Dignity Health
French Hospital Medical Center

French Hospital Medical Center

Community Benefit 2016 Report and 2017 Plan

Dignity Health.
French Hospital Medical Center

A message from

Alan Iftiniuk, President and CEO of French Hospital Medical Center, and Patricia Gomez, Chair of the Dignity Health French Hospital Medical Center Community Board.

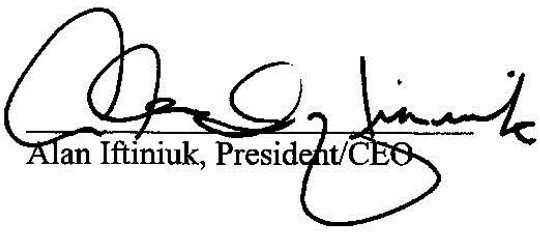
Dignity Health's comprehensive approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community 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 to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2016 Report and 2017 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 complies with both mandates in 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.

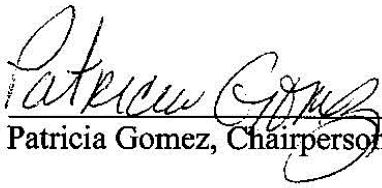
In Fiscal Year 2016 (FY16), French Hospital Medical Center provided $7,524,538 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital's total community benefit expense was $24,438,840.

Dignity Health's French Hospital Medical Center Board of Directors reviewed approved and adopted the Community Benefit FY2016 Report and FY2017 Plan at its October 20, 2016 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.



Alan Iftiniuk, President/CEO



Patricia Gomez, Chairperson, Board of Directors

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EXECUTIVE SUMMARY

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. 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.

The significant community health needs that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at http://www.dignityhealth.org/frenchhospital/about-us/community-benefits. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report. The top four community health needs identified through the CHNA are access to health care, including behavioral health, homelessness, cancer screenings, and cardiovascular disease and stroke.

In FY16, French Hospital Medical Center took numerous actions to help address identified health needs. These included: Diabetes Prevention and Management Program; Chronic Disease Self-Management Program; Care Transitions Program; Cardiac Wellness; Cancer Education and Prevention and Community Grants Program.

For FY17, the hospital plans to enhance its Cardiac Wellness program by adding a stroke component as well as the Cancer Education and Prevention Program by increasing screenings and access for those identified as the target population in the CHNA. The Community Grants Program will support programs that increase access to healthcare. Ongoing collaboration with community partners will continue to address behavioral health needs. Stanford University School of Medicine's Chronic Disease Self – Management Program has been integrated into all existing applicable programs.

The economic value of community benefit provided by French Hospital Medical Center in FY16 was $7,524,538 excluding unpaid costs of Medicare in the amount of $16,914,302.

This document is publicly available at http://www.dignityhealth.org/frenchhospital/about-us/community-benefits. Written comments on this report can be submitted to the French Hospital Medical Center: Community Benefit Department, 1911 Johnson Ave, San Luis Obispo, Ca. 93401 or by e-mail to CHNA-CCSAN@dignityhealth.org.

MISSION, VISION AND VALUES

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.

Hello humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

OUR HOSPITAL AND OUR COMMITMENT

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. This year FHMC added a 14 bed patient wing. The new unit is designed to focus on the unique needs of orthopedic patients as well as other medical and surgical patients. FHMC has long been ranked as a top provider of orthopedic care, and has created this modernized unit in order to further their ongoing commitment to the specialized care of orthopedic patients. This new addition to FHMC is the first patient wing to be added since 1972 and brings the total licensed bed count to 117. Once again this year, FHMC has been named one of the Nation's 100 Top Hospitals® for a third 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.

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.

The Hospital Community Board, Community Benefit Committee, Senior Leadership and Community Benefit Staff responsibilities related to oversight of community benefit activities are indicated below:

- Hospital Community Board is responsible for ensuring the hospital develops and supports programs that address the disproportionate unmet health-related needs of the community. The Community Board approves the Annual Community Benefit Report and Plan as well as the Community Health Needs Assessment (CHNA) and Implementation Strategy (every three years)
- Community Benefit Committee provides oversight for the Community Benefit Programs (program digests), Community Health Needs Assessment and the Community Grants Program. The committee members provide input for program design, content, goals and objectives ensuring appropriate focus on the poor, underserved, and disadvantaged in the community, as well as being aligned with the most recent CHNA. Program Coordinators are accountable for meeting their program's community benefit goals and reporting to the Community Benefit Committee on a quarterly basis. The Community Benefit Committee is made up of members of the Hospital Community Board, members of the hospital's senior management team, and Community Benefit Program Coordinators. The Chairperson of the Community Benefit Committee reviews Community Benefit Activities and minutes from the quarterly meetings with the Community Board. Rosters of Community Board and Community Benefit Committee members are found in Appendix A.
- Community Benefit staff work with others (senior management, clinicians, physicians and community organizations) to plan, develop, implement and evaluate outreach services in accordance with the hospital's strategic plans. The Senior Director for Community Benefit reports to the Vice President of Post-Acute Care Services, and attends monthly Senior Leadership meetings for the Service Area to keep leadership updated on Community Benefit activities.

- The CHNA is completed every three years and is reviewed by the Community Benefit Committee with a final draft for approval to the Hospital Community Board.
- FHMC senior leadership approves the Community Benefit annual budget.

French Hospital Medical Center's community benefit program includes financial assistance provided to those who are unable to pay the cost of medically necessary care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, community health improvement services, health professions education, and research Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report.

DESCRIPTION OF THE COMMUNITY SERVED

The primary service area for 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. 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.
A summary description of the community is below, and additional community facts and details can be found in the CHNA report online.

According to the CHNA report of June 2016 FHMC's primary service area is home to just over approximately 180,000 people of which 71% of consider themselves Caucasian, with 20% considering them 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). San Luis Obispo (and North San Luis Obispo) (93401, 93405) is home to a combined, 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.

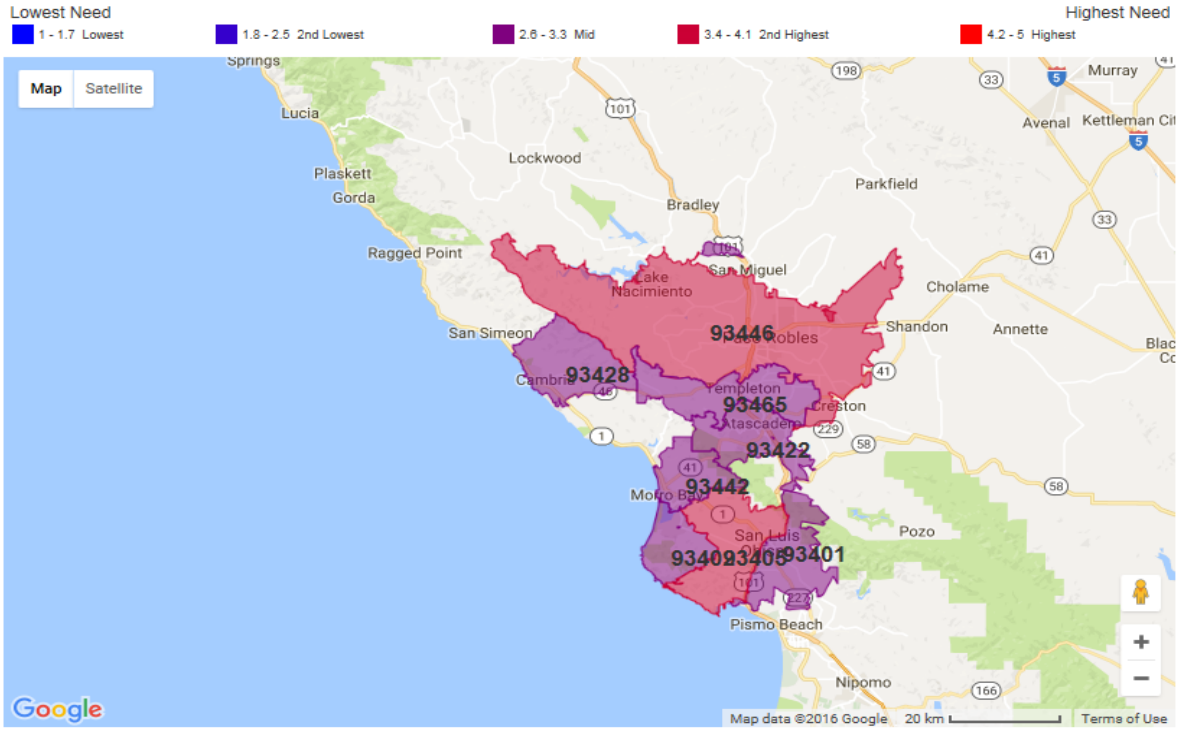
In addition to the residents captured by the U.S. Census discussed above, the FHMC primary service area attracts a farm-worker population drawn to work in the fields. There is no known current estimate of the number of indigenous-language population of Mexicans from the State of Oaxaca and neighboring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

Demographic information taken from © 2016 The Nielsen Company, © 2016 Truven Health Analytics Inc., provides data on the following, which will be reported on IRS Form 990 Schedule H:

- Total Population: 185,838
- Hispanic or Latino: 20.1%
- Race: 70.2 % White, 2.2 % Black/African American, 3.9 % Asian/ Pacific Islander, 3.6% all other
- Median Income: $59,640
- Uninsured: 6.7%
- Unemployment: 3.9%
- No HS Diploma: 9.9%
- CNI Score: 3.1
- Medicaid Population: 23.7 %
- Other Area Hospitals: 2

French Hospital Medical Center defines the community's geographic area based on hospital patients discharged data. The Community Needs Index (CNI) is utilized to identify the target population and to assess the health need. The CNI was created and made publicly available by Dignity Health and Truven Health Analytics. 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.

2016 Community Needs Index Map
FHMC Primary Service Area



Mean(zipcode): 3.2 / Mean(person): 3.4 CNI Score Median: 3.1 CNI Score Mode: 3,3.2

Zip Code	CNI Score	Population	City	County	State
93401	3.2	29337	San Luis Obispo	San Luis Obispo	California
93402	2.6	14204	Los Osos	San Luis Obispo	California
93405	4	35631	San Luis Obispo	San Luis Obispo	California
93422	3.2	32624	Atascadero	San Luis Obispo	California
93428	3	6489	Cambria	San Luis Obispo	California
93442	3	11016	Morro Bay	San Luis Obispo	California
93446	3.6	46990	Paso Robles	San Luis Obispo	California
93465	2.8	9547	Templeton	San Luis Obispo	California

COMMUNITY BENEFIT 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 engaging the Community Benefit Committee and other stakeholders in the development of the annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment Process

The most recent Community Health Needs Assessment (CHNA) was adopted in June 2016 and was completed through a compilation of primary and secondary data sources, including an original health needs assessment survey, key stakeholder focus groups, community leader interviews, as well as established secondary public health statistics and U.S. Census data. The CHNA aimed to capture the health status of the medically underserved, low income, and minority populations living in each primary service.

Primary data was collected from an original health behavior survey that was developed based upon select questions from the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey Questionnaire (BRFSS), previous CHNAs prepared by Dignity Health, and input provided by those representing community benefit/outreach activities at FHMC. The community health survey was designed to try and gain a perspective of each individual's social determinants as well as their health behavior and health conditions. The final survey contained a total of 44 questions, was made available in both Spanish and English and was administered in person by Spanish speaking lay health educators (Promotoras). The original health survey was completed by a 448 individuals from FHMC service area. Using a convenience sampling (non-probability) approach, locations were selected based on the perception of being able to encounter our medically underserved, low-income and minority populations.

In addition to the health behavior survey, one community stakeholder focus groups were held. Over 40 individuals from known community organizations were invited. Participants included individuals who work with low-income, minority, or medically underserved populations. Qualitative data was collected during interviews with key community stakeholders, community leader interviews, community organizations, political leaders, emergency department staff and public health departments.

The CHNA utilized the following secondary data sources, and where possible, was compared directly to data collected during the community health survey providing a comparison of service area data to county, state, or national levels:

- Center for Disease Control Behavioral Risk Factor Surveillance System
- California Department of Public Health
- Healthcare Utilization Data
- Healthy People 2020
- Prevention Quality Indicators
- U.S. Census

While potential resources are available to address the needs of the community, the needs are too significant for any one organization. Making a substantial and upstream impact will require the collaborative efforts of community organizations, local government, local business leaders, and

institutions. San Luis Obispo County is home to a wealth of organizations, businesses, and non-profits, including a local community college. FHMC conducted an inventory of community assets that are potentially available to address the identified community health needs. A list of these resources can be found on page 24 of the Community Health Needs Assessment report (http://www.dignityhealth.org/frenchhospital/about-us/community-benefits).

CHNA Significant Health Needs

Community health needs were prioritized based upon need, presence in both the qualitative data (community interviews, key stakeholder interviews) and quantitative data. In addition, the community health survey results were compared (when available) to state and national rates, as well as, the Healthy People (HP) 2020 benchmark.

Key community leaders were invited to participate in a nominal group process to identify, prioritize, and discuss health issues for the community, based on their knowledge of the community. Based on these discussions and subsequent discussions with key community leaders, the three greatest needs facing our community were substantiated. Community leaders and key stakeholders mentioned access to health care including behavioral health, homelessness and cancer prevention. The community health survey found that health insurance disparities depend on race, educational attainment, and place of residence. Overall, 16.3% of survey participants reported they do not have any health insurance and 7.3% reported only having emergency Medi-Cal. The highest levels of survey participants reporting they either have no health insurance or only restricted Medi-Cal, reside in Paso Robles, where by 24.5% have no health insurance and 14.5% have restricted Medi-Cal.

The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability. Recent figures suggest that in 2004 approximately 1 in 4 adults in the United States had a mental health disorder in the past year – most commonly anxiety or depression – and 1 in 17 had a serious mental illness.

In 2016, the community benefit committee reviewed the identified needs. In accordance with Dignity Health policy, the following criteria were also utilized to evaluate the prioritization of community needs:

- Size of problem (i.e., number of people affected);
- Seriousness of problem (i.e., health impact at the individual, family and community level);
- Economic feasibility (i.e., program cost, internal and potential external resources);
- Available expertise (i.e., can we make an important contribution);
- Time commitment (i.e., overall planning, implementation, and evaluation); and,
- External salience (i.e., evidence that it is important to community stakeholders).

The top four significant community health needs identified through the CHNA are:

- Access to Health Care including, behavioral health;
- Homelessness or housing;
- Cancer screenings;
- Cardiovascular Disease and Stroke.

Time and time again community leaders and key stakeholders mentioned access to health care including behavioral health and homelessness or housing as the greatest challenges affecting our communities. While healthcare is more readily available in the incorporated areas of the county, 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. Lastly, the poverty rate of San Luis Obispo is worth mentioning although it may include a large number of college students. While some may be students, there is a more hidden population working locally in the service industry, in occupations such as waitress, dishwasher or housekeeper. The low-income housing in San Luis Obispo is home to many individuals in great need and lacking basic needs and with significant healthcare needs. In the U.S., the overall rate of cancer (excluding skin cancer) is 6.1% comparable to California's rate of 6.0%. Based upon State of California Death Profiles, cancer is the leading cause of death in the FHMC service area. 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.

Behavioral Health and Homelessness are each 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 and 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.

Creating the Community Benefit Plan

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**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Emphasize Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Contribute to a Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Build Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Demonstrate Collaboration**: Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.

Program planning for fiscal year 2017 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.

Planning for the Uninsured/Underinsured Patient Population

FHMC seeks to deliver compassionate, high quality, affordable health care and to advocate for those who are poor and disenfranchised. In furtherance of this mission, the hospital offers financial assistance to eligible patients who may not have the financial 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 FY16 is listed in the Economic Value of Community Benefit section of this report.

FHMC notifies and informs patients about the Financial Assistance Policy by offering a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process. At the time of billing, each patient is offered a conspicuous written notice containing information about the availability of the Policy.

Notice of the financial assistance program is posted in locations visible to the public, including the emergency department, billing office, admissions office, and other areas reasonably calculated to reach people who are most likely to require financial assistance from the hospital. The hospital provides brochures explaining the financial assistance program in registration, admitting, emergency and urgent care areas, and in patient financial services offices.

The Financial Assistance Policy, the Financial Assistance Application, and plain language summary of the Policy are widely available on the hospital's web site, and paper copies are available upon request and without charge, both by mail and in public locations of the hospital. Written notices, posted signs and brochures are printed and available online in appropriate languages.

2016 REPORT AND 2017 PLAN

This section presents strategies, programs and initiatives the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It includes both a report on actions taken in FY16 and planned programs with anticipated impacts and measurable objectives for FY17. Programs that the hospital plans to deliver in FY2017 are denoted by *.

The strategy and plan 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.

Strategy and Program Plan Summary

Access to Health Care, Including Behavioral Health

- Community Grants*-- Encourage partners of accountable care community to have an behavioral health aspect to their program
- Support Groups*-- Cancer, Diabetes, Stroke and Grief; offered at a variety of locations throughout the service area
- Charity Care for uninsured/underinsured and low income residents*
- Alliance for Pharmaceutical Access provides access to prescriptions, increasing access for those who are underinsured or uninsured*
- Transportation vouchers for discharged patients*
- Patient Care Coordinator Initiative: Provides smooth transitions discharged patients to home*

Homelessness/Housing

- Community Grants*-- Encourage partners of accountable care community to have an aspect to their program regarding homelessness and/or housing
- Case Management of Chronically Homeless Individuals: FHMC social workers and care coordinators collaborate with community partners*
- 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*
- FHMC donates amenity bags containing personal hygiene products to Prado Day Homeless Shelter and El Camino Homeless Organization shelter*

Cancer Screenings

- Cancer Awareness*--Community education at outreach events and local schools
- Cancer Screenings*--An enhancement of the existing Cancer Care Program reflective of the CHNA will address increasing cancer screenings (such as colonoscopies, mammogram, and cervical) in the target population.
- Hereditary Cancer Risk Assessment and Genetic Counseling*
- Cancer Experience Registry Program*
- Cancer Support Groups*

Cardiovascular Disease and Stroke

- Community Education*-- Education in Spanish and English that includes prevention, detection, and management of risk factors for heart attack and stroke
- Assessment of Cardiovascular Risk Status*-- At targeted locations in the community (such as health fairs, shopping centers, low cost housing units) to assess and identify those medical or lifestyle conditions that may lead to development of the disease
- Partners with American Heart Association*--Annual Heart and Stroke Walk
- Heart Aware Program--Online screening tool
- Care Transitions Program*--Includes those with heart failure for telephonic nursing support
- Chronic Disease Self-Management Program*--Empowering individuals to effectively manage their chronic disease (Diabetes, Heart, Stroke, etc.)
- Nutrition Programs*-- Heart healthy diet education

Anticipated Impact

The anticipated impacts of specific, major program initiatives, including goals and objectives, 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 care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Community Benefit Committee, hospital executive leadership, Community Board, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

The recent Community Health Needs Assessment has led to a search and discovery step; a search of existing services and programs and a discovery of the opportunities available to develop relationships with other community based organizations who with us can address the health needs of the community. 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

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.

Program Digest's from FY2016 including changes for FY2017

- Hearst Cancer Resource Center: Cancer Education and Prevention Program FY2016
  - Changed name to Cancer Prevention and Screenings FY 2017
- Cardiac Wellness FY2016
  - Changed name to Cardiovascular Disease and Stroke FY2017
  - Enhanced objectives and strategies for FY2017
- Care Transitions FY2016
  - Enhanced objectives and strategies for FY2017
- Chronic Disease Self-Management Program FY2016
  - No longer a program digest for FY2017
  - Added as an intervention strategy to other Program Digests for FY2017
- Diabetes Education and Prevention FY2016
  - Changed name to Diabetes Prevention and Self-Management FY 2017
  - Enhanced goal, objectives and strategies for FY2017
- Dignity Health Community Grants Program FY 2016
  - Community Grants to include new CHNA identified needs for FY2017

Cancer Prevention and Screenings (formerly Hearst Cancer Resource Center: Cancer Education and Prevention)	
Significant Health Needs Addressed	❑ Access to Healthcare, including Behavioral Health ❑ Homelessness ☒ Cancer Screenings ❑ Cardiovascular Disease and Stroke
Program Emphasis	☒ 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 2016 Report	
Program Goal / Anticipated Impact	Improve the health and well-being of the underserved in the FHMC service area through education and screening for early detection and prevention of cancer.
Measurable Objective(s) with Indicator(s)	1. To bring awareness of a culturally-appropriate healthy diet for the prevention of cancer in the Latino population through increasing attendance of the Spanish Cooking series by 5%. 2. Eliminate the barriers of transportation for medical appointments for the underserved and uninsured population of the FHMC service area by 5% for the 2016 fiscal year. 3. Increase attendance to the skin cancer screening of the Latino population in the FHMC service area by 10%. 4. Increase the breast cancer outreach and navigation program for awareness of breast health, screening and navigation services to the uninsured and underinsured Spanish speaking population by 25%.
Intervention Actions for Achieving Goal	1. Collaboration with CAPSLO Childcare Resources Connection for a Latino Childcare Provider three-part lecture series and demonstration on healthy recipes to educate the younger Latino population and childcare provider. Work with the program coordinator in identifying the distribution of a healthy snack for children's lunches. 2. In collaboration with San Luis Obispo Mission and The Wellness Kitchen to present "Home Cooking: Familiar Foods for Better Health" a lecture and demonstration presentation in Spanish. Targeting the Latino population. 3. Assistance from the Hispanic Lay Navigator in the distribution of transportation flyers and word of mouth to the Latino/Hispanic population will increase awareness of the Ride-On Transportation program. 4. Partner with FHMC Community Benefits department and the Hispanic Lay Navigator 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. 5. Provide three offsite presentations in collaboration with SLO Housing Authority for the underserved senior population. Programs to include: Advance Directive, Medicare Seminar partnership presented by HICAP, and a lecture demonstration provided by Well- Fit for healthy movement for the prevention of cancer. 6. Partner with local oncologist and dermatologist to provide a skin cancer screening for Latinos and the underserved population. In collaboration with Self-Help Housing in North County. Forms and follow-up procedures will adhere to the standards of the Dermatologic Society. 7. Through a grant from the Hearst Foundation to expand the nurse navigation program, it will include the availability of a full time bilingual Lay Patient Navigator services, and the purchasing of nurse navigation software for tracking of patients through the continuum of care. 8. Launch the HCRC Cancer Care newsletter in a Spanish version.
Planned Collaboration	American Cancer Society, Cancer Well- fit, local oncologist offices, Women's Imaging Center, FHMC patient care coordinators and social workers.
Program Performance / Outcome	1. Collaboration with CAPSLO Child Care Resources Connection for a Latino Childcare Provider. "Nutritional Education for Childcare Providers" is a three-part lecture series and demonstration on cooking nutritious to teach children how to choose nutritious food for the younger Latino population. Total of 51 attended the workshops from zip codes 93401, 93405, 93420, 93449, 93447, 93433, 93445. This is a 15% increase over 2015. Also, the Registered Dietitian consultations are beginning to be utilized by the Spanish speaking population due to assistance with Lay Patient Navigator's interpretations. 3 Hispanics had consultations in the 4th qtr. of 2016. 2. Collaborated with the Wellness Kitchen for their 12 session class entitled "Healthy Cooking for People Touched with Cancer." To date 118 have attended the sessions in 2016. Those attended were from the broader community. The evaluations indicated an appreciation of learning to prepare healthy meals for the prevention of cancer and reoccurrence. 3. Launched a gas card program in the 3rd quarter of 2015. Funds are provided by the Angel of Hope Charity fund for the uninsured and underinsured cancer patients who need transportation to and from doctor appointments, treatments and screenings. Total of 162 patients have been recipients of this program in FY 2016. This is a 200% increase from 2015. 4. Avon Grant & Hearst Foundation grant provided a fund with Ride-On transportation for the underinsured and uninsured cancer patients to medical treatments, screenings and doctor appointments. This fund began in July of 2016. 42 patients have used this transportation service with a total of 90 rides. Zip codes from 93442, 93428, 93433, 93401, 93465, and 93447. 5. Offered a Skin Cancer Screening at the FHMC Free Health Day, in November at ECHO in Atascadero. Target population was the underinsured and uninsured Hispanic residents of the north county service area Two physicians (local oncologist and a dermatologist) were assisted by one certified medical interpreter, and a promotoras. The outcome: 22 patients screened. 21

	had no suspicious spots identified. One person was encouraged to get a biopsy and referrals to CHC. This is a 29% increase over 2015 6. Through Avon and the Hearst Foundation grant's the Bi-lingual Hispanic Lay Navigator is now full time. These grants increase our outreach and navigation program to the uninsured and underinsured population of the FHMC service area. The Lay Navigator has increase participation with our Latino community through bilingual pamphlets, educational lectures, and assistance with patients through the healthcare system. The Lay Navigator since January 2016 has assisted 525 patients for medical visits, interpretation, and screenings. Education, outreach and health fairs contacts totals: 671. 7. With the funding support from Avon, FHMC now offers four free mammography clinics for low income Hispanic women. A total of 22 women have been screening during the May and June free screening clinic and all received normal results. We exceeded our 25% goal.
Hospital's Contribution / Program Expense	Hearst Cancer Resource Center and FHMC provided in kind space, nutritional services, advertisement, and printing. Expense: $954,541
FY 2017 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. Identify 6 health fair events for target population to promote free cancer screenings and cancer awareness. 2. Increase patients served 25% over baseline and focused on target population (25% senior and 75% Spanish speaking community) ▪ FHMC-Mammograms – baseline for FY 2106 was 40 ▪ FHMC – Colonoscopy - establish baseline; ▪ FHMC – Pap (cervical cancer)- establish baseline;
Intervention Actions for Achieving Goal	1. Develop a bilingual pamphlet with basic cancer information, resources, dates, times and locations of free screenings for target population (75% Spanish speaking, 25% low income seniors) 2. Establish free colonoscopy screening program at FHMC. 3. Establish referral system for free colonoscopy program for target population with potential partners (SLO Noor, CHCCC, and other GI groups) 4. Schedule free screenings for each of the following for: mammogram and colonoscopy. 5. Establish partnerships with agencies that provide cervical cancer awareness education and screening. 6. Increase # of patients served through patient reminder using telephone reminders, discussions with information indicating benefit regarding potential barriers to screenings.) 7. Provide cancer awareness information and community resources to target population at specified community locations indicated below 8. Patient navigator will track the following: # screened, # referred for further evaluation, # patients cancer detected, # patients receiving cancer treatment. 9. Work with PCCHC to facilitate cancer screenings.
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.

Cardiovascular Disease and Stroke (formerly Cardiac Wellness)	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness ❑ Cancer Screenings ☒ Cardiovascular Disease and Stroke
Program Emphasis	☒ 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. Assessment of cardiovascular risk status will be implemented to identify those medical or lifestyle conditions that may lead to development of the disease. This program 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 2016 Report	
Program Goal / Anticipated Impact	Provide education regarding heart disease risk factors and heart disease prevention to residents in the FHMC service area.
Measurable Objective(s) with Indicator(s)	1. Screen at least 10 people for cardiovascular disease, including free lipid test every other month, for a total of at least 60. 2. Educate 50 at-risk individuals regarding healthy lifestyle to reduce cardiac risk. Follow-up with 6 at-risk individuals at 6 or 12 months to track risk factor reduction in response to lifestyle change. 3. Participate in education and outreach activities including at least 2 Health Fairs, and 2 lecture presentations to groups. 4. Use promotoras to target 10 Hispanic women per quarter for heart disease risk screening.
Intervention Actions for Achieving Goal	1. Assess cardiac risk, including lipid screening at health fairs, free clinics, work-site wellness programs and other venues. 2. Collaborate with other community agencies that serve those at-risk for cardiovascular disease. 3. Educate groups or individuals regarding healthy lifestyle to reduce risk and prevent heart disease. 4. Refer at-risk individuals to a primary care practitioner or clinic for retesting and/or treatment. 5. Follow at-risk clients at 6 months or 1 year to track risk factor reduction with lifestyle change and/or medical treatment of risk factors. 6. Offer one educational presentation specifically regarding women and heart disease. 7. Partner with FHMC Community Benefits department on numerous SLO County health fairs using bi-lingual health educators to assess cardiovascular risk factors and dispense prevention pamphlets and information. Work with the SLO County Promotoras to reach out to the Hispanic community.
Planned Collaboration	Program coordinator collaborates with local cardiologists, case managers, American Heart Association, and SLO Noor clinic.
Program	1. Screened 146 people for cardiovascular disease via the on-line HeartAware

Performance/Outcome	risk assessment. 86 found to be at risk were offered additional screening, including free Lipid Panel screening, 87 individuals had a consult which included the free lipid panel screening and education regarding cardiac disease risk reduction. 2. Educated 86 at-risk individuals regarding healthy lifestyle to reduce cardiac risk. Follow-up via personal MD or clinic for those found to have elevated lipids or glucose. 6 or 12 month follow-up to track risk factor reduction in response to lifestyle change was deferred to personal MD or clinic. 3. Participated in education and outreach activities at 3 Health Fairs, and 2 lecture presentations to groups (RAMS and Go Red Luncheon). 4. Was not successful in collaborating with promotoras to target 10 Hispanic women per quarter for heart disease risk screening
Hospital Contribution/Program Expense	Hospital provided in-kind space, nutritional services, advertising, and printing. Expense: $ 3,858
FY2017 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. All Healthy for Life Nutrition participants contact information will be forwarded to program digest owner and a minimum 50% will receive cardiovascular and stroke education. 2. Screen a minimum 15 people for cardiovascular disease (free blood pressure and glucose screening) at each of 6 target population health fair events. 3. Educate 50 screened at-risk individuals regarding healthy lifestyle to reduce cardiovascular risk in the target population. 4. Increase 25% FAST Fridays to target population providing education on CV Risk, BP, Stroke Screening and identifying potential at risk to conduct blood pressure check and document. 5. 60% of participants in Understanding Stroke 101 identified as at risk will be provided telephonic support post 30 days to self-report they had an appointment with their physician. 6. 80% of participants enrolled in CDSMP program will complete the workshop.
Intervention Actions for Achieving Goal	1. Identify a Program Champion 2. Cardiologists have a consensus of blood pressures for seniors (120/80 or 150/90) 3. Train promotoras on Cardiovascular Risk Assessment Tool and how to record results on web. 4. Use Cardiovascular Risk Assessment tool at health events to identify risk levels of target population. 5. Train promotoras to conduct BP and glucose finger stick checks. 6. High risk screened individuals whose criteria are the following: no primary care provider, aware for the first time they have elevated glucose and blood pressure will self-report lifestyle modifications at 3 months. 7. RN will train promotora on risk factors for conducting 3 month telephonic support for participants to self-report 8. Track monthly results of HeartAware 9. Conduct a blood pressure awareness campaign for target population. 10. Establish baseline for target population's use of Cardiac Risk Assessment

	Tool (to have comparative results of target population between fiscal year 2017 and 2018) (# of people assessed # of people at risk) 11. Provide "Explaining Stroke 101" for target population in English and Spanish. 12. Schedule and facilitate Stroke Support Group in English and Spanish. 13. FAST Friday facilitator will document number of people served for each event. 14. Train promotoras on process of FAST Friday and "Explaining Stroke 101". 15. All patients participating in program are referred to CDSMP program via programs sign in sheets (email name and telephone #).
Planned Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, American Heart Association

Care Transitions

Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness ❑ Cancer Screening ☒ Cardiovascular Disease and Stroke
Program Emphasis	☒ 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	A3e-Health Care Support Services
FY 2016 Report	
Program Goal / Anticipated Impact	Avoid hospital and emergency department admissions for all participants enrolled in the Care Transition program.
Measurable Objective(s) with Indicator(s)	1. 80% of participants enrolled in the program will verbalize they take their medications as prescribed. 2. 80% of participants enrolled in the program have a follow-up appointment within two weeks to one week of discharge from hospital. 3. 75% of participants enrolled in the program keep their follow-up appointment after being discharged. 4. 98% of identified patients for tele-monitoring will be placed on the monitors within 4 days of documented need by physician. 5. Beginning 3rd quarter, 40% of patients registered as users with the Emmi education system will complete their assigned classes.
Intervention Actions for Achieving Goal	1. Provide evidence-based health education to 100% of participants enrolled in Care Transition Program. 2. All Care Transition clinicians will use standardized patient education material related to COPD and Heart Failure. 3. All patients enrolled in the program will be called 1 time a week during the first 30 days of being enrolled in the program. 4. All patients will be referred to community resources as needed (i.e. social worker, diabetes program). 5. Provide monthly referrals to CDSMP Program of all ambulatory patients. 6. Beginning 3rd quarter Emmi education will be offered to COPD and heart failure patients and 40% of patients will be enrolled and assigned classes.
Planned Collaboration	Coordinator is actively involved in the following: San Luis Obispo Health Commissioner, board member of the Long Term Care Ombudsman Program, member of Adult Services Policy Council and POLST – Central Coast Coalition for Compassionate Care.
Program Performance / Outcome	Quarter/yr. / # of people enrolled/ # of readmission/ within 3 months of intervention / % of readmissions / within 3 months of intervention / Program Expense Q1/2016 102 6 5.8% $ 37,374 Q2/2016 106 8 7.54% $ 55,503 Q3/2016 132 8 6.06% $ 37,225

	Q4/2016 73 2+0+0 2.73% $ 48,858 1. 100% of the enrolled patients were asked about medication compliance with the first phone call. 2. 100% of the enrolled patients were asked if they were taking weights. No new Phillips monitors were deployed due to the process of getting a new remote monitoring system, and removing all the older models in the field. 3. The EMMI education system that had been identified as a metric for the 3rd and 4th quarters did not materialize as planned. The EMMI education available was not available for our patient population, and did not have the education that we wanted for CHF or COPD for the out- patient setting. Therefore, this indicator was not able to be used as planned.
Hospital's Contribution / Program Expense	This program serves cardiac patients and CHF clients in the community through education, risk assessment and referrals. Expense: $233,886
FY 2017 Plan	
Program Goal / Anticipated Impact	Avoid hospital and emergency department admissions for all participants with COPD, diabetes, pneumonia, cardia event sepsis and heart failure enrolled in the program.
Measurable Objective(s) with Indicator(s)	1. 85% of participants enrolled in the program will verbalize they take their medications as prescribed. 2. 85% of participants enrolled in the program have a follow-up appointment within one week of discharge from hospital. 3. 80% of participants enrolled in the program kept their follow-up appointment after being discharged. 4. 98% of identified patients for tele-monitoring were placed on the monitors within 4 days of documented need by physician. 5. Using secure email, make referral for 40% of low risk patients to CDSMP.
Intervention Actions for Achieving Goal	1. Intervention will include question on patient ability to get follow up MD appointment, involve MSW to assist with additional resources and services. 2. Provide home visit by the MD as temporary solution until long term plans can be arranged. 3. Identify barriers for those patients unable to make their appointment. 4. Work with IT to request changes to Case Management software program to include fields for reporting patient complaints of medications and keeping physician appointment. 5. Patients identified on Dashboard as appropriate for Care Transition and are not contacted due to capacity limit, will all be referred/triggered to Community Education for CDSMP program. 6. Lay navigators will be identified for help in Care Transition program for English and Spanish patients. Lay navigator to help make non-critical calls. 7. The Lay Navigators will be trained for making follow up calls and will follow script/documentation, and notification of RN for any identification of problems requiring RN follow up. 8. Home visits from physician and medical social worker will be tracked for effectiveness in meeting social needs of patient and for preventing complications from their chronic illness. 9. Measure visits, access to community resources, and for compliance with any recommendations from the physician and any evidence of physician communication to primary care physician. 10. Describe or list the specific, principal program/initiative activities planned.
Planned Collaboration	CenCal, Family Caregiver Program and MSW navigator, readmission team at Santa Maria and French Hospital Medical Center, COPD Task Force (Central

	Coast Service Area), Pulmonary Rehab, Pharmacy, Care Transition, Respiratory Care, In-patient Nursing, Physician, Home Health, SNF, Coastal Cardiology for a follow up program for Pulmonary Arterial Hypertension patients in an effort to develop a comprehensive accredited Pulmonary Hypertension Clinic.

Chronic Disease Self-Management Program (CDSMP)	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness ❑ Cancer Screenings ☒ Cardiovascular Disease and Stroke
Program Emphasis	☒ Focus on Disproportionate Unmet Health-Related Needs ☒ Emphasize Prevention ☒ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	A six session evidence-based Chronic Disease Self-Management Workshop that teaches participants to understand their chronic condition, and how to respond to it by becoming a skilled self-manager on a continuing basis.
Community Benefit Cat	A1a- Community Health Education: Lectures/Workshops
FY 2016 Report	
Program Goal / Anticipated Impact	The evidence-based chronic disease self-management programs (CDSMP) offered in the community will offer the participants in the program empowerment skills to better self-care through enhanced self-efficacy.
Measurable Objective(s) with Indicator(s)	1. Implement 2 CDSMP lay leader trainings. 2. Of those attending the CDSMP workshop, 70% will complete 4 or more of the workshop sessions. 3. Of the chronic disease self-management program participants, 30% will identify 2 coping techniques they are using at 90 days after completion date of the workshop.
Intervention Actions for Achieving Goal	1. FHMC community benefit coordinator will attend the CDSMP master trainer training to be able to train lay leaders. 2. Train lay leaders in both English and Spanish to increase the number of workshops offered. 3. Implement telephonic follow-up of graduated participants of Chronic disease self-management program at 90 days of completion of workshop. 4. Offer 4 Chronic Disease Self-Management Program workshops in the FHMC service area.
Planned Collaboration	FHMC case managers, patient care coordinators, SLO Noor Clinic, People Self-help housing, Housing Authority of SLO County, churches, and community centers.
Program Performance / Outcome	1. A total of 22 lay leaders were trained by the end of January 2016. 2. A total of 65 participants registered and a total of 45 completed 4 or more of the workshop sessions indicating a 69.2% completion rate. 3. 100% of participants that completed the workshop self-reported 2 coping techniques and self-reported using one of the tools on a regular basis.
Hospital's Contribution / Program Expense	Hospital has provided in-kind space, nutrition services, advertising, printing, supplies for workshops: $31,346
FY 2017 Plan	
Program Goal / Anticipated Impact	CDSMP program digest will be incorporated into the following program digests: Cancer Prevention and Screenings, Cardiovascular Disease and Stroke, and Care Transitions. For specific goals, measurable objectives, intervention actions, and planned collaboration review the following program digests: Cancer Prevention and Screenings, Cardiovascular Disease and Stroke, and Care Transitions.

Diabetes Prevention and Self-Management (formerly Diabetes Education and Prevention)	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ❑ Homelessness ❑ Cancer Screenings ❑ Cardiovascular Disease and Stroke
Program Emphasis	☒ 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 with a registered dietitian. 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 2016 Report	
Program Goal / Anticipated Impact	Increase diabetes self-management skills in the targeted population by providing diabetes self-management education and support groups.
Measurable Objective(s) with Indicator(s)	1. Increase diabetes support group participation by 10%. 2. Increase series classes participation by 15%. 3. 85% of the class and support group participants will report no ER visit during a follow up call at 3 months after completing the series and every 3 months for the support group. 4. 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. 5. 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. Identify high risk patients from inpatient population at French Hospital via referrals from patient care coordinator. 2. 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. 3. Partner with Diabetic Youth Connection to hold support group for children and teens with diabetes. 4. Offer four community diabetes education class series. 5. Implement 3 month follow up calls on diabetes class series participants. 6. Implement post surveys on both diabetes support group and class series participates.
Planned Collaboration	SLO Noor clinic, People self-help housing, and Diabetes Youth Connection.
Program Performance / Outcome	1. Increase diabetes support group participation by 10%: 121 total participants in 2016, 25% increase in participation (91 participants in 2015) 2. Increase series classes participation by 15%. 74 participants in 2016, down 12% from 2015 (84 participants in 2015) 3. 85% of the class and support group participants will report no ER visit during a follow up call at 3 months after completing the series and every 3

	months for the support group—100% reported no ER visits for all 4 quarters 4. 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—100% indicated enjoyed series and beneficial for DM management for all 4 quarters 5. Complete eight one on one individual session per quarter from the Noor Clinic and referrals from French Hospital patient care coordinator: Q1: 14, Q2: 11, Q3 17, Q4: 21, total for 2016: 63 6. Additional diabetes education/promotion for classes completed at Honey Bee Festival, reached 36 participants
Hospital's Contribution / Program Expense	Hospital provided in kind space, nutritional services, advertising, and printing. Expense: $ 8,010
FY 2017 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 diabetes support group participation by 10%. 2. Increase series classes participation by 15%. 3. 85% of the class and support group participants will self- 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 their A1C once every 3 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. Request 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, Pacific Central Coast Health Centers

Dignity Health Community Grants Program	
Significant Health Needs Addressed	☒ Access to Healthcare, including Behavioral Health ☒ Homelessness ❑ Cancer Screenings ❑ Cardiovascular Disease and Stroke
Program Emphasis	☒ 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 2016 Report	
Program Goal / Anticipated Impact	Distribute grant funds to organizations in the FHMC service area to those agencies meeting the "Accountable Care Community" grant requirements that align with the Community Health Needs Assessment and whose proposal is approved by the Community Benefit Committee and the System Office.
Measurable Objective(s) with Indicator(s)	100% of the proposals approved will address one or more of the health needs identified in the community health needs assessment.
Intervention Actions for Achieving Goal	1. Community Benefit team will send LOI invitation to over 30 not-for-profit organizations. 2. Community Benefit Committee members will carefully review Letters of Intent. 3. Invite organizations to complete a full proposal. 4. Proposals will be reviewed by the Community Benefit Committee. 5. Recommendations for funding will be sent to Dignity Health's System Office for final approval. 6. Central Coast Service Area agencies funded with Dignity Health Community Grants will be requested to provide a quarterly Sustainability Report on the status of their program. 7. Community Benefit Committee will review quarterly reports for adherence to proposal and funding. 8. Community Benefit Committee will provide feedback to funded agencies.
Planned Collaboration	Invitations to submit LOI's were sent to over 30 not for profit organizations in San Luis Obispo County.
Program Performance / Outcome	Grant money awarded to the community for the purpose of improving the quality of life of the residents of San Luis Obispo County. Accountable Care Communities receiving grant funds were: 1. **Central Coast Latino Mental Health Enhancement**- fiscal agent Community Counseling Center The proposed project will address disparities in Latino mental health care by expanding access to culturally and linguistically appropriate psychotherapy and reducing barriers to treatment by mobilizing peer-based advocacy and support services in the region. $23,397. 2. **Working Together to Optimize Healthy Outcomes for the Uninsured and Underinsured**-fiscal agent SLO Noor Foundation. Collaboration expands the

	opportunity to elevate the general health of an underserved population and contribute social and economic benefits to the community by treating various medical issues and managing chronic conditions free of cost to the patient before they can escalate to more serious levels. $23,396
Hospital's Contribution / Program Expense	Provided press releases to the local newspaper, media and, $46,235 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 2017 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. Funded ACC will present at Community Benefit Committee meetings. 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
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

366 French Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit
For period from 7/1/2015 through
6/30/2016

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses
Benefits for Poor					
Financial Assistance	**705**	**325,745**	**0**	**325,745**	**0.2**
Medicaid	**9,740**	**19,795,337**	**14,495,222**	**5,300,115**	**3.8**
Community Services					
A - Community Health Improvement Services	10,783	525,763	78,000	447,763	0.3
C - Subsidized Health Services	4,005	111,598	70,192	41,406	0.0
E - Cash and In-Kind Contributions	522	254,727	23,015	231,712	0.2
F - Community Building Activities	0	1,185	0	1,185	0.0
G - Community Benefit Operations	1	117,815	0	117,815	0.1
Totals for Community Services	**15,311**	**1,011,088**	**171,207**	**839,881**	**0.6**
Totals for Poor	**25,756**	**21,132,170**	**14,666,429**	**6,465,741**	**4.6**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	7,115	817,468	88,514	728,954	0.5
B - Health Professions Education	150	290,643	0	290,643	0.2
F - Community Building Activities	0	15,600	0	15,600	0.0
G - Community Benefit Operations	0	23,600	0	23,600	0.0
Totals for Community Services	**7,265**	**1,147,311**	**88,514**	**1,058,797**	**0.8**
Totals for Broader Community	**7,265**	**1,147,311**	**88,514**	**1,058,797**	**0.8**
Totals - Community Benefit	**33,021**	**22,279,481**	**14,754,943**	**7,524,538**	**5.3**
Medicare	**37,563**	**64,163,054**	**47,248,752**	**16,914,302**	**12.0**
Totals with Medicare	**70,584**	**86,442,535**	**62,003,695**	**24,438,840**	**17.3**

Note: Calculations were derived using a cost accounting methodology

APPENDIX A: FHMC COMMUNITY BOARD FY2016

Patricia Gomez
Chair of the Board
Attorney-at-Law

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

Michael DeWitt Clayton, MD
Secretary
Urology Associates

Sister Susan Blomstad, OSF
Retired Retreat Presenter/Director

Father Russell Brown
Pastor, SLO Old Mission Church

James Copeland
Co-Owner, Copeland Properties

Armando Corella
Former Paso Robles Housing Authority Dir

Reese Davies
Foundation Board Chair
Retired Executive Banker

Robert Doria, MD
Coastal Cardiology

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

Sister Linda Gonzales
Retired Teacher/Administrator

Alan Iftiniuk
President, French Hospital Medical Center

Jim Lokey
Retired Executive Banker

Lennie Michelson
Managing Director of the Gary A. and Lennie F. Michelson Family Foundation

Kerry Morris
COO, Morris & Garritano Insurance

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

Kevin Okimoto
Founder, Trellis Wealth Advisors

Peter Oppenheimer
Retired CFO, Apple

Sister Marianne Rasmussen, OSF
Retired Teacher/Administrator

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

Mike Ryan, MD
Central Coast Chest Consultants

Wayne Simon
Attorney-at-Law

Antonia Torrey, RN, PhD
Nurse Educator, Cuesta College

Christian Voge, MD
Chief of Staff

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

APPENDIX A: FHMC COMMUNITY BENEFIT COMMITTEE FY2016

Armando Corella
Chair of the Committee
FHMC Community Board Member

Fr. Russell Brown
Pastor, SLO Old Mission Church

Patricia Gomez
Attorney–at-Law
FHMC Community Board Member

Denise Gimbel, MPH, RN
Cardiac Wellness – FHMC Program Coordinator

Patricia Herrera, MS
Community Benefits Coordinator,
Chronic Disease Self-Management Program – FHMC Program Coordinator

Beverly Kirkhart
Hearst Cancer Resource Center – FHMC Program Coordinator

Jean Raymond, MSN, RN
Care Transitions Program – 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

Molly Wagman, RD CDE
FHMC Diabetes Prevention & management

Tamra Winfield-Pace, RN
Prenatal & New Parent Education – FHMC Program 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 5 Health for the Community events throughout the primary service area of FHMC. These events have provided over 450 free health screenings to individuals who are uninsured and underinsured. Health screening consisted of the following: vision, oral, blood pressure, lipid and glucose.
- FHMC provides a 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.
- FHMC provides hospital experience based training opportunities for nursing students needing to conduct clinical rounding.
- FHMC has partnered with local community college by donating money so the college could disperse funding as needed for purposed of addressing community wide workforce issues such as school –based programs on health care careers.
- FHMC Anderson Hotel Homeless Respite Care program is a 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.
- 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, and lactation counseling at the local Women, Infant, and Child (WIC) clinics, has provided 4,005 lactation consultations for FY 2016.
- FHMC employees donated clothing to our Caring Closet, which provides clothing to patients upon discharge. FHMC employees annually participate in the following drives that help the poor and needy in our communities: Coats for Kids, Stuff the Bus, Poncho drive for the homeless, 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 much need personal hygiene products to our US troops overseas.
- 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 FY2016 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

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured 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.

Arroyo Grande Community Hospital 345 South Halcyon Road, Arroyo Grande, CA 93420
Financial Counseling 805-489-4261 ext 4411 | **Patient Financial Services** 888-488-7667
www.dignityhealth.org/arroyo-grande/paymenthelp

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

Marian Regional Medical Center 1400 East Church St, Santa Maria, CA 93454 | **Financial Counseling** 805-739-3541
Patient Financial Services 888-488-7667 | www.dignityhealth.org/marianregional/paymenthelp

St. John's Pleasant Valley Hospital 2309 Antonio Ave, Camarillo, CA 93010 | **Financial Counseling** 805-389-5616
Patient Financial Services 877-877-8345 | www.dignityhealth.org/pleasantvalley/paymenthelp

St. John's Regional Medical Center 1600 North Rose Ave, Oxnard, CA 93030 | **Financial Counseling** 805-988-7109
Patient Financial Services 877-877-8345 | www.dignityhealth.org/stjohnsregional/paymenthelp

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Dignity Health.