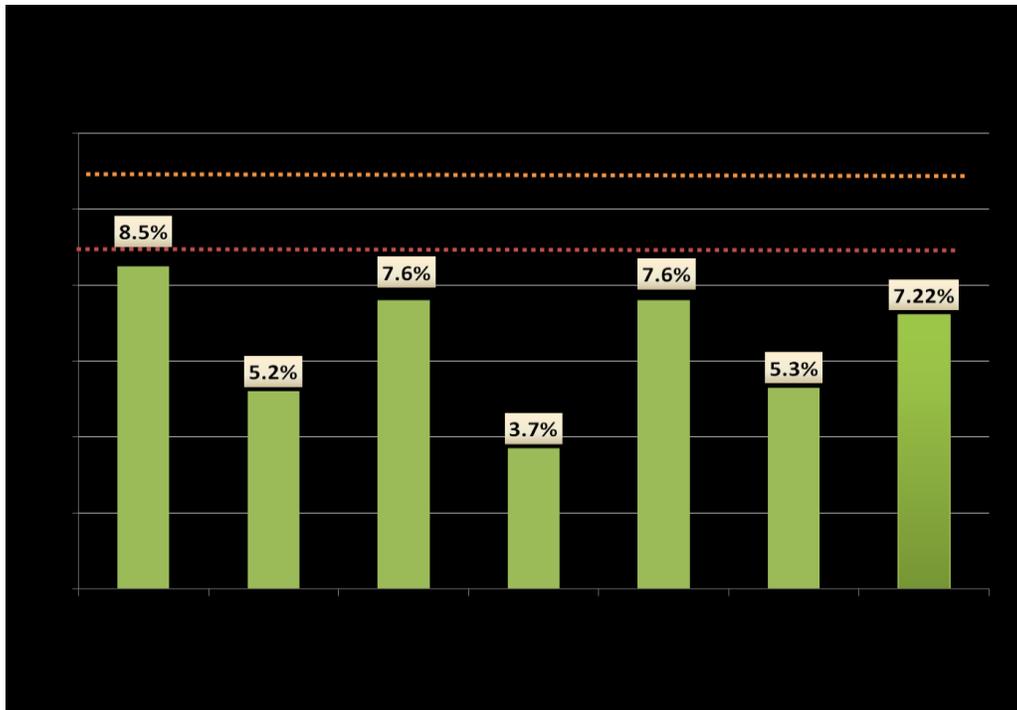
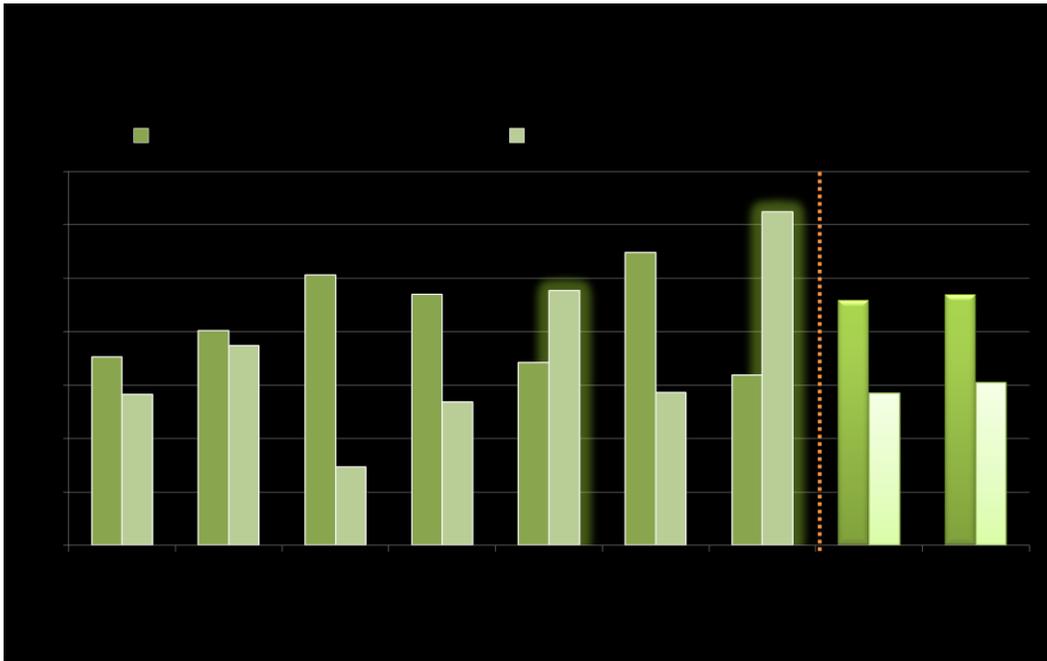
Attachment E

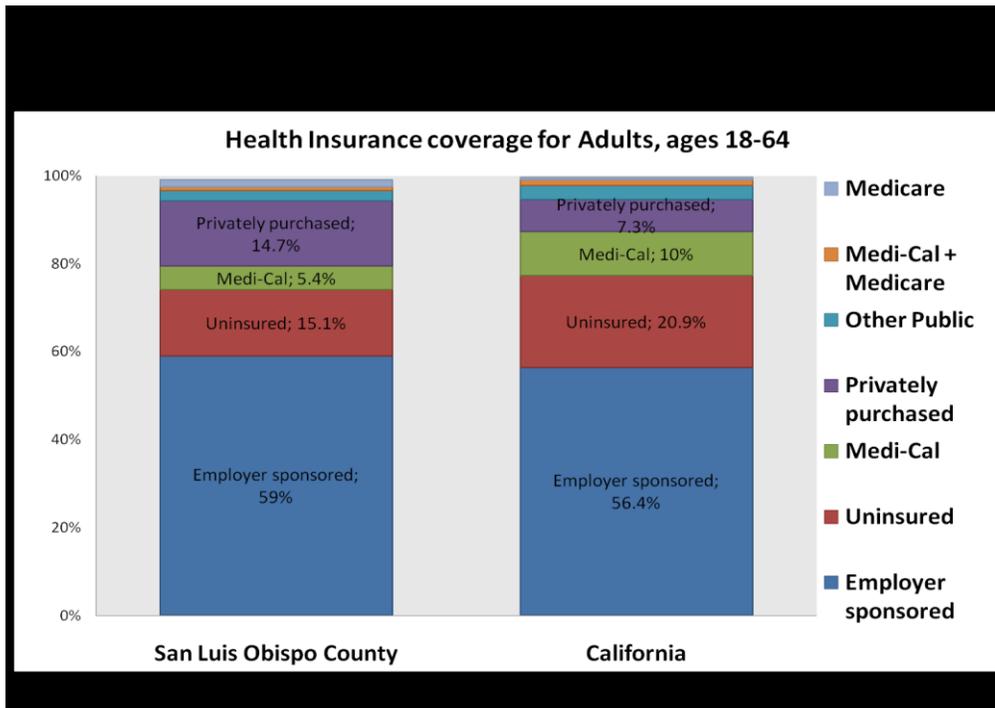
Attachment F

Population		
	2000	2010
93401 San Luis Obispo	27,034	28,033
93402 Los Osos	14,842	14,318
93405 NW San Luis Obispo	31,972	35,440
93422 Atascadero	29,532	31,375
93442 Morro Bay	10,891	10,789
93446 Paso Robles	35,578	43,714
93428 Cambria	6,515	6,314
FHMC Service area	156,364	169,983
San Luis Obispo County	246,681	269,637
California	33,871,648	37,253,956

Source: U.S. Bureau of the Census, 2000, 2010







	Number of Households	Median Household Income
	2006-2010	2006-2010
San Luis Obispo city	19,734	\$40,812
Los Osos city	6,383	\$56,918
Atascadero city	10,453	\$65,479
Morro Bay city	4,646	\$53,585
Paso Robles city	10,766	\$57,459
Cambria city	2,941	\$72,066
FHMC Service area 2	54,923	\$57,720
San Luis Obispo County	102,434	\$57,365
California	12,392,852	\$60,883

