Dignity Health
French Hospital Medical Center

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Community Benefit 2018 Report and 2019 Plan

Dignity Health.
French Hospital Medical Center

A message from

Alan Iftiniuk, president and CEO of French Hospital Medical Center, and Leopold Selker, Chair of the Dignity Health French Hospital Medical Center Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

French Hospital Medical Center shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2018 (FY18), French Hospital Medical Center provided $13,382,872 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $ 18,963,282 in unreimbursed costs of caring for patients covered by Medicare.

French Hospital Medical Center's Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its October 18, 2018 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.

President/CEO
Alan Iftiniuk

Chairperson, Board of Directors
Leopold Selker

TABLE OF CONTENTS

At-a-Glance Summary

Community Served	The primary service area for French Hospital Medical Center (FHMC) encompasses the areas of San Luis Obispo (93401, 93405), Atascadero (93422), Templeton (93465), Morro Bay (93442), Los Osos (93402), Cambria (93428) and Paso Robles (93446). The overall service area for FHMC extends from the City of San Luis Obispo to the East, North, and West into the unincorporated areas of San Luis Obispo County to the county limits.
Economic Value of Community Benefit	$13,382,872 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $18,963,282 in unreimbursed costs of caring for patients covered by Medicare.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are: • Access to Health Care, including Behavior Health • Homelessness/Housing • Cardiovascular Disease and Stroke • Cancer Screenings and Prevention
FY18 Actions to Address Needs	In FY18, French Hospital Medical Center took numerous actions to help address identified needs. These included: Cancer Prevention and Screenings; Cardiovascular Disease and Stroke lectures and screenings; Care Transitions for discharged patients with heart disease, pneumonia, and chronic obstructive pulmonary disease; Chronic Disease Self-Management workshops; Diabetes Prevention and Management and Diabetes Education Empowerment Program (DEEP). A total of $ 66,826 was awarded in the Dignity Health Community Grants program to Accountable Care Communities that address Access to Healthcare and Homelessness/Housing.
Planned Actions for FY19	For FY19, the hospital plans to increase the number of chronic disease and diabetes self-management workshops offered, increase cancer awareness on the importance of early detection for colon and cervical cancer, and continue the Spanish speaking support group for women who have been diagnosed with cancer.

This document is publicly available at http://www.dignityhealth.org/frenchhospital/about-us/community-benefits. This document is shared with the Foundation and Hospital Community Board. Electronic distribution of the report to local health and social related coalitions will be provided by the hospital's community health department.

Written comments on this report can be submitted to the French Hospital Medical Center Community Health office, 1911 Johnson Ave. San Luis Obispo Ca. 93401 or by e-mail to CHNA-CCSAN@dignityhealth.org

MISSION, VISION AND VALUES

French Hospital Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

Our Mission

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.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

OUR HOSPITAL AND THE COMMUNITY SERVED

About French Hospital Medical Center

French Hospital Medical Center (FHMC), founded in 1946, is located at 1911 Johnson Avenue, San Luis Obispo, California. It became a member of Dignity Health in 2004. FHMC has long been ranked as a top provider of orthopedic care, made possible by the 14 bed modernized unit which shows FHMC's ongoing commitment to the specialized care of orthopedic patients. FHMC's has a total of 98 licensed beds. Once again this year, FHMC has been named one of the Nation's 100 Top Hospitals® for a fourth time by Truven Health Analytics, a leading provider of information solutions to improve the cost and quality of health care. FHMC has a staff of more than 500, 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. FHMC is the home to the Central's Coast's first and only cardiac hybrid suite, a space where interventional radiologists, cardiologists, and cardiovascular surgeons can work side-by-side in the same room at the same time.

Description of the Community Served

French Hospital Medical Center serves the areas of San Luis Obispo (93401, 93405), Atascadero (93422), Templeton (93465), Morro Bay (93442), Los Osos (93402), Cambria (93428) and Paso Robles (93446). A summary description of the community is below, and additional details can be found in the CHNA report online.

French Hospital Medical Center defines the community's geographic area based on the residence zip codes of the majority of discharged patients. The overall service area for FHMC extends from the City of San Luis Obispo to the East, North, and West into the unincorporated areas of San Luis Obispo County to the county limits. FHMC's primary service area covers a large area, with approximately 35-miles between FHMC and the furthest service area locations to the north and northwest. The City of San Luis Obispo is the largest city within FHMC's primary service area and aside from the other incorporated areas within the service area mentioned above, the remainder of the area is either agricultural land or open space.

According to the CHNA report of June 2016 FHMC's primary service area is home to just over approximately 180,000 people of which 69.7% of consider themselves Caucasian, with 20.6% considering themselves Latino (a) or Hispanic. Overall, approximately 1 in 5 individuals in the FHMC primary service area reside in poverty although 89% have a high school degree or equivalent. The youth population (under age 18) residing within the FHMC primary service area is 17%, and a similar 15% represent those 65 years of age and over. U.S. Census data was obtained through use of ZIP codes, to ensure that the larger, unincorporated areas were included. In San Luis Obispo (and North San Luis Obispo), specifically, those residing in ZIP codes 93401 and 93405 have the largest young adult population (attributed to the local university), as well as the highest poverty level.

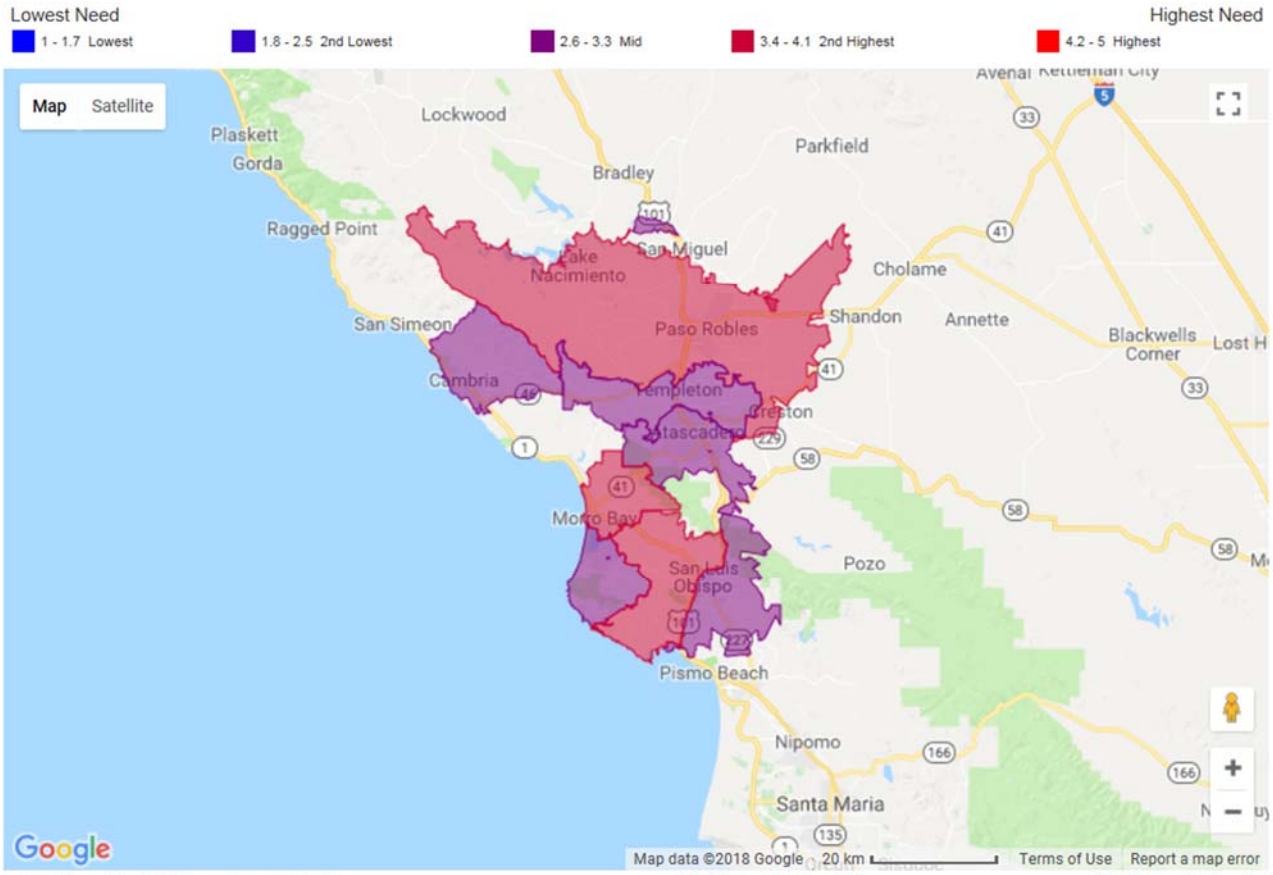
Overall, 20.7% and 42.3% of individuals residing in 93401 and 93405, respectively, are living in poverty exceeding state 16.4% and national 15.6% poverty rates. In addition, the largest Hispanic or Latino (a) population of approximately 13,900 individuals resides in Paso Robles (93446) and San Luis Obispo (93401, 93405) is home to approximate 10,250 individuals who identify themselves as Hispanic or Latino (a). The 2015 Homeless Point-in-Time Report for San Luis Obispo County documented a total of 1,257 of unsheltered and sheltered individuals in North County (Atascadero, Paso Robles, San Miguel, and Templeton), Coastal Areas (Cambria, Cayucos, Los Osos, and Morro Bay), and the City of San Luis Obispo.

In addition to the residents captured by the U.S. Census discussed above, the FHMC primary service area attracts a farm-worker population drawn to work in the fields. There is no known current estimate of the number of indigenous-language population of Mexicans from the State of Oaxaca and neighboring Guerrero that currently reside within the FHMC primary service area.

Demographic information for the FHMC primary service area taken from 2018 The Claritas Company, © Copyright IBM Corporation 2018 provides data on the following:

- Total Population: 187,235
- Hispanic or Latino: 20.6%
- Race: 69.7% White, 2.0% Black/African American, 4.1% Asian/Pacific Islander,
- 3.6% All Others
- Median Income: $67,694
- Uninsured: 8.2 %
- Unemployment: 2.9%
- No HS Diploma: 9.7%
- CNI Score: 3.2
- Medicaid Population: 22.5%
- Other Area Hospitals: 2
- Medically Underserved Areas or Populations: Yes

* Does not include individuals' dually-eligible for Medicaid and Medicare.



Mean(zipcode): 3.3 / Mean(person): 3.4 CNI Score Median: 3.2 CNI Score Mode: 3.2

Zip Code	CNI Score	Population	City	County	State
93401	3.2	29505	San Luis Obispo	San Luis Obispo	California
93402	3.2	14166	Los Osos	San Luis Obispo	California
93405	4	35184	San Luis Obispo	San Luis Obispo	California
93422	3.2	33079	Atascadero	San Luis Obispo	California
93428	3	6502	Cambria	San Luis Obispo	California
93442	3.4	11207	Morro Bay	San Luis Obispo	California
93446	3.6	47780	Paso Robles	San Luis Obispo	California
93465	3	9812	Templeton	San Luis Obispo	California

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and©2018 IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

COMMUNITY ASSESSMENT AND PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Community Benefit Committee and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in June 2016.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

- Access to Health Care including, behavioral health: FHMC serves many unincorporated or small communities within the county. Residents may have to travel more than 30 miles to reach FHMC and/or to San Luis Obispo to visit a specialist. Secondly, there is a population of agriculture employees in FHMC's service area. These individuals often have families that are under-educated, under-insured, and do not regularly access healthcare until the need is too significant.
- Homelessness or housing: Lack of affordable housing and overcrowding in rentals was identified in community stake holder interviews and key stakeholder groups.
- Cancer screenings: Based upon State of California Death Profiles, cancer is the leading cause of death in the FHMC service area. FHMC Community Health Needs Assessment report indicated 40% of women over 40 in the targeted survey population living in Atascadero and the Coastal Areas (Baywood, Los Osos, Morro Bay, and Cambria) reported not receiving a mammogram in the past year.
- Cardiovascular Disease and Stroke: According to California Vital Statistics in 2012, the second leading cause of death for 21.3% of individuals residing in the FHMC service area were diseases of the heart. FHMC Community Health Needs Assessment reported that health survey

participants' residing in Paso Robles were less likely to have received a lifetime cholesterol check then those residing in the City San Luis Obispo.

Behavioral Health is a significant health needs the hospital has chosen not to address alone. The hospital is limited in resources to address behavioral health and homelessness/housing independent of our community partners. Considerable investigation revealed behavioral health and homelessness/housing are being addressed by a number of organizations. By invitation to community-based organizations we can facilitate a seamless continuum of care, develop relationships that can be addressed through the Dignity Health Community Grants Program.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at http://www.dignityhealth.org/frenchhospital/about-us/community-benefits or upon request at the hospital's Community Health office.

Creating the Community Benefit Plan

Rooted in Dignity Health's mission, vision and values, French Hospital Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

Program planning for fiscal year 2019 included the review of existing activities for effectiveness, the need for continuation, or the need for enhancement. Specific attention was given to the program's ability to address the identified needs and serve the vulnerable population. Members from the Community Benefit Committee, senior leadership, clinical experts and program owners met to evaluate the existing programs and develop new programs. Current literature along with Healthy People 2020 were utilized when identifying program goals and developing measurable outcomes. Collaboration with community partners also led to improved program design, best practices and effective interventions. These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, senior leadership, Community Board and the system office (Dignity Health) receive regular program updates.

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. Working together with Latino Health Coalition will continue to increased awareness and attendance among the Latino community for nutrition, chronic disease management, health screenings, diabetes, cardiovascular disease, stroke and cancer awareness.

2018 REPORT AND 2019 PLAN

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

Report and Plan Summary

Health Need: Access to Health Care, including Behavioral Health			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Fund Accountable Care Communities (ACC) whose goal is to provide access to health care for vulnerable populations	• Community Grant to SLO Noor Foundation for free primary medical clinic • Alliance for Pharmaceutical Access provides access to prescriptions, increasing access for those who are underinsured or uninsured	☒	☒
Support Groups	Cancer, Diabetes, Stroke and Grief; offered at a variety of locations throughout the service area	☒	☒
Patient Care Coordinator Initiative	Provides smooth transitions discharged patients to home.	☒	☒
Provide financial assistance to the vulnerable population	• Charity Care • Transportation vouchers: taxis • Bus passes • Gas cards	☒	☒
Anticipated Impact: Increase access to free medical care and resources to provide early detection, prevention, and management of illness. Increase smooth transitions for discharged patients by providing access to "medical homes" and pharmaceutical patient assistance programs.			

Health Need: Homelessness/Housing			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Fund Accountable Care Communities (ACC) whose goal is address homelessness/ housing	Community Grant to Recuperative Care Program which provides both shelter, medical care, and case managing with the goal of meeting all the basic needs, medical care and mental health the individual needs	☒	☒
Provide respite care to homeless discharged patients	FHMC Anderson Hotel Homeless Respite Care program is collaboration between FHMC and the Housing Authority of SLO County in which a room is reserved for FHMC homeless discharged patients that need respite care.	☒	☒
Provide in-kind amenity bags containing personal hygiene	FHMC donates amenity bags containing personal hygiene products to Prado Day Homeless Shelter and El Camino Homeless Organization shelter	☒	☒
Anticipated Impact: Increase healthy outcomes after hospital stay of homeless patients. Offer a possible housing opportunity for the homeless.			

Health Need: Cancer Screening and Prevention			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Offer bilingual and bicultural cancer awareness information at community health events and community lectures	Bilingual/bicultural lay patient educator provides cancer awareness lectures and participates in local health events throughout SLO county.	☒	☒
Offer free screening mammograms to the vulnerable population	Cancer Care program offers free screening mammograms to women who are uninsured or underinsured.	☒	☒
Anticipated Impact: Increase cancer awareness and prevention to the most vulnerable populations in SLO county to increase early cancer detection.			

Health Need: Cardiovascular Disease and Stroke			
Strategy or Activity	**Summary Description** [1-3 sentences or dot points]	**Active FY18**	**Planned FY19**
Offer bilingual and bicultural cardiovascular disease and stroke awareness information and risk assessments at community health events and community lectures	• Community Health educators provide cardiovascular disease and stroke awareness information and risk assessments at community health events and community lectures. • FAST Fridays-Stroke assessments in the community. Heart Aware program- online risk assessment tool.	☒	☒
Offer disease self-management workshops	• Healthier Living, Take Care of Your Life • Healthy for Life Wellness Program • Diabetes Empowerment Education Program (DEEP)	☒	☒
Offer telephonic support to discharged heart failure patients	Telephonic nursing support through Care Transitions Program.	☒	☒
Anticipated Impact: Increase cardiovascular disease and stroke awareness, prevention, and management to the most vulnerable populations in SLO county to increase early detection.			

Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY18, the hospital awarded two grants totaling $66,826. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	**Project Name**	**Amount**
SLO Noor Foundation	Expanding Access to Cancer Screening and Primary Care in North County San Luis Obispo	$ 50,121
Community Action Partnership of SLO County	Recuperative Care Program	$ 16,705

Anticipated Impact

The anticipated impacts of the hospital's activities on significant health needs are summarized above, and for select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

Planned Collaboration

While the hospital has available resources to address Cancer, Cardiovascular Disease and Stroke, the identified needs of Access to Health Care, including behavioral health and Homelessness and Housing are too significant for any one organization. Making a substantial and upstream impact will require collaborative efforts. The following is a list of the community-based organizations with which the hospital can work to deliver programs specifically related to Access to Health Care, including behavioral health and Homelessness and Housing.

Access to Health Care including Behavioral Health:

- Latino Health Coalition: Providing Health for the Community Events with free health screening and community resources are available to the community
- Community Health Centers of the Central Coast
- SLO Noor Free Medical, Dental, and Vision Clinics
- Transitions Mental Health Association
- Community Counseling Center
- Mental Health Evaluation Team

Homelessness/Housing:

- Anderson Hotel Respite Care Program
- Community Action Partnership of SLO's (CAPSLO) Prado Day Center
- El Camino Homeless Organization (ECHO)
- Maxine Lewis Homeless Shelter
- San Luis Obispo Housing Authority
- Local Churches
- Catholic Charites
- Local Police Department

Financial Assistance for Medically Necessary Care

French Hospital Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Actions taken to inform the community about the hospital's Financial Assistance Policy are as follows:

- Community Benefit Report: Included the policy's plain language summary and a statement about the availability of financial assistance in the report posted online.
- Community Health/Community Benefit Committee: Shared the policy or plain language summary with the committee, which includes community representatives.
- Community Partner Agencies or Networks: Shared the policy or plain language summary with public and/or private community partner agencies or networks that serve the health and social needs of poor and vulnerable populations. Agencies/networks are as follows: Latino Health Coalition Members, ACTION for Healthy Communities committee members, and SLO County Health Commission

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Cancer Prevention and Screenings	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness/Housing ☒ Cancer Screenings ❑ Cardiovascular Disease and Stroke
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	FHMC's Hearst Cancer Resource Center addresses medical, physical, social, financial, spiritual and emotional needs of cancer patients and their families. The Center provides expert care while advancing the understanding of early diagnosis, treatment, and prevention of cancer. Social and rehabilitative support services are provided for cancer patients, their families and loved ones that include consultations with oncology nurse, social worker, certified cancer exercise trainer and registered dietician.
Community Benefit Category	A1a, A1d, A1e-Community Health Improvement Services; A1e-Health Care Support Services; A2d- Community Based Clinical Services; E3d-Financial and In-Kind Donations
FY 2018 Report	
Program Goal / Anticipated Impact	Improve the health and well-being of the target population on the Central Coast Service Area through health education and screenings for early detection and prevention of cancer
Measurable Objective(s) with Indicator(s)	1. Increase participation in health fairs by 50% over FY 2017 to the total of 17 and increase patients served for breast cancer screenings by 20% over FY 2017 to the total of 25 2. Facilitate 8 Spanish speaking support group sessions for women diagnosed with cancer. 3. Offer one community lecture on Colon cancer in Spanish. 4. Establish referral system with local providers for cervical cancer screenings.
Intervention Actions for Achieving Goal	1. Increase # of patients served through patient reminder using telephone reminders, discussions with information indicating benefit regarding potential barriers to screenings. 2. Provide cancer awareness information and community resources to target population at specified community locations and health events. 3. Patient navigator will track the following: # screened, # referred for further evaluation, # patients cancer detected, # patients receiving cancer treatment. 4. Establish a Spanish speaking support group for women diagnosed with cancer. 5. Offer a community forum, targeting the Hispanic population, with local experts to educate this population about the importance of screening colonoscopy. 6. Collaborate with Noor to promote this lecture and distribute Spanish information on awareness and prevention of colon cancer. 7. Provide cancer awareness information and community resources to target populations which will include Breast, Cervical, and Colon Cancer Screenings.
Planned Collaboration	Planned Collaboration Community Health Centers of the Central Coast, SLO Noor Free Clinic, PCCHC, Planned Parenthood (Santa Barbara, Ventura and San Luis Obispo County), Community Action Partnership of San Luis Obispo

	County, People Self Help Housing, and San Luis Obispo County Health Department.
Program Performance / Outcome	1. Goal was reached for health fair attendance, 17 health fairs, resulting in outreach to a total of 1,021 individuals for FY 2018. Outcome for lectures: 30 lectures, reaching 577 individuals. FHMC Mammograms: Surpassed our projected goal of 25. FY 2018 = 107 women were screened. This is a 53% increase from last fiscal year. 2. Eight support groups were held, with a total of 26 Spanish speaking individuals. This group began September 2017 and held in Paso Robles. 3. Due to time conflicts with providers to hold an educational session on colon cancer awareness this had been postpone for next FY 2019 plan. 4. Lay Patient Navigator continues to collaborate with the SLO county health community centers with informational pamphlets, lectures and referrals for cervical cancer.
Hospital's Contribution / Program Expense	Program Expense: $ 106,455
FY 2019 Plan	
Program Goal / Anticipated Impact	Improve the health and well-being of the target population on the Central Coast Service Area through health education and screenings for early detection and prevention of cancer.
Measurable Objective(s) with Indicator(s)	1 Increase participation in health fairs by 25% over the baseline of 17 = 22 health fair participation in FY 2019 2. Mammograms: Increase patients served by 30% over the baseline of 107 = 139 breast cancer screening for 2019 FY 3. Spanish Support Group: Increase cancer patient attendance by 30% over the baseline of 26 = 34 cancer patients. 4. Offer 3 lecture community lectures in Spanish.
Intervention Actions for Achieving Goal	1. Participate in all the Latino Health Coalition and French Hospital health fairs. 2. Increase outreach to north county schools, churches and medical clinics. 3. Continue to provide cancer awareness information and community resources to target populations. 4. Expand the marketing and promotion of the free breast cancer screening clinics by outreaching to the DH medical offices and clinics. 5. Schedule regular meeting with the breast cancer screening health community collaborators for continued promotion and awareness of these free clinics. 6. Grow the collaboration with Spanish radio for public announcements and radio interviews. 7. Distribute the flyer in the north county to churches, schools, vineyards, community health centers and health fairs. 8. Distribute a flyer to all newly diagnosed Spanish speaking cancer patients who live in the north county. 9. Offer a community forum, targeting the Hispanic population, with local health experts to educate this population about the importance of HPV and cervical cancer. 10. It was requested by the Lay Patient Navigator to offer an educational lecture addressing what and when of radiology, and the practical application of treatment.

	11. An educational lecture on colonoscopy. "What Hispanic Men and Women need to know about the importance of Colonoscopy for Colorectal Cancer." Speakers Dr. Hernandez, Urology and Angela Fissell, Registered Dietitian.
Planned Collaboration	FHMC Women Imaging Center, La "M" radio, Community Health Centers of the Central Coast, SLO Noor Foundation (SLO & PR), Community Action Partnership of San Luis Obispo County, Peoples Self Help Housing, San Luis Obispo County Health Department, North County Catholic Churches, and numerous schools in the SLO County school district.

Cardiovascular Disease and Stroke	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness/Housing ❑ Cancer Screenings ☒ Cardiovascular Disease and Stroke
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity Demonstrate Collaboration
Program Description	Cardiovascular disease/stroke is one of the leading causes of death in the north Santa Barbara and San Luis Obispo County. As the leading cardiac hospital in SLO County FHMC strongly emphasizes early dictation and prevention. Through a risk assessments and education program of cardiovascular and stroke it can enable community members to take control of their health and encourage follow-up and treatment of risk factors by their health care provider.
Community Benefit Category	A1a – Community Health Education; A2d- Community Based Clinical Services; A1d – Community Health Education: Support Group
FY 2018 Report	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase cardiovascular disease screenings by 10% at 6 target population health fair events.(target 206) 2. 20% of the participants identified with no primary care provider, and aware for the first time they have elevated glucose, BP and cholesterol will self-report at 3 months self-report lifestyle modifications 3. Provide 4 FAST Friday events in target populations (Spanish and elderly) for FY2018. 4. Present "Explaining Stroke 101" class in Spanish two times and to an elderly population two times during FY2018. 5. 80% of participants enrolled in CDSMP program will complete the workshop.
Intervention Actions for Achieving Goal	1. Establish baseline for target population's use of Cardiac Risk Assessment Tool. 2. Provide "Explaining Stroke 101" and "Cardiovascular Disease" lectures for target population in English and Spanish. 3. All screened participants will be referred to all Dignity Health Wellness Programs. 4. At-risk individuals will be provided appropriate education, referrals, and follow-up and will be placed on a 3 month follow up call list. 5. At –risk individuals will self-report lifestyle modification at their 3 month follow up call.
Planned Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, American Heart Association, Latino Health Coalition.
Program Performance / Outcome	1. A total of 174 cardiovascular disease screenings were done which was a 2% decrease from last FY2017. 2. A total of 25 individuals were deemed high risk for cardiovascular disease and were placed on a 3 month follow up call list. At 3 months 17 had self-reported that they established a follow appointment with a PCP and were

	complying with doctors' orders. A total of 8 phone contacts were either disconnected or voice messages was not replied back. 3. A total of 8 FAST Fridays events were provided, 3 in Spanish and 5 to seniors a total of 196 were screened at these events. 4. At total of 4 "Explaining Stroke 101"classes were done 2 in Spanish and 2 to seniors. A total of 85 participants attended the educational session. 5. A total of 43 participants completed the CDSMP 6 week workshop indicating an 85% completion rate.
Hospital's Contribution / Program Expense	Program Expense: $13,135
FY 2019 Plan	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention, detection, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase cardiovascular disease screenings by 8% at 6 target population health fair events.(target 174) 2. 20% of the participants identified with no primary care provider, and aware for the first time they have elevated glucose, BP and cholesterol will self-report at 3 months self-report lifestyle modifications 3. Provide 4 FAST Friday events in target populations (Spanish and elderly) for FY2018. 4. Present "Explaining Stroke 101" class in Spanish two times and to an elderly population two times during FY2018. 5. 80% of participants enrolled in CDSMP program will complete the workshop.
Intervention Actions for Achieving Goal	1. Establish baseline for target population's use of Cardiac Risk Assessment Tool. 2. Provide "Explaining Stroke 101" and "Cardiovascular Disease" lectures for target population in English and Spanish. 3. All screened participants will be referred to all Dignity Health Wellness Programs. 4. At-risk individuals will be provided appropriate education, referrals, and follow-up and will be placed on a 3 month follow up call list. 5. At –risk individuals will self-report lifestyle modification at their 3 month follow up call.
Planned Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, American Heart Association, Latino Health Coalition.

Care Transitions	
Significant Health Needs Addressed	❑ Education ❑ Access to Mental Health ❑ Homelessness or Housing ☒ Cardiovascular Disease and Stroke ❑ Cancer Screenings
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	The Care Transitions program provides consistent telephonic patient follow-up and education thereby decreasing the number of participant admissions to the hospital focusing on COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure
Community Benefit Category	A3-e Health Care Support Services
FY 2018 Report	
Program Goal / Anticipated Impact	Decrease hospital readmissions and decrease unnecessary emergency department use for all participants with Chronic Obstructive Pulmonary Disease (COPD), diabetes, pneumonia, cardiac event, sepsis and heart failure enrolled in the program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage.
Measurable Objective(s) with Indicator(s)	1. 90% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis. 2. 90% of participants enrolled in the program will self-report that they keep follow-up appointments with their physician(s) on an ongoing basis. . 3. Readmission rate for CHF and COPD patients enrolled in Care Transitions (CT) will be at 6% or less on a quarterly basis. 4. Emergency Room use of patients on CT will be tracked quarterly to identify the % of patients using ER on a monthly basis, reported quarterly. 5. Reinstate a Patient Satisfaction Survey Tool that is sent out when a patient is discharged and achieve a score 90% Excellent on the overall care provided, starting in the 2nd Quarter. Reported quarterly. 6. Utilizing available communication tools (Dashboard, Octavia, e-mail) send at least 75% of patients not taken for care (NTFC) and 100% of appropriate mobile patients enrolled in Care Transition to Community Benefit Education Department for enrollment in CDSMP workshop. 7. Those NTFC and Care Transitions patients registered for CDSMP, 65% will complete the workshop
Intervention Actions for Achieving Goal	1. Patients referred to Care Transitions (CT) from hospital discharge will be called within 48-72 hours to enroll into the program, nurse will identify any problems or symptoms they may have and intervene with education and medication reconciliation. 2. CT will utilize Medical Social Worker support by phone or home visit to assist with patient barriers to success with their plan of care. 3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their meds. 4. Identify patients who are having difficulty with physician follow up and assist in locating MD and getting appointments.

	5. Provide information to patients and their caregivers on home safety, Family Caregiver Program, medication and disease information specific to their needs and identify those needing support. 6. A quarterly statistical summary will be conducted to identify Emergency Room (ER) use for patients with COPD, CHF and all cause readmissions to tract ER use/readmission rate. 7. Patient Satisfaction Survey will be sent out beginning 2nd quarter, to all Care Transition patients who are discharged with a "graduate" (3 months) designation within 2-3 weeks of post intervention, with a return envelope, and scores will be tracked to identified issues.
Planned Collaboration	CenCal and the community resources that provide care transition interventions – post acute care services. Home Health Care Services; Hospice services; Dignity Health Hospitals and the Care Coordinators; .Family Caregiver Program at MRMC with the MSW Navigator.
Program Performance / Outcome	1. There were a total of 208 patients admitted to Care Transitions this last FY and a total of 236 patients served. 2. For Medication compliance FHMC CT program had a 97% compliance rate as well as the same for patients having physician follow up appts. 3. The Readmission rate for CHF was 3.2% and the readmission rate for COPD was 2.4%. 4. There were a total of 3516 patient contacts attempted and a total of 2267 actually made. 5. The FHMC Care Transition program continued to participate in the Regional Centers of Excellence Pulmonary Arterial Hypertension Program with Dr. Ryan, and provided ongoing care to 33 patients. These patients are on longer than the usual 90 days. 6. For all Care Transition programs – in late April, Octavia was initiated, which facilitates referrals for Care Transition and coordination of care for all post-acute hospital care providers 7. Those NTFC and Care Transitions patients registered for CDSMP, on five out of three completed the workshop which indicated a 60% completion rate.
Hospital's Contribution / Program Expense	Program Expense: $ 118,267
FY 2019 Plan	
Program Goal / Anticipated Impact	Decrease hospital readmissions and decrease unnecessary emergency department use for all participants with all high risk and complex patients discharged from the hospital – to include diagnosis of COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure enrolled in the program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage
Measurable Objective(s) with Indicator(s)	1. 95% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis. 2. 95% of participants enrolled in the program will self-report that they keep follow-up appointments with their physician(s) on an ongoing basis. . 3. Readmission rate for CHF and COPD patients enrolled in Care Transitions (CT) will be at 6% or less on a quarterly basis. 4. Emergency Room use of patients on CT will be tracked quarterly to identify the % of patients using ER on a monthly basis, reported quarterly.

	5. Patient Satisfaction Survey Tool that is sent out when a patient is discharged/ graduated will achieve a score 90% Excellent on the overall care provided, reported quarterly. 6. Utilizing available communication tools (Octavia) send at least 75% of patients not taken for care (NTFC) and 100% of appropriate mobile patients enrolled in Care Transition to Community Benefit Education Department for enrollment in CDSMP workshop. 7. Those NTFC and Care Transitions patients registered for CDSMP, 65% will complete the workshop
Intervention Actions for Achieving Goal	1. Patients referred to Care Transitions (CT) from hospital discharge, and who are identified as appropriate for Care Transition, will be called to enroll into the program, nurse will identify any problems or symptoms they may have and intervene with education and medication reconciliation. 2. CT will utilize Medical Social Worker support by phone or home visit to assist with patient barriers to success with their plan of care. 3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their meds. 4. Identify patients who are having difficulty with physician follow up and assist in locating MD and getting appointments. 5. Provide information to patients and their caregivers on home safety, Family Caregiver Program, medication and disease information specific to their needs and identify those needing support. 6. A quarterly statistical summary will be conducted to identify Emergency Room (ER) use for patients with COPD, CHF and all cause readmissions to tract ER use/readmission rate. 7. Patient satisfaction Survey will be sent out to patients who are discharged due to "graduation" designation within 2-3 weeks from the last call and will be given a return envelope and scores will be tracked.
Planned Collaboration	Care Coordinators at the Dignity Health Hospitals; Home Health, Hospice, Cardiac Rehab; Family Caregiver Program; Octavia program; CCN dept., QI dept., ER, hospitalists, MSW staff, and Readmission Committees.

Diabetes Prevention and Self-Management	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness ❑ Cancer Screenings ❑ Cardiovascular Disease and Stroke
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity Demonstrate Collaboration
Program Description	Provide a comprehensive evidence-based diabetes management program which includes a program providing education with registered dietitian or nurse specializing in diabetes management. The program will improve behavior and self-management practices of diabetic patients; enhance and improve the access and delivery of effective preventive health care services.
Community Benefit Category	A1c.- Community Health Education: Individual Health Education for uninsured/under insured
FY 2018 Report	
Program Goal / Anticipated Impact	Increase diabetes self-management skills in the target population for pre diabetic and diabetics.
Measurable Objective(s) with Indicator(s)	1. Increase diabetes support group participation by 12%. 2. Increase series classes participation by 17%. 3. 85% of the class and support group participants will report no ER visit and hospital admissions during a follow up call at 3 months after completing the series and every 3 months for the support group 4. 85% of the participants in the support groups will self-report stabilization or improvement in their A1C value every three months. 5. 95% of diabetes class series and support group participants will indicate on a post survey that they enjoyed the series and it was beneficial for their diabetes management 6. Complete eight one on one individual session per quarter from the Noor Clinic and referrals from French Hospital patient care coordinator.
Intervention Actions for Achieving Goal	1. Continue access to Dr. Duke's dashboard to identify high risk diabetic patients to refer to diabetic class series and support groups. 2. Offer four community diabetes education class series. 3. Implement 3 month follow up calls on diabetes class series participants. 4. Implement post surveys on both diabetes support group and class series participates. 5. Partner with the SLO Noor clinic by providing one on one nutrition and diabetes education counseling and to encourage these patients to attend ongoing community classes and support group. 6. Partner with Diabetic Youth Connection to hold support group for children and teens with diabetes.
Planned Collaboration	Pacific Central Coast Health Centers, SLO Noor, Alliance for Pharmaceutical Access, Inc., Central Coast Patient Care Coordinators, CenCal, CHCCC, Dr. Lai, Diabetes Youth Connection
Program Performance / Outcome	1. Diabetes Support Group Attendance: 84 total attendees- Met 100% of target goal for the year.

	2. Series Class participation: 89 attendees- Met 124% of target goal for the year. 3. 100% of support group participants reported no ER visits during follow up call and 100% of the class participants reported no ER visits. 4. 92 % of the diabetes class series and support group participants indicated they enjoyed the series and it was beneficial for their DM management. 5. Average of 12 one-on-one individual sessions completed per quarter for Noor clinic and referrals from in-house (153% of goal met for the year).
Hospital's Contribution / Program Expense	Program Expense: $10,266
FY 2019 Plan	
Program Goal / Anticipated Impact	Increase diabetes self-management skills in the target population for pre diabetic and diabetics.
Measurable Objective(s) with Indicator(s)	1. Increase DEEP series class participation by 5%. 2. 95% of the DEEP class series will indicate on a post survey that they enjoyed the series and it was beneficial for their diabetes management. 3. Complete twelve one-on-one individual sessions per quarter from the Noor Clinic and referrals from French Hospital patient care coordinator. 4. Aim for 32 attendees as the goal for the diabetes quarterly support meeting.
Intervention Actions for Achieving Goal	1. Continue access to Octavia to identify high risk diabetic patients to refer to diabetic class series and/or individual sessions. 2. Offer four DEEP education class series with Registered Dietitian involvement. 3. Implement post surveys on class series participates. 4. Offer ongoing support through quarterly educational group meetings/lectures. 5. Partner with the SLO Noor clinic by providing one on one nutrition and diabetes education counseling and to encourage these patients to attend ongoing community classes and various health promotion classes.
Planned Collaboration	Pacific Central Coast Health Centers, SLO Noor, Alliance for Pharmaceutical Access, Inc., Central Coast Patient Care Coordinators, CenCal, CHCCC, Central Coast Endocrinology

Dignity Health Commuinity Grants Program	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ☒ Homelessness/ Housing ❑ Cancer Screening ❑ Cardiovascular Disease and Stroke
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ☒ Build Community Capacity ☒ Demonstrate Collaboration
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospitals health priorities identified in the Community Health Needs. Non-profit agencies will serve target populations identified in the CHNA providing services, activities and events to improve quality of life.
Community Benefit Category	E2-Cash and In-Kind Contributions
FY 2018 Report	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address Access to Behavioral Health and Homelessness/Housing.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year. 2. Build richer ACC that are focused on multiple significant health needs. 3. 100% of funded ACC will update local community benefit committees on their project. 4. 100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained
Intervention Actions for Achieving Goal	1. Community Education Coordinator will work closely with agencies to form a more succinct "Accountable Care Community" (ACC) for services the hospital is unable to address itself. 2. Coach ACC to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACC will present at Community Benefit Committee meetings.
Planned Collaboration	SLO Noor Foundation, Community Counseling Center, Transitions Mental Health Association, Promotores Collaborative of SLO County, Home Share SLO,and other community organization addressing the community health needs.
Program Performance / Outcome	1. A grant writing workshop was held in May 2018 at the Arroyo Grande campus with 27 participants representing the Central Coast. 2. Community Education Coordinators worked closely with local community agencies in forming Accountable Care Communities that would meet the needs of the hospitals prioritized health needs. 3. All 3 ACC was scheduled to present in at the quarterly Community Benefit meetings to give updates on their projects. 4. Community Education Coordinator continues to work with ACC to provide concise descriptive quarterly outcomes for committees review.

	5. 100% of funded ACC have scheduled quarterly and sometimes meeting more often to ensure outcomes are accomplished and they continue their work with the local hospital.
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and, $ 66,826 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 2019 Plan	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment and programs with an emphasis for those identified priorities health needs we are unable to address Access to Behavioral Health and Homelessness/Housing.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year. 2. Build richer ACC that are focused on multiple significant health needs. 3. 100% of funded ACC will update local community benefit committees on their project. 4. 100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained
Intervention Actions for Achieving Goal	1. Community Education Coordinator will work closely with agencies to form a more succinct "Accountable Care Community" (ACC) for services the hospital is unable to address itself. 2. Coach ACC to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACC will present at Community Benefit Committee meetings.
Planned Collaboration	SLO Noor Foundation, Community Counseling Center, Transitions Mental Health Association, Promotores Collaborative of SLO County, Home Share SLO,and other community organization addressing the community health needs.

ECONOMIC VALUE OF COMMUNITY BENEFIT

French Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2017 through 6/30/2018

	Persons Served	Net Benefit	% of Org. Expenses
Benefits for Poor			
Financial Assistance	**1,013**	**716,259**	**0.5**
Medicaid	**10,462**	**11,066,147**	**7.0**
Community Services			
A - Community Health Improvement Services	14,195	419,866	0.3
C - Subsidized Health Services	2,597	79,461	0.1
E - Cash and In-Kind Contributions	194	150,455	0.1
F - Community Building Activities	0	1,445	0.0
G - Community Benefit Operations	0	104,581	0.1
Totals for Community Services	**16,986**	**755,808**	**0.5**
Totals for Poor	**28,461**	**12,538,214**	**7.9**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	9,099	685,111	0.4
B - Health Professions Education	87	133,561	0.1
G - Community Benefit Operations	0	25,986	0.0
Totals for Community Services	**9,186**	**844,658**	**0.5**
Totals for Broader Community	**9,186**	**844,658**	**0.5**
Totals - Community Benefit	**37,647**	**13,382,872**	**8.5**
Medicare	**40,544**	**18,963,282**	**12.0**
Totals with Medicare	**78,191**	**32,346,154**	**20.5**

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue and expense in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue and expense had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $10,977,079.

APPENDIX A: COMMUNITY BOARD ROSTER

French Hospital Medical Center Community Board
FY 2018

Leopold Selker, PhD, MBA
Chair of the Board
Research Scholar in Residence, CPSU, SLO

Michael DeWitt Clayton, MD
Vice –Chair of the Board
Retired Urologist

Peter Oppenheimer
Secretary
Retired CFO, Apple

Alan Iftiniuk
President, French Hospital Medical Center

Sister Susan Blomstad, OSF
Retired Retreat Presenter/Director

Father Russell Brown
Asst. Pastor, St. Patrick School

James Copeland
Co-Owner, Copeland Properties

Robert Doria, MD
Coastal Cardiology

John Dunn
Retired City Administrator

Kathleen Enz Finken, PhD
Provost & Executive VP for Academic Affairs
CPSU, SLO

Patricia Gomez
Attorney-at-Law

Sister Linda Gonzales
Retired Teacher/Administrator

Margaret Keeler, OSF
Retired LVN & Teacher

Thomas L Miller, MD
Radiology Associates of SLO

Kerry Morris
COO, Morris & Garritano Insurance

Kevin Okimoto
Founder, Trellis Wealth Advisors

Kevin M. Rice, Colonel, USA (Ret.)
Retired Pismo Beach City Manager

John Ronca
Attorney-at-Law

Mike Ryan, MD
Central Coast Chest Consultants

Joseph Schwartz, MD
Chief of Staff

Wayne Simon
Attorney-at-Law

Aaron Steed
CEO
Meathead Movers & Mini Storage

Liz Summer
Foundation Board Chair
VP/Sr. Client Relationship Manager, Banking

Antonia Torrey, RN, PhD
Nurse Educator, Cuesta College

Deborah Wulff, Ed.D
Asst Superintendent/VP Academic Affairs,
Cuesta College

APPENDIX A: COMMUNITY BENEFIT COMMITTEE ROSTER

French Hospital Medical Center
Community Benefit Committee FY2018

John Dunn
Chair of the Committee
Retired SLO City Manager
FHMC Community Board Member

Fr. Russell Brown
Pastor, SLO Old Mission Church

Patricia Gomez
Attorney–at-Law
FHMC Community Board Member

Aaron Steed
CEO
Meathead Movers & Mini Storage
FHMC Community Board Member

Jackie Starr
Interior Design
FHMC Foundation Board
Hearst Cancer Resource Center Advisory Board

Angela Fissell, RD
Diabetes Prevention and Self-Management-
FHMC Program Coordinator

Denise Gimbel, MPH, RN
Cardiovascular Disease & Stroke – FHMC
Program Coordinator

Patricia Herrera, MS
Community Benefits/ Outreach Coordinator
Dignity Health Wellness –FHMC Program
Coordinator

Beverly Kirkhart
Hearst Cancer Resource Center – FHMC
Program Coordinator

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

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

Sandy Underwood
Senior Community Education Coordinator
Central Coast Service Area

Tina McEvoy, RN
Care Transitions, Service Area Coordinator

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- FHMC has been an active partner in the Latino Health Coalition and has helped organized 4 Health for the Community events throughout the primary service area of FHMC. These events have provided over 700 free health screenings to individuals who are uninsured and underinsured. Health screening consisted of the following: vision, oral, blood pressure, lipid and glucose.

- Health Profession Education at FHMC is offered by providing the following:
  - clinical setting for undergraduates training and internships for dietary professionals, technicians, physical therapist, social workers, pharmacists, and other health care professionals from universities and colleges.
  - hospital experience based training opportunities for nursing students needing to conduct clinical rounding
  - partners with local community college by donating money so the college could disperse funding as needed for purpose of addressing community wide workforce issues such as school –based programs on health care careers.

- The Anderson Hotel Homeless Respite Care program is collaboration between FHMC and the Housing Authority of SLO County in which a room is reserved for FHMC homeless discharged patients that need respite care. Quarterly, FHMC donates amenity bags containing personal hygiene products to Prado Day Homeless Shelter and El Camino Homeless Organization shelter.

- Supporting the efforts to address mental health and homelessness FHMC has committed to donating funds for the next 5 years to Transitions-Mental Health Association for their Bishop Street Studio Project, a project addressing housing options that will be available for mental health homeless individuals.

- Our Prenatal and New Parent Education Program provided education to mothers, and their partners, regarding prenatal preparation, birth classes and family support classes. Our breastfeeding clinic in San Luis Obispo clinic has provided 2597 lactation consultations for FY 2018.

- In November 2015, Dignity Health renewed a $500,000 loan to San Luis Obispo County Housing Trust Fund (HTF), to help the organization respond to increased demand for local affordable housing projects. Preference is given to projects that benefit women and children, and can include single-family ownerships as well as multifamily rental units. Special-needs housing may include transitional housing and group and supportive housing. HTF provides financing and technical assistance for local affordable housing projects, and advocates for affordable housing legislation, programs, and projects at the local, state, and federal levels.

- Employees donated to the following drives: Stuff the Bus, Christmas in July, and the Salvation Army Angel Tree. The hospital also provided in-kind medical supply donations to Reaching for the Stars camp for children with special needs, and the free north county SLO Noor medical clinic.

- 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 FY2018 included executive, system leadership and staff involvement in community boards such as: Cencal Health Board, Hospital Council of Northern and Central California Board, American Heart Association, YMCA of SLO County, San Luis Obispo Health Commission, Adult Services Policy Council, Long term Ombudsman program, Healthy Eating Active Living (HEAL-SLO), Cal Poly Prevention Committee, Latino Health Coalition of SLO County, ACTION: For Healthy Communities, and Promotoras Collaborative of SLO County.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

French Hospital Medical Center; 1911 Johnson Ave, San Luis Obispo, CA 93401; Financial Counseling, 805-542-6321; Patient Financial Services, 888-488-7667;
www.dignityhealth.org/frenchhospital/paymenthelp