French Hospital Medical Center

Community Benefit 2020 Report and 2021 Plan

Adopted October 2020

Dignity Health
French Hospital Medical Center

A message from

Alan Iftiniuk, president and CEO of French Hospital Medical Center], and Michael De Witt Clayton, MD, 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 initiatives to deliver community benefit 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 2020 Report and 2021 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 hospitals in Arizona and Nevada voluntarily produce these reports and plans, as well. 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 2020 (FY20), French Hospital Medical Center provided $12,376,968 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $24,663,637 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its October 15, 2020 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching to out to Patty Herrera MS 805-542-6268.

President/CEO
Alan Iftinuik

Chairperson, Board of Directors
Michael De Witt Clayton, MD

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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	$12,376,968 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $24,663,637 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). Needs being addressed by strategies and programs are: • Access to primary health care, dental care, and behavioral health • Aging, more mature population • Chronic disease prevention and management
Y20 Programs and Services	The hospital delivered several programs and services to help address identified significant community health 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 $ 79,002 was awarded in the Dignity Health Community Grants program to Accountable Care Communities that address access to dental Care for adults and basic needs for the aging and more mature population in our community.
FY21 Planned Programs and Services	For FY21, 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 groups for women who have been diagnosed with cancer and diabetes. Establish a chronic disease self-management program support group. Implement the Faith Community Nursing/Health Ministry program which will focus on identifying and serving the needs of the more mature population in our community. Also the Perinatal Mood and Anxiety Disorder (PMAD) program will be implemented which will provide mental health support for families in San Luis Obispo county which are impacted by PMAD.

This document is publicly available online at http://www.dignityhealth.org/frenchhospital/about-us/community-benefits

Written comments on this report can be submitted to the FHMC Manger of Community Health at 1911 Johnson Avenue in San Luis Obispo, CA 93401 or by e-mail to CCSAN-CHNA@dignityhealth.org

Our Hospital and the Community Served

About French Hospital Medical Center

French Hospital Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

FHMC is a 98 bed facility situated on 15-acres at 1911 Johnson Avenue in the City of San Luis Obispo, California and has a long and rich history of serving the needs of the community since it was founded in 1946, and joined Dignity Health in 2004. On January 25, 2020 the Oppenheimer Family Center for Emergency Medicine Grand Opening Celebration took place. The new facility was designed for a high volume of emergency patients with a very strong commitment to comfort, efficiency, holistic healing, and privacy. It was carefully designed with patient comfort and safety in mind utilizing best-in-class modalities and technologies. At the forefront of cutting-edge emergency medicine, the new building features 18 private treatment rooms compared to the five bed ward and semi-private rooms that previously existed. Specialized rooms are designated for critical care, geriatric patients, trauma, infectious disease isolation, pediatrics, and orthopedic emergencies, as well as fast-track beds for patients with less urgent conditions. It also features specialized exam accommodations for patients experiencing behavioral health related issues. FHMC offers programs and services including cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics. FHMC is home to the Central 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. FHMC focuses on increasing access to health care for the broader and underserved disadvantaged members of the surrounding community.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

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 our 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 policy is at the end of this report. The financial assistance policy and plain language summary are on the hospital's web site.

Description of the Community Served

French Hospital Medical Center serves a community that extends over 35-miles in San Luis Obispo County including the communities of the City of San Luis Obispo, Atascadero, Templeton, Morro Bay, Los Osos, Cambria, and Paso Robles. A summary description of the community is below. Additional details can be found in the CHNA report online.

- FHMC's service area is home to over 185,000 individuals, of which approximately 68% consider themselves Caucasian and 21% consider themselves Hispanic or Latino (a). Overall, approximately 18% of individuals residing in the FHMC primary service area are below the poverty level, although 91% have a high school degree or equivalent.

- FHMC's primary service area is unique due to its location on the Central Coast of California with the vast unincorporated areas, striking natural beauty, and thriving communities'. Behind the natural beauty are geographically isolated communities that may host one of the 766 homeless individuals in the area. Within FHMC's primary service area over 1,600 school-aged children have been classified as homeless by the Department of Education. Underrepresented individuals can be found residing in poverty working in the shadows of the agriculture, tourism, or retail industry.

- The communities within FHMC's primary service area are also home to a disproportionate number of aging adults, who reside furthest from FHMC's facilities. Almost half of the population in Cambria (49.0%) are age 62 years and over, followed by approximately one-third of the population in Morro Bay. The Health Resources and Services Administration (HRSA) designated Morro Bay as a medically underserved area/population within FHMC's primary service area.

- In addition to the residents captured by the formalized data sources discussed above, the FHMC's primary service area attracts a farm-worker population drawn to work in the fields. There is no known current estimate for the number of indigenous-Indians from the states of Oaxaca and Guerrero in Mexico, many of whom are monolingual in one of the native Mixteco and/or Zapotec languages.

- Demographic information for the FHMC's primary service area taken from Claritas Pop-Facts 2020; SG2 Market Demographic Module provides data on the following:

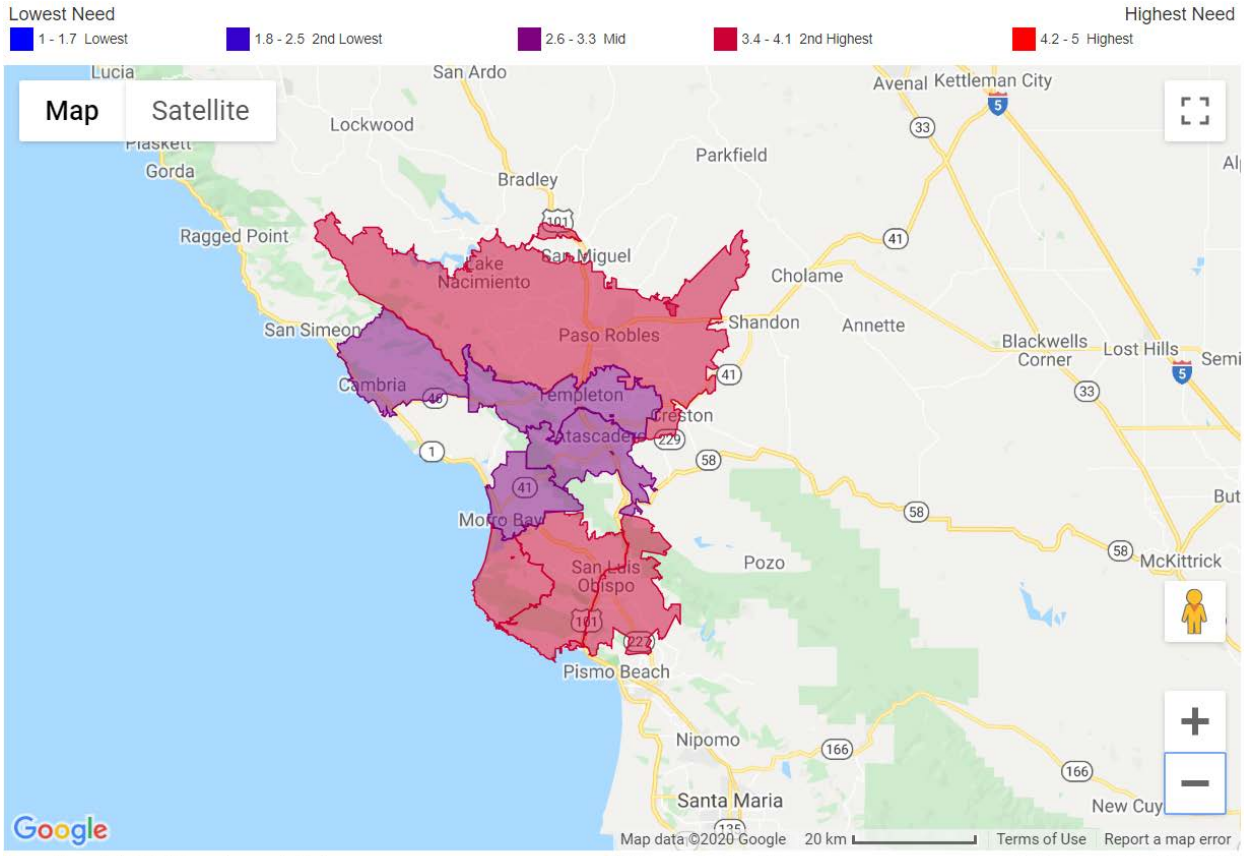
    - **Total Population:** 185,586
    - **Race:**
        - 68.8% White
        - 2.0% Black/African American,
        - 21.5%Hispanic or Latino
        - 4.0% Asian/Pacific Islander
        - 3.6% All Others
    - **% Below Poverty** 5.6%
    - **Unemployment:** 3.7%
    - **No HS Diploma:** 8.0%

- **Medicaid (household):** 6.3%
- **Uninsured (household):** 4.0 %

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and 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.



Mean(zipcode): 3.3 / Mean(person): 3.4 CNI Score Median: 3.3 CNI Score Mode: 2.6,3.2,3.4

Zip Code	CNI Score	Population	City	County	State
93401	3.4	29400	San Luis Obispo	San Luis Obispo	California
93402	3.4	14037	Los Osos	San Luis Obispo	California
93405	4	33873	San Luis Obispo	San Luis Obispo	California
93422	2.6	33083	Atascadero	San Luis Obispo	California
93428	3.2	6410	Cambria	San Luis Obispo	California
93442	3.2	11190	Morro Bay	San Luis Obispo	California
93446	3.6	47659	Paso Robles	San Luis Obispo	California
93465	2.6	9934	Templeton	San Luis Obispo	California

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its 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, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in May 2019.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

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

Significant Health Needs

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

- Improve access to primary health care, dental care, and behavioral health for the low income population found in San Luis Obispo, CA and migrant farmworker population found in Paso Robles, CA. Individuals with limited resources have the most difficulty accessing health care, including the homeless adults and school-aged children within FHMC's primary service area.
- Focus on underserved needs of the aging, more mature population residing in FHMC's primary service area. FHMC's primary service area is home to a disproportionate number of aging adults, who reside furthest from FHMC facilities. The aging population faces challenges with everyday activities such as transportation, housekeeping, personal care, nutrition, food, and finances.
- Prevention and management of chronic disease was the third identified need within this CHNA Report. Cancer and heart disease are the leading causes of death at local, state, and national levels. SLO County ranks almost highest in the state for the incidence of breast cancer and melanoma. In 2017, 50% of Medicare beneficiaries in San Luis Obispo County were treated for hypertension, 18% were treated for diabetes, and 38% were treated for high cholesterol.

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2020 Report and 2021 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 FY20 and planned activities for FY21, 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.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. 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 works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

French Hospital Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.
Rooted in Dignity Health's mission, vision and values the Community Board and Community Benefit Committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see page 35). These parties review community benefit plans and program updates prepared by the hospital's community health manager 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 2021 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 which will be dependent by the current COVID-19 situations 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 we will continue to develop increased awareness and attendance among the Latino community for nutrition, chronic disease management, health screenings, diabetes, cardiovascular disease, stroke and cancer awareness.

Impact of the Coronavirus Pandemic

As the stay home orders and State started to shut down due to COVID-19 French Hospital Medical Center acted proactively by engaging staff in activating the Incident Command Center, collaborating with San Luis Obispo County Public Health, and accessing the needs of our community partners. A bilingual COVID-19 Information line was established and staffed by the Community Health Department. Financial support, in-kind staff hours, hygiene and quiet kits which include ear plugs, eye masks, and stress balls, and thermometers where donated to various community partners. Bilingual PSAs were developed and aired on the local radio stations and television stations. Collaboration efforts between San Luis Obispo Public Health, City of Paso Robles, and FHMC Community Education focused on developing COVID-19 prevention education outreach to the Latino population which resulted in the distribution of COVID-19 prevention kits to strategic neighborhoods in SLO County.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Access to Primary Health Care, Dental Care, and Behavioral Health

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, dental care, medical prescriptions, and behavioral health care.	☒	☒
Bilingual Support groups	• Free Cancer, diabetes, Stroke, and grief support groups offered.	☒	☒
Transitional Care Management Program	• Provide smooth transitions for discharged patients by providing follow up calls and follow up appointments to primary medical homes and other services.	☒	☐
Financial assistance programs	• Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.	☒	☒

Impact: Increase access to free medical care and community 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.

Collaboration: Planned collaboration with SLO Noor free medical and dental clinics, FHMC care coordination and social work departments, Alliance for Pharmaceutical Assess (APA Inc.), Hearst Cancer Resource Center, Pacific Central Coast Health Centers, and FHMC Community Health Department.

Health Need: Aging, more Mature Population

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Community Grants Program	• Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, dental care, medical prescriptions, and behavioral health care.	☒	☒
Transitional Care Management Program	• Provide smooth transitions for discharged patients by providing follow up calls, visits, and follow up appointments to primary medical homes and other services.	☒	☐
Financial assistance programs	• Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.	☒	☒
Dignity Health Wellness programs	• Free evidence based self-management disease workshops.	☒	☒

Faith Community Nursing/Health Ministry program digest	• Free program which approaches care as a "whole person" address the spiritual, physical, mental and social health of the person in their faith community.	☐	☒

Impact: Increase support for the development of an Adult Based Health Care Program which: approaches the needs of the mature adult in a whole person approach which should include the following: a lunch/nutrition program, caregiver program, behavioral wellness component, and end of life discussion component.

Collaboration: Planned collaboration with Dignity Heath's Home Health, Care Coordination, Care Transitions, Social Work, Family Service Agencies, and Meals on Wheels, SB Foodbank, APA Inc., SLO Noor free medical clinics, Pacific Central Coast Health Centers, and Area on Aging Agency.

Health Need: Chronic Disease and Management

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dignity Health Wellness programs	• Free evidence based self-management disease workshops.	☒	☒
Transitional Care Management Program	• Provides smooth transitions for discharged patients by providing follow up calls, visits, and follow up appointments to primary medical homes and other services.	☒	☐
Free Screening Mammogram clinics	• Cancer Care program offers free screening mammograms to women who are uninsured or underinsured.	☒	☒
Faith Community Nursing/Health Ministry program digest	• Free program which approaches care as a "whole person" to address the spiritual, physical, mental and social health of the person in their faith community.	☒	☒
Bilingual Support groups	• Free Cancer, diabetes, Stroke, and grief support groups offered	☒	☒

Impact: Increase cancer cardiovascular disease, diabetes, and stroke awareness, prevention, and management to the most vulnerable populations in SLO county and to increase early detection and management.

Collaboration: Planned Collaboration with the Latino Health Coalition. Community Clinics of the Central Coast, Pacific Central Coast Health Centers, SLO Noor free clinics and SLO Public Health Department. FHMC Women's Imaging center, Hearst Cancer Resource Center

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. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY20, the hospital awarded the grants below totaling $79,002. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Los Osos Cares,Inc	Basic Needs and Resources-Navigation for Estero Bay Community	$29,002
SLO Noor Foundation	Dental Care Access and Service Expansion for Uninsured and Underinsured Adults	$50,000

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. 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, Dental Care including Behavioral Health ❑ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
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 2020 Report	
Program Goal / Anticipated Impact	The goal of the Hearst Cancer Resource Center is to improve the health and well-being of the medically underserved population of the French Hospital 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 20% over the baseline of 18 = 22 health fair participation in FY 2020. 2. Mammograms: Increase patients served by 10% over the baseline of 94 = 104 breast cancer screening for FY 2020. 3. Spanish language Support Group: Increase cancer patient attendance by 15% over the baseline of 14 = 16 cancer patients. 4. Offer 3 Medical Professional community lectures in Spanish language. 5. Offer 12 Spanish language presentation by the Community Cancer Educator.
Intervention Actions for Achieving Goal	1. Track the number of health fairs and contacts made by the new Community Cancer Educator to the Hispanic community. 2. Participate in all the Latino Health Coalition and French Hospital health fairs. 3. Increase outreach to north county schools, churches and medical clinics. 4. Continue to provide cancer awareness information and community resources to target populations. 5. Expand the marketing and promotion of the free breast cancer screening clinics by outreaching to the DH medical offices and clinics via flyers, eblast and face-to-face.

	6. Schedule regular meeting with the breast cancer screening health community collaborators for continued promotion and awareness of these free clinics. 7. Grow the collaboration with Spanish language radio for public announcements and radio interviews. 8. Offer cancer resources and cancer literature to those attending the free clinical breast cancer screenings. 9. Hold 10 support groups for FY 2020 10. Distribute the flyer in the north county to churches, schools, vineyards, community health centers and health fairs. 11. Distribute a flyer to all newly diagnosed Spanish speaking cancer patients who live in the north county. 12. Create and distribute Spanish language flyers for awareness of programs. 13. Conduct a survey to determine the cancer related topics requested by the medically underserved population. 14. Develop a list of new potential groups, organizations and business organizations.
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, schools in the SLO County school district Los Osos Cares, Inc. and collaborative grant partners of Dignity Health/ FHMC.
Performance / Impact	1. Lay Patient Navigator attended 17 Health fairs with a total of 1,523 people attending. From the zip area of 93401, 93422, 93446, 93442, 93432 & 93461. • Outcome: 17 health fairs 2.Mammograms for 2020 • With COVID-19 restrictions starting March 16 all breast cancer screening clinics were canceled. • Outcome: A total of 89 screenings, all normal 3.Spanish Speaking Cancer Support Group for 2020 • Due to COVID-19 CDC and FHMC social distancing guidelines the Spanish language Support Group was canceled starting in March indefinitely. • Outcomes: Total of 14 participated in various forms of support 4.Spanish language Community lectures for 2020: • Outcome: 1 physician lectures. Total of 60 in attendance 5.Spanish language presentations by the Community Cancer Educator for 2020: • Outcome: 3 Spanish language lectures on cancer prevention, risks and screening. Total 48 in attendance.
Hospital's Contribution / Program Expense	Hearst Cancer Resource Center and FHMC provided in kind space, nutritional services, advertisement, and printing. Program Expense $99,079

FY 2021 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 screening for early detection and prevention on cancer.
Measurable Objective(s) with Indicator(s)	1. Increase patients served by 8% over the baseline of 89 = 96 breast cancer screening for 2021 FY. 2. Obtain one grant to fund colonoscopy for the Latino population in the San Luis Obispo County. 3. Offer 3 virtual Spanish language community clinical lectures by medical physicians. 4. Increase virtual Spanish language Cancer Support group attendance by 25% over the baseline of 14 = 18. 5. Develop and launch a virtual Spanish language Cancer Prevention Module. Offer 2 workshops in FY 20201.
Intervention Actions for Achieving Goal	1. Coordinate physician's referral orders with FHMC Women's Imaging weekly scheduled mammogram appointments. 2. Expand the marketing and promotion of the free mammogram program with digital flyers to Dignity Health medical offices and clinics. 3. Schedule regular calls with the breast cancer screening health community collaborators for continued awareness of breast cancer screening program. 4. Participate with Dignity Health Central Coast Grants Manager to secure a colonoscopy grant for the underserved population. 5. Develop a virtual Spanish language Cancer Prevention Module which includes general cancer prevention, self-exam, and screening. 6. Expand the marketing and promotion of the Spanish language Cancer Prevention Module by outreaching to the Dignity Health medical offices, clinics and community health partners through digital flyers, e-blast, and social media.
Planned Collaboration	FHMC Women's Imaging Center, Community Health Centers of the Central Coast, SLO Noor foundation, Community Action Partnership of SLO County, Peoples Self Help Housing, Central Coast Gastroenterology, SLO Oncology, HCRC Nurse Navigator, and numerous schools in the SLO County school district.

Care Transitions	
Significant Health Needs Addressed	☒ Access to Healthcare, Dental Care including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
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 2020 Report	
Program Goal / Anticipated Impact	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. Overall, helping patients to participate in their health management.
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. Utilizing available communication tools (Octavia) send at least 50% of patients not enrolled in the CT program. For those enrolled in Care Transition and discharged at the end of their care, refer at least 45% to community education for ongoing support. 6. Those referred to community education from Care Transition, 5% will register for ongoing program s and 70% will complete at least 1 program. 7. Of the patients who are discharged from service, 90% will verbalize that their overall needs were met with the Care Transition program and at least 95% would recommend this program to others.
Intervention Actions for Achieving Goal	1. Patients referred to Care Transitions (CT) from hospital discharge or the Discharge Call RN, 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, community based palliative care 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. When patients have completed the Care Transition program, the RN who is discharging the patient will ask about their overall satisfaction of the program and if their needs were met. The RN will also ask if they would refer this program to others. Any other comments given will be recorded and turned in for review. 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.
Collaboration	Will work with Care Coordinators at the Dignity Health Hospitals; Discharge Call RN, Home Health, Hospice, Cardiac Rehab; Family Caregiver Program; Octavia program; CCN dept; QI dept.; ER, hospitalists and MSW staff. As well as the Readmission Committees.
Performance / Impact	For the FY 2020, FHMC Care Transition program was under the goal for pt. self-reporting of compliance with self-medication and just under for follow up with their MD. (Med compliance for FY = 89% and MD follow up = 92%). For Readmission rate of CHF, readmission rate for FY 20 = 3.35% and for COPD = 13.15%. Unable to track the ER usage as initially identified in the Digest. For all the patients who were followed by the Care Transition RN, 57% graduated with all or most goals met; 24.2% were referred for ongoing education through Community Benefits and 2.4% were referred to community based palliative care. All patients who were followed by the Care Transition team were connected with available resources and services that they were either available to and/or those the patient/caregiver accepted. Of the patients followed, 83.6% had a chronic illness (CHF, COPD, DM); 22.7% had a diagnosis of Diabetes or an elevated A1C; For FHMC the patient satisfaction was only calculated in the 3rd quarter, and all programs were combined, due to a variety of reasons. The statistics show that 100% would recommend the program; 74.*% felt the program was excellent/very good; 83.3% felt the program information on illness was excellent/very good; 87.5% found information on managing illness excellent/very good; 74% found written materials excellent/very

	good and 87.3% evaluation of services excellent/very good. 79% found needs met excellent/very good.
Hospital's Contribution / Program Expense	Program Expense:$91,110
FY 2021 Plan	
Program Goal / Anticipated Impact	Program will be merging into the Transitional Care Center which focuses on Population Health.
Measurable Objective(s) with Indicator(s)	
Intervention Actions for Achieving Goal	
Planned Collaboration	

Cardiovascular Disease and Stroke

Significant Health Needs Addressed	☒ Access to Healthcare, Dental Care including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
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 2020 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 cardio/stroke screening by 5% (447) at target population health fair events. 2. 80% of the participants deemed at-risk and identified with no primary care provider, and/or become aware for the first time they have an elevated blood pressure reading will self-report at 3 months appropriate lifestyle changes 3. Increase number of participants in the Healthier Living (8) and the Diabetes Empowerment Education program (DEEP-35) by 5% 4. Provide 4 FAST Friday events for target populations (Spanish speaking and elderly) 5. Present Explaining Stroke 101 class in Spanish language twice and to an elderly population two times.
Intervention Actions for Achieving Goal	1. All screened participants will be referred to all Dignity Health Wellness Programs. 2. At-risk individuals will be provided appropriate education, referrals, and follow-up and will be placed on a 3 month follow up call list. 3. At –risk individuals will self-report lifestyle modification at their 3 month follow up call. 4. Maximize usage of current referral pipelines to increase enrollment in the Healthier Living and DEEP workshops.
Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education. Local partner invitations for health fair events.
Performance / Impact	1. A total of 172 cardio/stroke risk assessments were done at 7 health fair events. The goal of increasing to 5% was not reached due to the sudden halt of health fairs due to COVID-19. 2. A total of 79 individuals were screened and deem at risk through our cardiac/stroke risk assessment.

	3. Less than 1 % of those deemed high risk also indicted not having a medical home. Over 97% of the immediate follow up recommendation was re-taking their blood pressure and making a follow up appointment with their primary provider. At 3 month follow up 93% self-reported that they had retaken their blood pressure medication and were complying with their primary providers' orders. 4. A total of 17 participants attended the Healthier Living workshop indicating a 7% increase in attendance. A total of 33particpants attended the DEEP workshop which did not see an increase of 5% this has due to the sudden halt of workshops due to COVID-19, 5. Two FAST Fridays were completed. 6. Two Spanish language Stroke 101 presentations were completed.
Hospital's Contribution / Program Expense	Hospital provided in-kind space, nutritional services, advertising, and printing. Program Expense$10,810

FY 2021 Plan	
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention education, and management of risk factors for heart attack and stroke.
Measurable Objective(s) with Indicator(s)	1. Increase attendance in our Healthy for Life (HFL) Nutrition Class and Diabetes Education Empowerment Program (DEEP) by 5%. 2. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 risk factors for cardiovascular disease and stroke. 3. Eighty percent of the participants in our HFL and DEEP workshop will identify 2 ways to reduce their risk of cardiovascular disease and stroke. 4. Forty percent of the participants attending our DEEP workshops will self-report taking their blood pressure during the course of the 6 week workshop.
Intervention Actions for Achieving Goal	1. Promote our ZOOM HFL and DEEP workshops on social media, hospital website, and other printed media outlets. 2. Recruit participants using Octavia. 3. Ask participants the 4 pre workshop questions on cardiovascular disease and stroke at the 3rd session for HFL and at the post survey phone call for DEEP participants. 4. Track responses of the both pre and post workshop questions on cardiovascular disease and stroke on spreadsheet after each workshop. 5. Ask DEEP participants to take their blood pressure and weight on the 1st, 3rd, and 6th session and record in their body measurement form in their manual. 6. Instructors will track the blood pressure reading and weights on a spreadsheet of each participant that self-reports to them.
Planned Collaboration	Dignity Health Hospital Department: Cardiovascular, Stroke and Community Education, Community Partners, and Pacific Health Centers of the Central Coast.

Diabetes Prevention and Self-Management Program	
Significant Health Needs Addressed	☒ Access to Healthcare, Dental Care including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
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 2020 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 DEEP series class participation by 5%. Include the homeless population as a potential group to target 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. If the waitlist at Noor Clinic exceeds 5 clients, an additional dietitian visit to Noor will be provided monthly until the waitlist is completed. 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. Collaborate with Cardio/Pulmonary Rehab department to identify clients who would benefit from DEEP classes and/or individual sessions. 3. Offer four DEEP education class series with Registered Dietitian involvement. 4. Offer ongoing support through quarterly educational group meetings/lectures 5. Implement post surveys on class series participates. 6. 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. 7. Work with Prado Day to provide DEEP classes as able.
Collaboration	Pacific Central Coast Health Centers, SLO Noor, Alliance for Pharmaceutical Access, Inc., Central Coast Patient Care Coordinators, CenCal, CHCCC, Central Coast Endocrinology, CapSLO and Prado Day Center
Performance / Impact	1. We attempted inclusion of the homeless population through Prado Day Center but were met with obstacles. DEEP series class

	participation was 22 out of the goal of 36.75 participants (met 60% goal for the year). Covid 19 halted classes and effected participation. 2. 100% of DEEP class series participants indicated on a survey the series was beneficial 3. 40 out of 48 one-on-one individual sessions were completed, so 83% goal was met. Covid 19 halted sessions at NOOR clinic and referrals from French hospital temporarily. 4. 23 participants attended the quarterly diabetes support group meeting out of the goal of 32. This met 72% of goal. Covid 19 halted classes temporarily before ZOOM could be up and running.
Hospital's Contribution / Program Expense	Hospital provided in kind space, nutritional services, advertising, and printing. Program Expense:$9,094
FY 2021 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% from FY2020 results. (Goal will be 23. participants). 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 28 attendees as the goal for the Zoom 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. Collaborate with Cardio/Pulmonary Rehab department to identify clients who would benefit from DEEP classes and/or individual sessions. 3. Offer four DEEP education class series with Registered Dietitian involvement. 4. Offer ongoing support through quarterly educational group meetings/lectures via ZOOM. 5. Implement post surveys on class series participates. 6. 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, CAPSLO and Prado Day Center

Dignity Health Community Grants Program

Significant Health Needs Addressed	☒ Access to Healthcare, Dental Care including Behavioral Health ☒ Aging, More mature Population ❑ Chronic Disease Prevention and Management, including Cancer
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 2020 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 with Access to Behavioral Health and Dental Care.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year. 2. Build richer ACCs that are focused on multiple significant health needs. 3. 100% of funded ACCs will update local community benefit committees on their project. 4. 100% of funded ACCs 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 ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Collaboration	SLO Noor Foundation, Community Counseling Center, Transitions Mental Health Association, and other community organizations addressing the community health needs.
Performance / Impact	1. Community Health Manager worked closely with local community agencies in forming Accountable Care Communities that would meet the needs of the hospitals prioritized health needs. 2. Both ACC were scheduled to present at the quarterly Community Benefit meetings to give updates on their projects. 3. Community Health Manager continues to work with ACC to provide concise descriptive quarterly outcomes for committees review.

	4. 100% of funded ACCs have scheduled mid-year meeting 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, $ 79,002 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 2021 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 with Access to Behavioral Health and Dental Care. Due to the current COVID-19 Pandemic 25% of the funds will be granted to single non for profit organization whose daily operations has been affected by COVID-19.
Measurable Objective(s) with Indicator(s)	1.100% of funded Coronavirus Pandemic Impact Grants will address an emerging need due to COVID-19 situation. 2.100% of the funded ACC will schedule at least quarterly meetings to ensure outcomes are attained.
Intervention Actions for Achieving Goal	1. Send an information letter to community partner announcing the criteria to apply for Coronavirus Pandemic Impact Grants. 2. Coach ACCs to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.
Planned Collaboration	SLO Noor Foundation, Community Counseling Center, Transitions Mental Health Association, and other community organizations addressing the community health needs.

Faith Community Nursing/Health Ministry Program	
Significant Health Needs Addressed	☒ Access to Healthcare, Dental Care including Behavioral Health ☒ Aging, More mature Population ☒ Chronic Disease Prevention and Management, including Cancer
Program Description	The faith community nursing program uses the nursing process to address the spiritual, physical, mental, and social health of the healthcare consumer. With the intentional focus on spiritual health, the Faith Community Nurse primarily uses intervention of education, counseling, prayer, presences, active listening, advocacy, referral, and wide variety of resources available to the faith community.
Community Benefit Category	A1-c Community Health Education
FY 2020 Report	
Program Goal / Anticipated Impact	FY 2020 pilot program was launched.
Measurable Objective(s) with Indicator(s)	
Intervention Actions for Achieving Goal	
Collaboration	
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2021 Plan	
Program Goal / Anticipated Impact	The approach to care is "whole person" and addresses the spiritual, physical, mental and social health of the members and the greater community.
Measurable Objective(s) with Indicator(s)	There is an intentional focus on spiritual health, the FCN/HM will use active listening, consultation, counseling, decision making support, education, emotional and spiritual support, presence and referral. The individual interactions will be collected and recorded in a secure documentation system. Each FCN will have a Collaborative Agreement with the Faith & Health Partnership and make 20 contacts per quarter.
Intervention Actions for Achieving Goal	1. Promote growth of the FCN/Health Ministry Concept in the community, which will enhance the link between hospital and the community. • Commission, Hospital Staff/ Chaplains and Spiritual/Church communities

	2. Provide Faith Community Nurse (FCN) Course for RNs that are interested in Health Ministry to become FCN in their own congregation/place of worship • Offer 2 FCN courses per year 3. Establish a team of health ministers/health advocates that have a combined knowledge, experience and willingness to serve to implement programs that respond to the unique needs of the congregation and surrounding community. • Each FCN will Survey his/her Church community and provided the identified programs/support for that population. • The Program Coordinator will be available to the team and have quarterly Support meetings. 4. Partner with other Community Benefit participants (i.e. Health and Wellness Programs – Health for Nutrition class, Healthier Living - Your life Take Care, DEEP and Fall Prevention) • Consult with Community Benefit Program Manager Monthly to Coordinate identified programs.
Planned Collaboration	Work with Catholic Health Initiatives on the Mission and Ministry Grant Project. The purpose of the project is to establish quality documentation of the value added by the services provided by Faith Community Nursing and Health Ministers (FCN/HM).

Perinatal Mood and Anxiety Disorder Program

Significant Health Needs Addressed	☒ Access to Primary Health Care including Behavioral Health ❑ Aging, More Mature Population ❑ Chronic Disease Prevention and Management, including Cancer
Program Description	This program provides mental health support for families in San Luis Obispo county who are impacted by Perinatal Mood and Anxiety Disorder (PMAD) by engaging pediatricians, obstetricians, primary care providers, community-based organizations, and other key stakeholders in maternal health to address the needs of a woman's mental health during and after pregnancy. There is no other program in SLO County that provides this service to the community.
Community Benefit Category	A1-a Community Health; A2-d Community-Based Clinical Services

FY 2020 Report

Program Goal / Anticipated Impact	First year program will be launched.
Measurable Objective(s) with Indicator(s)	
Intervention Actions for Achieving Goal	
Collaboration	
Performance / Impact	
Hospital's Contribution / Program Expense	

FY 2021 Plan

Program Goal / Anticipated Impact	To support pregnant and postpartum women and their families by facilitating access to needed social and behavioral health services
Measurable Objective(s) with Indicator(s)	1. Forty-five pregnant and postpartum women will attend The Mommy Hour, the PMAD support group. 2. Twenty women will be referred to appropriate community resources. 3. At least three women per month will receive individualized navigation support, connecting them to behavioral health support and community resources. 4. At least one provider office per month will receive technical support related to improved screening and referrals for mental health support.

Intervention Actions for Achieving Goal	1. Flyers for The Mommy Hour will be distributed electronically to community partners, directly to patients identified by hospital staff as high-risk for PMAD, and physically posted where relevant. 2. Connect women to psychiatric care, individual and/or group counseling and community programs to help strengthen the family system. 5. Provide technical assistance via phone, email, and in-person meetings to help enhance coordination of care for their patients.
Planned Collaboration	San Luis Obispo County Public Health Department; CHC; Pregnancy and Parenting Support of SLO;

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services 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. Only 2 health events took place due to COVID-19 the other two events were cancelled. These events have provided over 559 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 rounds
  - 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.

- DOVE Self Esteem FHMC started their DOVE Self Esteem program for girls in August 2016. The program focuses on girls who are between the ages of 8 to 12 years of age. Girls are referred by school counselors and school program coordinators. They identify girls who have difficulties in social interaction with their peers, have been bullied, or are the bullies. The free program is a week-long series in which the sessions are 2 hours long. Workshops provide a combination of activities and communication tools that encourage conversation on difficult subjects: body confidence and self-esteem. Sixty- two young women attended the DOVE program before halting the program due to COVID-19.Monthly support groups were implemented as a request by DOVE graduates. The support groups were implemented at 2 elementary school sites and on at a community center with a total of 31 DOVE graduates attending.

- Human Trafficking(Suspected Abuse Task Force) – This initiative was launched in FY 2015 with an emergency response team established and a roll out of the first phase of education and training for hospital clinical staff to increase awareness. Training has been expanded to include other hospital departments. Since the launch the task force has decided to include and address all types of suspected abuse. The task force was able this year to update the Community Resources guide for both Santa Barbara and San Luis Obispo counties. Dr. David O. Duke and couple of other members developed a phone call algorithm when calling a patient that has been identified as a potential victim.

- 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 2177 lactation consultations for FY 2020.

- 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.

- In November 2018, Dignity Health approved a $2,500,000 loan to CHCCC for 7 years to construct a 26,000 square foot health facility in Paso Robles, California as well as renovate an existing facility in Lompoc, California. The Lompoc facility will encompass a full range of health care services including medical, dental, and mental health services along with primary care, optometry and chiropractic services. The facility renovation in Paso Robles will include additional exam rooms, a pharmaceutical dispensary, complementary medicine, conference room space, and exterior improvements, signage, and sidewalk repair.

- Employees donated to the following drives: Stuff the Bus virtual drive, Salvation Army Angel Tree, and Vitalant Blood drives. The hospital also provided in-kind medical supply donations to Reaching for the Stars camp for children with special needs, Global Brigades and Loloma Medical Missions, and Restorative Partners group homes.

- 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 FY2020 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 Promotores Collaborative of SLO County

Economic Value of Community Benefit

10/1/2020
366 French Hospital Medical Center
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2019 through 6/30/2020

	Persons	Net Benefit	% of Expenses
Benefits for Poor			
Financial Assistance	**1,666**	**1,201,312**	**0.7%**
Medicaid	**10,670**	**9,375,861**	**5.4%**
Means-Tested Programs	**2**	**13,980**	**0.0%**
Community Services			
A - Community Health Improvement Services	9,687	754,863	0.4%
C - Subsidized Health Services	2,211	49,780	0.0%
E - Cash and In-Kind Contributions	161	203,794	0.1%
F - Community Building Activities	0	3,954	0.0%
G - Community Benefit Operations	38	61,800	0.0%
Totals for Community Services	**12,097**	**1,074,191**	**0.6%**
Totals for Poor	**24,435**	**11,665,344**	**6.7%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	8,410	528,121	0.3%
B - Health Professions Education	147	160,542	0.1%
G - Community Benefit Operations	0	22,961	0.0%
Totals for Community Services	**8,557**	**711,624**	**0.4%**
Totals for Broader Community	**8,557**	**711,624**	**0.4%**
Totals - Community Benefit	**32,992**	**12,376,968**	**7.1%**
Medicare	**44,245**	**24,663,637**	**14.1%**
Totals with Medicare	**77,237**	**37,040,605**	**21.2%**

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Committee Rosters

HOSPITAL COMMUNITY BOARD FISCAL YEAR 2020

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

Peter Oppenheimer
Vice –Chair of the Board
Retired CFO, Apple

Anita Robinson
Secretary
Banking Executive, 1st Capital Bank

Alan Iftiniuk
President & CEO, French Hospital Medical Center

James Copeland
Co-Owner, Copeland Properties

Robert Doria, MD
Cardiologist, Coastal Cardiology

Maria Escobedo, EdD
Dean, No. County Campus & So. County Center
Cuesta College

Terrance L Harris
Assistant Vice Provost for Admissions Operations & Enrollment Development, CPSU, SLO

Erik Justesen
Foundation Board Chair
President & CEO, RRM Design Group

Ermina Karim
Past CEO, SLO Chamber of Commerce

Margaret Keeler, OSF
LVN & Teacher, Retired

Bianca Lin, MSN, RN
Retired Nursing Director

Thomas L Miller, MD
Radiologist, Radiology Associates of SLO

Kerry Morris
COO, Morris & Garritano Insurance

Ahmad Nooristani, MD
Hospitalist, SL Hospitalists

Sister Jeanne Rollins, OSF
Educator

John Ronca
Attorney-at-Law

Mike Ryan, MD
Internist, Central Coast Chest Consultants

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

Wayne Simon
Attorney-at-Law

Andrea Tackett, MD
Cardiologist, Chief of Staff

Antonia Torrey, PhD, RN
Nurse Educator, Retired

Ke-Ping Tsao, MD
Retired physician

FRENCH HOSPITAL MEDICAL CENTER
COMMUNITY BENEFIT COMMITTEE FY2020

John Dunn
Retired SLO City Manager
FHMC Community Board Member

Fr. Russell Brown
Pastor, SLO Old Mission Church

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

Patricia Gomez
Attorney–at-Law
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

Antonia Torrey, RN, PhD
Nurse Educator, Cuesta College
Chair of the Committee

Patricia Herrera, MS
Manager of Community Health
California Central Coast Division: North

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

Tina McEvoy, RN
Care Transitions, Service Area Coordinator

Alan Iftiniuk
President & CEO, French Hospital Medical Center

Debbie Wettlaufer
Chief Financial Officer
French Hospital Medical Center

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 250% 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 250-350% 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

Central Coast_CA2016

Dignity Health.