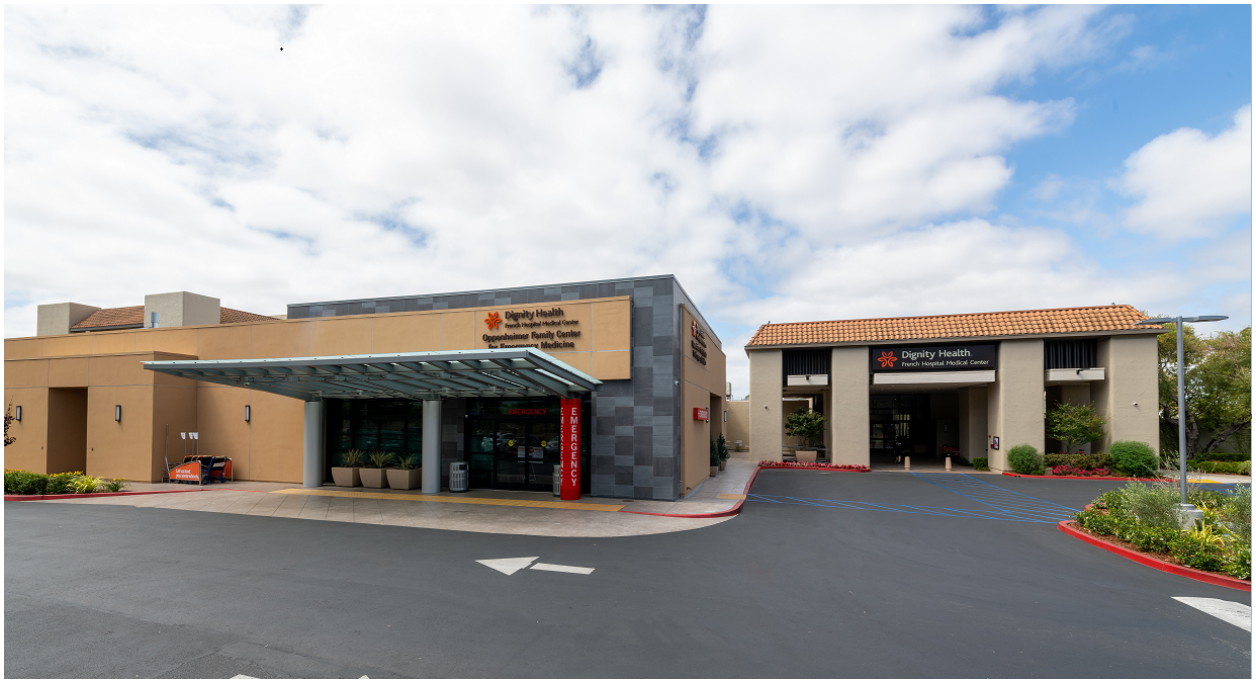
French Hospital Medical Center

Community Benefit 2022 Report and 2023 Plan

Adopted October 2022



Dignity Health
French Hospital Medical Center

A message from

Alan Iftiniuk, President, and Anita Robinson, 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 2022 Report and 2023 Plan describes much of this work. This report meets requirements in California (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 2022 (FY22), French Hospital Medical Center provided $ 19,803,231 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $ 21,544,573 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its October 20, 2022 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 out to Patty Herrera, 805-542-6268.

Alan Ifitinuk, President & CEO Anita Robinson, Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary

Community Served	The primary service area for French Hospital Medical Center (FHMC) encompasses the areas of San Luis Obispo (93401, 93405), Atascadero (93422), Templeton (93465), Morro Bay (93442), Los Osos (93402), Cambria (93428) and Paso Robles (93446). The overall service area for FHMC extends from the City of San Luis Obispo to the East, North, and West into the unincorporated areas of San Luis Obispo County to the county limits.
Economic Value of Community Benefit	$ 19,803,231 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $ 21,544,573 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: • Educational Attainment • Access to primary health care, behavioral health, and dental health • Health Promotion and Prevention
FY22 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; Chronic Disease Self-Management workshops; Diabetes Prevention and Management and Diabetes Education Empowerment Program (DEEP). The Faith Community Nursing/Health Ministry program was launched to focus on identifying and serving the needs of the more mature population in our community. The Perinatal Mood and Anxiety Disorder (PMAD) program was also launched which provided mental health support for families in San Luis Obispo county. A total of $83,135 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.
FY23 Planned Programs and Services	For FY23, the hospital plans to continue to offer the chronic disease and diabetes self-management workshops via the ZOOM platform due to the uncertainty of COVID infection. Increase cancer awareness on the importance of early detection for colon, breast, and cervical cancer. Continue offering our mental health support to SLO county families impacted by Perinatal Mood Anxiety Disorder. Our Faith Community Nursing/Health Ministry will continue to access the needs of the more mature population. Develop a Community Health Navigation program that will serve discharge patients in complying with their discharge plan but also navigate any other social and/or basic need the individual may need. Expand our Street Medicine program to SLO county and Highlight our Physician Mentoring program to help address Educational Attainment.

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 Manager of Community Health at 1911 Johnson Avenue, 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 112 bed acute care 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.

French's Oppenheimer Family Center for Emergency Medicine is the area's most advanced emergency services center. The modern facility is home to the Copeland, Forbes, and Rossi Cardiac Care Center, is the county's premier cardiac center, providing the latest cardiac and imaging technology. On April 2, 2022 French Hospital Medical Center started to offer a new treatment option for patients with severely calcified coronary artery disease living on the Central Coast. The new technology is an approach that uses sonic pressure waves to safely break up kidney stones. It's now available to treat problematic calcium in the coronary arteries that can reduce blood flow in the heart. The new shockwave technology, also known as intravascular lithotripsy or IVL, allows physicians to fracture the problematic calcium - using sonic pressure waves - so that the artery can be safely expanded, and blood flow is restored with the placement of a stent and without unnecessary complications.

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

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance

policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

French Hospital Medical Center (FHMC) 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. The FHMC defined community does not exclude any low-income or underserved populations and includes all members of the community. The communities served by FHMC align with the residence location for 75% of all inpatient discharges.

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

According to the American Community Survey (2016-2020, 5-year average), the FHMC community is home to 186,377 residents, of which, approximately 47,000 reside within the City of San Luis Obispo.[1] Approximately 70% of the FHMC community considers themselves White alone, not Hispanic or Latino(a). The Hispanic or Latino (a) population of the FHMC community is approximately one-fifth (20.4%) of the total population, and the Asian community accounts for 4% of the total population. Additionally, nearly 4% of the FHMC community identifies as two or more races. The FHMC community is home to a youth/young adult population (under age 25) that accounts for over 65,000 residents. However, 36% (23,357) of these reside in zip code 93405 (San Luis Obispo), are between the ages of 18 to 24 years, and are likely affiliated with Cal Poly. High school graduation rates in the FHMC community (age 25 and over) varies by zip code and ranges from a low of 86.6% in zip code 93405 (San Luis Obispo) to a high of 96.9% in 93465 (Templeton).

The FHMC community is home to over 33,000 residents aged 65 years and over, or nearly 18% of the FHMC community. The majority of 65 and over residents in the FHMC community reside in Paso Robles, Atascadero, and San Luis Obispo. The U.S. Census reports that the median age in California is 36.7 years, which is lower than the median age of six FHMC communities. The median age in 93428 (Cambria) is 60.9 and in 93442 (Morro Bay) it is 50.7. The median age in 93446 (Paso Robles) just exceeds the state level, however 93402 (Los Osos) and 93465 (Templeton) are approximately 10 points above the state median age.

According to the U.S. Census, 2016-2020 American Community Survey 5-Year Estimates, poverty levels exceed state (12.6%) and national levels (12.8%) in the following FHMC community locations:

- Zip code 93401 (San Luis Obispo), 13.6% of the population are below 100% of the poverty level; and,

- Zip code 93405 (San Luis Obispo), 40.4% or 9,323 individuals are below 100% of the poverty line.

In addition to the residents captured by the formalized data sources above, the transient farmworker population drawn to work in the fields of San Luis Obispo County are supported by indigenous migrants from the Mexican states of Oaxaca and Guerrero. These indigenous migrants are often monolingual in their native pre-Hispanic indigenous language of Mixtec or Zapotec. According to the National Center for Farmworker Health in 2017, there were an estimated 17,771 farmworkers in San Luis Obispo County.

Due to the COVID-19 pandemic, the 2021 local homeless population count in San Luis Obispo County was not completed and delayed to 2022. The 2022 Homeless Census and Survey for San Luis Obispo County was conducted in February 2022, and their results should be referenced and utilized for any future programming once released. The 2019 Homeless Census and Survey for San Luis Obispo County documented 988 sheltered and unsheltered individuals experiencing homelessness in the following FHMC communities:

- 482 individuals in San Luis Obispo;
- 239 individuals in Paso Robles;
- 173 individuals in Atascadero; and,
- 94 individuals in Morro Bay.

In addition, the 2019 Homeless Census and Survey documented 393 sheltered and unsheltered individuals experiencing homelessness in the unincorporated areas of San Luis Obispo County, which includes portions of the FHMC community.

Demographic information for the FHMC's primary service area taken from Claritas Pop-Facts 2022; SG2 Market Demographic Module provides data on the following:

- **Total Population:** 235,646
- **Race:**
  - 64.1% White
  - 1.7 % Black/African American,
  - 24.2 %Hispanic or Latino
  - 3.9 % Asian/Pacific Islander
  - 6.2 % All Others
- **% Below Poverty:** 5.3 %
- **Unemployment:** 3.6 %
- **No HS Diploma:** 8.5 %
- **Medicaid (household):** 25.0 %
- **Uninsured (household):** 5.1 %

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 2022.

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous CHNA report.

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.

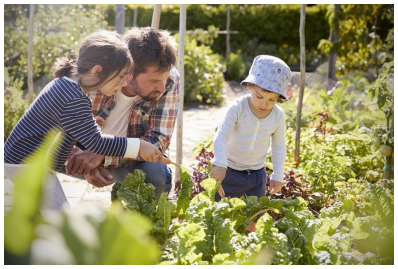
Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/central-coast/locations/frenchhospital/about-us/community-benefits or upon request at the hospital's Community Health office.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Educational Attainment	Adults with a lower educational attainment level have an increase in encountering barriers in obtaining quality health care and are more prone to being negatively impacted by other social determinants of health.	yes
Access to Primary Health Care, Behavioral Health, and Dental Health	Adults have barriers in accessing primary health care which also includes behavioral health and dental health.	yes
Health Promotion and Prevention	Adults have barriers accessing preventive health screenings awareness, and education	yes

2022 Report and 2023 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 FY22 and planned activities for FY23, with

statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital 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.

Hospital and health system participants included in the contribution in creating this implementation strategy and/or will help in the delivering of programs are the following: Care Coordination, Marian Residency Program, OB department, Nutrition Services, and Hearst Cancer Resource Center.

Community input or contributions to this implementation strategy included members from the Community Benefit Committee, senior leadership, clinical experts and program owners met to evaluate the existing programs and develop new programs. Collaboration with community partners also led to improved program design, best practices and effective intervention.

The programs and initiatives described here were selected on the basis of the current 2022 CHNA report and Healthy People 2030 were utilized when identifying program goals and developing measurable outcomes. 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.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Advance Community Health Alignment and Integration	Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.
Expand Clinical - Community Partnerships and Linkages	Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.
Build Capacity for More Equitable Communities	Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.
Inspire, Innovate and Scale High Impact Initiatives	Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

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: Educational Attainment

Strategy or Program	Summary Description	Active FY22	Planned FY23
Community Health Improvement Grant program	● Fund Accountable Care Communities (ACC)whose goal is to encourage higher education, adult literacy and medical literacy.	☒	☒
Physician Mentoring Program	● The Dignity Health Physician Mentoring Program provides local high school and college students the opportunity to witness and understand the importance of professions in the medical field, from evaluation and treatment for follow-up care. Students participate in a rotation which introduces them to the many multidisciplinary facets of medicine. By exposing the students to many specialties, participants have a more complete understanding of the diversity of medical career opportunities	☐	☒
Health Professions	● The hospital provides a clinical setting for	☒	☒

Education	undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, and pharmacists. Nursing students conduct their clinical rounding at the hospital. ● The hospital provides the local community colleges financial support to further address community wide workforce issues, such as school-based programs for health care careers.	☒	☒
Financial assistance programs to improve access	● Financial assistance programs are offered to medically underserved individuals to cover basic needs, hospital bills, transportation vouchers, and hotel vouchers. ● The cancer center also provides financial assistance for basic needs (mortgage payment assistance, rent, gas cards) to community members affected by cancer.	☒ ☒	☒ ☒
Goal and Impact: Increase awareness of the different careers in health care and to encourage students toward the field of medicine.			
Collaborators: Planned collaboration San Luis Coastal School District, San Luis Lucia Mar School District Allan Hancock College, Cuesta College, Future Leaders of America Inc.			

Health Need: Access to Primary Health Care, Behavioral Health, and Dental Health			
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Community Health Improvement Grant program	● Fund Accountable Care Communities (ACC) whose goal is to provide access to health care, dental care, medical prescriptions, and behavioral health care.	☒	☒
Behavioral Wellness Support Groups	● Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). ● Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. ● Prenatal education programs for expectant mothers. ● A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	☒ ☒ ☒ ☒	☒ ☒ ☒ ☒

Financial assistance programs	● Financial assistance programs are offered to medically underserved individuals to cover basic needs, hospital bills, transportation vouchers, and hotel vouchers. ● The cancer center also provides financial assistance for basic needs (mortgage payment assistance, rent, gas cards) to community members affected by cancer.	☒ ☒	☒ ☒
Chronic Disease Prevention and Self-Management Programs	● Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program (DEEP) are offered to community members.	☒	☒
Street Medicine Program	● In collaboration with the Marian Regional Medical Center Family Residency program, basic health and needs assessments are provided to unsheltered individuals in the FHMC community.	☐	☒
Behavioral Wellness Center (Crisis Stabilization Unit)	● The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.	☐	☒
Community Health Navigator Program	● The Community Health department will coordinate with the Transition Care Center to develop a "whole person" approach, for example, the DEEP participants, in helping those patients navigate access to medical, behavioral health, and basic needs services.	☐	☒
Faith Community Nurse Program	● Further develop and expand the FCN program throughout the CA Central Coast market. ● The FCN program will support the whole person including their spiritual, physical, mental and social well-being.	☒	☒
Cancer Prevention and Screening Program	● Support patients' psychosocial emotional needs and assess using the Distress Screening Tool. ● Conduct community outreach surrounding cancer awareness, nutrition, and screening. ● Provide financial support to medically underserved patients for transportation and genetic counseling.	☒	☒
Substance Use Navigation Program	● Dedicated social workers assist patients presenting with Substance Use Disorder to link with appropriate resources. A naloxone distribution program is also part of the program.	☐	☒

Goal and 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

Collaborators: 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: Health Promotion and Prevention

Strategy or Program	Summary Description	Active FY22	Planned FY23
Faith Community Nurse Program	• Further develop and expand the FCN program throughout the CA Central Coast market. • The FCN program will support the whole person including their spiritual, physical, mental and social well-being.	☒	☒
Behavioral Wellness Support Groups	• Provide mental health support to families impacted by perinatal mood and anxiety disorder (PMAD). • Community support groups are offered to community members that have been affected by cancer, stroke, chronic illnesses, and grief. • Prenatal education programs for expectant mothers. • A breastfeeding program offers a warm line where mothers can all in with questions or come in to see a nurse. New mothers are also offered free lactation consultants.	☒	☒
Chronic Disease Prevention and Self-Management Programs	• Promote to the community and provide Chronic Disease Self-Management Program and the Diabetes Education and Empowerment Program to community members. Conduct post workshop testing to determine efficacy of the program.	☒	☒

Goal and 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

Collaborators: 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 Health Improvement 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 related to CHNA priorities.

In FY22, the hospital awarded the grants below totaling $ 83,135. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Community Counseling Center	MARBLE- Multi-tiered Youth Mental Wellness Project	$20,000
Los Osos Cares, Inc	Basic Needs and Resources for Vulnerable Seniors	$35,000
SLO Noor Foundation	Dental Care Access and Service Expansion for Uninsured and Underinsured	$ 28,135

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Behavioral Wellness Support	
Significant Health Needs Addressed	• Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Program provides mental health support through individualized and group support.
Population Served	Underserved population that are seeking mental health support
Program Goal / Anticipated Impact	To support individuals living with a chronic illness and/ or pregnant and postpartum women and their families by facilitating access to needed medical, social and behavioral health services to achieve a healthier self.
FY 2022 Report	
Activities Summary	Program to be implemented in FY 2023.
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2023 Plan	
Program Goal / Anticipated Impact	1. A total of 20 unduplicated individuals will participate for the fiscal year in the monthly chronic illness support group. 2. A total of 60 pregnant women will attend The Pregnancy Hour support group. 3. At least 100 pregnant and postpartum women will attend The Mommy Hour, the PMAD support group. 4. A total of 40 individuals will be referred to appropriate community resources upon request.
Planned Activities	1. Recruit and invite participants that completed the Chronic Disease Self-Management program (CDSMP) and/or Diabetes Empowerment Education Program (DEEP) to the monthly support group. 2. Flyers for The Mommy Hour and The Pregnancy Hour will be distributed electronically to community partners such as OB clinics, directly to patients during their hospital stays, and physically posted where relevant. 3. Assist at least 40 patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs.

Cancer Prevention and Screening

Significant Health Needs Addressed	● Access to Primary Health Care, Behavioral Health, and Dental Health ● Health Promotion and Prevention
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 workers, certified cancer exercise trainer and registered dietician
Population Served	Underserved population emphasizing outreach to seniors.
Program Goal / Anticipated Impact	Offering patient navigation which outreach, health education, along with support of patient care, in their own language, offers patients a better understanding of how to access the resources which allows the patient to make more educated decisions and be involved in their own care.

FY 2022 Report

Activities Summary	1. Hire a new Community Cancer Educator and track the number of health fairs and contacts made to the Hispanic community. 2. Participate in all the Latino Health Coalition and French Hospital health fairs. 3. Increase outreach to schools, churches and medical clinics that serve the Latino community. 4. Expand the marketing and promotion of the free breast cancer screening clinics by outreaching to the Dignity Health medical offices and clinics via flyers, eblast and face-to-face. 5. Schedule regular meetings with the breast cancer screening health community collaborators for continued promotion and awareness of these free clinics. 6. Grow the collaboration with Spanish radio for public announcements and radio interviews. 7. Offer cancer resources and cancer literature to those attending the free clinical breast cancer screenings. 8. Distribute the flyer in the north county to churches, schools, vineyards, community health centers and health fairs. 9. Distribute a support group flyer to all newly diagnosed Spanish-speaking cancer patients. 10. Create and distribute Spanish flyers for all HCRC programs where appropriate. 11. Conduct a survey to determine the cancer related topics request by the medically underserved Spanish population. 12. Develop a list of new potential groups, organizations and business organizations to collaborate with. 13. Create appropriate targeted posts for Facebook in Spanish. 14. Coordinate with Oncology practices in SLO County to support Spanish-speaking patients' understanding of diagnosis and access to care.

	15. Create Spanish language patient folders to be given to all newly diagnosed patients. 16. Create a new committee of key community partners to facilitate Spanish-speaking patients' enrollment into the "Every Woman Counts" program for Breast and Cervical health care – meet quarterly. 17. Add a Spanish page and translation option to the HCRC website
Performance / Impact	FY 2022 services were still affected by Covid closures to several parts of our programming, but we were very successful in getting patients access to care in multiple ways. We added and updated flyers and a website page in Spanish, we supported patient appointments in the medical practices with certified translation services. We supported mammograms to the underserved far exceeding our expectations. We also started translating and disseminating our newsletter in Spanish.
Hospital's Contribution / Program Expense	FHMC provided in kind space, nutritional services, advertisement, and printing. Program Expense: $86,147
FY 2023 Plan	
Program Goal / Anticipated Impact	1. Health Fairs / Outreach: Participate in one health fair each month after it is deemed safe to attend in-person health fairs = 6 for FY23. 2. Mammograms: Offer 10 mammogram clinic dates, with a target of 10 patients each clinic = 100 free mammograms in FY 23. 3. Support female patients to enroll in the Every Woman Counts program to gain sustained access to free annual mammograms and PAP smears. Enroll 40 new patients annually. 4. Spanish Support Group: Host a Spanish speaking monthly support group, with a goal of in-person groups, as soon as safe to do so = 6 groups for FY 23. 5. Offer 3 community educational lectures in Spanish, either in-person or recorded. 6. Offer newsletter articles, program appropriate flyers and literature in Spanish and English = 6 Newsletters, 5 Flyers. 7. Post to social media in Spanish with appropriately targeted messages to support the education of the community. 6 posts per year 8. Support the education of SLO county about the importance of HPV Vaccines in reducing future cancers. Host a quarterly meeting with collaborators. 9. Offer 1 HPV vaccine clinic to reduce future cancer risk of HPV associated cancers. 10. Collaborate with clinics that provide medical care to the underserved to gain access to colon cancer screening kits. Provide 40 screenings.
Planned Activities	1. Support Lay Patient Navigators and track the number of health fairs and contacts made to the Hispanic community. 2. Participate in all the Latino Health Coalition and French Hospital health fairs. 3. Expand the marketing and promotion of the free breast cancer screening clinics by outreaching to the Dignity Health medical offices and clinics via flyers, and face-to-face. 4. Schedule regular meetings with the breast cancer screening health community collaborators for continued promotion and

	awareness of these free clinics and services. 5. Grow the collaboration with Spanish radio for public announcements and radio interviews. 6. Offer cancer resources and cancer literature to those attending the free clinical breast cancer screenings, in both English and Spanish. 7. Distribute flyers in the north county to churches, schools, vineyards, community health centers and health fairs. 8. Distribute a support group flyer to all newly diagnosed Spanish-speaking to cancer patients. 9. Create and distribute Spanish flyers for all HCRC programs where appropriate. 10. Collaborate with free clinics to support health care disparities. 11. Create appropriate targeted posts for Facebook in Spanish. 12. Coordinate with Oncology practices in SLO County to support Spanish-speaking patients' understanding of diagnosis and access to care. 13. Offer Spanish language patient folders for all newly diagnosed patients. 14. Support committee of key community partners to facilitate Spanish-speaking patients' enrollment into the "Every Woman Counts" program for Breast and Cervical health care – meet quarterly. 15. Update the Spanish page to the HCRC website quarterly, with appropriate support tools.

Cardiovascular Disease and Stroke	
Significant Health Needs Addressed	• Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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.
Population Served	Underserved population.
Program Goal / Anticipated Impact	Improve cardiovascular health and quality of life through prevention education, and management of risk factors for heart attack and stroke.
FY 2022 Report	
Activities Summary	1. Promote our ZOOM HFL and DEEP workshops on social media, hospital websites, and other printed media outlets. 2. Recruit participants using Octavia. 3. Track responses of the post workshop questions on carbohydrates and diabetes control.
Performance / Impact	1. At total 86 of participants combined attended the ZOOM Healthy for Life and ZOOM DEEP workshops. Demographics of the participants were 58 Latino, 22 white, 64 females, and 23 males. 2. 100 % of the participants attending either our HFL or DEEP workshop were able to identify 2 risk factors for cardiovascular disease and stroke post completion of the workshop. (Baseline 80%) 3. 92 % of the participants attending the DEEP workshop were able to answer correctly on their posttest survey that carbohydrates break down to glucose .(baseline 80%) 4. 99 % of the participants attending our DEEP workshops answered yes on the ability of them to identify goals to help control their diabetes which can affect their risk of heart disease and stroke. (baseline 85%)
Hospital's Contribution / Program Expense	FHMC provided advertisement, and printing. Program Expense: $ 79,618.
FY 2023 Plan	
Program Goal / Anticipated Impact	Program discontinued, and will be part of the Chronic Disease Prevention & Self-Management program digest for FY2023.
Planned Activities	N.A.

Chronic Disease Prevention & Self-Management	
Significant Health Needs Addressed	• Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	Dignity Health evidenced based Wellness workshops offer the participant the ability to learn skills that will enhance their capability of managing their chronic disease and help others identify tools that will help them make healthier life choices to prevent/ reduce the acute/long term complications from chronic disease.
Population Served	Underserved population emphasizing outreach to seniors.
Program Goal / Anticipated Impact	Improve the confidence level of the workshop participants in their self-management and/or prevention of their chronic disease.
FY 2022 Report	
Activities Summary	New program to start in FY 2023.
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2023 Plan	
Program Goal / Anticipated Impact	1. 80% of the Chronic Disease Self-Management Program (CDSMP) and Diabetes Education Empowerment Program (DEEP) participants will self-report 1 month after completion of the program 2 self-management skills that they have continued to practice. 2. Increase DEEP series class participation by 5 % from FY2022 results. (total for FY 22 was 31) 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 25 attendees as the goal for the Zoom diabetes quarterly support meeting. Hold half of these meetings in the evening hours to include working individuals. 5. 80% of the Healthy for Life participants will identify 2 risk factors for heart disease, stroke, and diabetes, 1 month after completion of the program.
Planned Activities	1. Promote the Dignity Health Wellness workshops on community health quarterly newsletter, social media, hospital website, and other media outlets. 2. Contact and ask workshop HFL participants at 1 month after completion of the workshop to identify 2 risk factors for heart disease, stroke, and diabetes type 1. 3. Contact and ask workshop CDSMP and DEEP participants at 1 month after completion of the workshop to self-report 2 self-management skills that they have continued to practice. 4. Track the responses of the HFL, CDSMP, and DEEP on a spreadsheet.

	5. Collaborate with the Cardio/Pulmonary Rehab department to identify clients who would benefit from DEEP classes and/or individual sessions. 6. Offer four DEEP education class series with Registered Dietitian involvement. 7. Offer ongoing support through quarterly educational group meetings/lectures via ZOOM. 8. 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. 9. Offer ongoing support through quarterly educational group meetings/lectures via ZOOM. 10. 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.

Community Health Improvement Grant Program	
Significant Health Needs Addressed	• Educational Attainment • Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	This program provides 501(3) c "accountable care communities" the opportunity to apply for funds designed to meet the hospital's 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.
Population Served	Underserved populations.
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in the hospital service area to "Accountable Care Community" which align with the hospitals Community Health Needs Assessment.
FY 2022 Report	
Activities Summary	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. Funded ACCs will present at Community Benefit Committee meetings.
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. All ACC were scheduled to present at the quarterly Community Benefit meetings to give updates on their projects. 3. 100% of funded ACCs have scheduled mid-year meetings 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, $ 83,135 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 2023 Plan	
Program Goal / Anticipated Impact	1. Provide grant writing workshops in the summer.. 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.
Planned Activities	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 a timely quarterly sustainability report to the Community Benefit Committee. 4. Funded ACCs will present at Community Benefit Committee meetings.

Diabetes Prevention and Self-Management Program	
Significant Health Needs Addressed	• Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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.
Population Served	Underserved population emphasizing outreach to seniors.
Program Goal / Anticipated Impact	Increase diabetes self-management skills in the target population for pre diabetic and diabetes.
FY 2022 Report	
Activities Summary	1. Continue access to Octavia to identify high risk diabetic patients to refer to diabetic class series and/or individual sessions. 2. Collaborate with the 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 participants. 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.
Performance / Impact	1. Increase DEEP series class participation by 5% from FY2021 results. This goal was exceeded with having 31 participants in FY2022 total. Goal was exceeded by 7 participants for the year. 2. 100% 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. Completed an average of 14 (vs. goal of 12) one-on-one individual sessions per quarter from the Noor Clinic and referrals from French Hospital patient care coordinator in FY2022. 4. Met 76% goal of 25 attendees for the Zoom diabetes quarterly support meeting. Total attendees for FY2022 was 19
Hospital's Contribution / Program Expense	FHMC provided advertisement, and printing. Program Expense: $19,618.
FY 2023 Plan	
Program Goal / Anticipated Impact	Program discontinued will be part of the Chronic Disease Prevention & Self-Management program digest for FY2023.
Planned Activities	

Faith Community Nursing/Health Ministry Program	
Significant Health Needs Addressed	• Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
Program Description	The Faith Community Nurse (FCN) program utilizes a Dignity Health employed Faith Community Nurse Coordinator who develops a faith community nursing program throughout the central coast market area. Faith community nurse programs use the nursing process to address the spiritual, physical, mental, and social health of those part of a local faith community
Population Served	Parish Congregation where Parish Nurses belong to emphasizing outreach to seniors.
Program Goal / Anticipated Impact	To support growth of the individual(s) by enhancing the health of the "whole person" (spiritual, physical, mental and social) through the FCN/HM Program.
FY 2022 Report	
Activities Summary	1) Formalize the relationships at prospective site/faith communities. a) Coordinator to meet with each FCN to understand the unique needs and expectations of each community. b) Coordinator to set up semi-annual coalition meetings that can be in person or via zoom. 2) Offer additional training for other nurses interested in FCN. Develop a timeline for next training with location (keep as in person and also zoom). 3) Coordinator will work with each FCN and share tools that can be used at the local faith community level to do a needs assessment. 4) Identify resources available in the community based on needs assessment. Build partnerships with community agencies for sharing of these community resources. 5) After needs have been identified, each FCN/Health Minister (HM) will develop a plan of appropriate health ministry action and submit data by category and zip code.
Performance / Impact	1) A) 2 churches in the Santa Maria area with FCN (Orcutt Christian Church, Lutheran Church of our Savior). B) 3 churches in San Luis Obispo County with FCN (St. William's Parish in Atascadero, Mission San Luis Obispo de Tolosa, Trinity United Methodist Church in Los Osos) C) 0 churches in Arroyo Grande with FCN 2) 0 of 6 trained: No additional training classes. There are continued discussions with the Mission about a FCN class in the fall. 3) From 1a) of the 2 churches in the Santa Maria area, there has been 1 needs assessment. From 1b) of the 3 churches in SLO county, there has been 3 needs assessment From 1c) no FCN so as of to date no needs assessment 4) # of Partnerships and shared resources= 10;

	FYI-Hospice SLO, Meals-That Connect, Geriatric Care Management, San Luis Obispo Public Health, the Long Term Care Ombudsman Program, the San Luis County Library and Dignity Health have been working on a National Healthcare Decision Day project. In addition, attend monthly meetings of the Adult Services Policy Council, where local Non Profit Agencies share information about available resources. Currently working with Wilshire Home Health and Hospice – Provided a Grief Education and Healing Program at St. Williams. This program is available for others in the FCN/HM Network. Also have made contact with the local Alzheimer's Association for shared resources. The Regional Common Spirit Faith Community Nurses are meeting in the Common Spirit Englewood, CO office in July to review the FCN grant, examine documentation, equity, and Social Determinants of Health. Health interventions at each site: 1a) Santa Maria locations- 488 1b) SLO locations-926 1c) AG locations-0 By Zip Code: Current FCN/Health Minister have provided outreach/interventions by the following zip codes: 93401 - 117, 93402 - 169 , 93422 - 640 , 93454 - 263, 93455 – 225 When talking with the FCN network members – Most of the 1-1 visits are provided for the older adult population. We have been part of a national program - Age-Friendly Health Systems which uses the 4Ms Framework (What Matters, Medication, Mentation and Mobility) to guide the Care of the Older Adult.
Hospital's Contribution / Program Expense	FHMC provided advertisement, and printing. Program Expense: $ 21,465.
FY 2023 Plan	
Program Goal / Anticipated Impact	1) Improve health literacy in the designated faith community(s) as evidenced by individual's ability to define health status and resources (count number per site). 2) Participate in the identified two programs per site to promote health in the faith community (count number of participants per program per site). 3) Provide education on Advance Directives at each site (count number educated per site). 4) The Faith Community Coordinator will build relationships/coalitions/agencies in the community and share the resources with FCN/HM (count number of relationships).
Planned Activities	1)Improve health literacy in the community ● Assess the health literacy of individual/church ● Partner with individuals/community members – Document concerns ● The individual will verbalize health status and willingness to participate in programs 2)Identify programs to promote health in each community settings ● Assess resources available for the identified concern

	● After needs have been identified, each FCN/Health Minister (HM) will develop a plan with the individual/agency and data submitted by category and zip code ● Link with identified health programs 3)Clarify the value of Advance Directives ● Provide education about Advance Directive (include directions, support – the discussion continues since this is a living document and may change over time) ● Document those who were given the information and those who completed the document. 4)Build relationships/coalitions with individuals and Agencies in the community ● Identify resources available and share with FCN/HM ● Participate in established Coalitions that provide Healthcare and Education ● Support individuals/agencies in navigating the health care options based on Health Related Social Needs (HRSN)

Perinatal Mood and Anxiety Disorder (PMAD) Program	
Significant Health Needs Addressed	• Access to Primary Health Care, Behavioral Health, and Dental Health • Health Promotion and Prevention
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
Population Served	Mothers who are experiencing PMAD symptoms or have had PMAD.
Program Goal / Anticipated Impact	To support pregnant and postpartum women and their families by facilitating access to social and behavioral health services.
FY 2022 Report	
Activities Summary	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. Assist patients with referrals to community resources such as support for lactation, parenting, basic needs, and other relevant needs. 3. Connect women to psychiatric care, individual therapy, and/or support groups.
Performance / Impact	No impact to report due to the program coordinator on medical leave.
Hospital's Contribution / Program Expense	FHMC provided advertisement, and printing. Program Expense: $ 72,837.
FY 2023 Plan	
Program Goal / Anticipated Impact	Program restructured into the Behavioral Health Support program.
Planned Activities	N.A.

Physician Mentorship Program	
Significant Health Needs Addressed	• Educational Attainment
Program Description	Local central coast students shadow physicians and other healthcare professionals from various specialties to give them an opportunity to see the variety and importance of the medical profession.
Population Served	High School Students
Program Goal / Anticipated Impact	To encourage local high school and college students to pursue a career in the medical health field.
FY 2022 Report	
Activities Summary	Program will be implemented in FY 2023.
Performance / Impact	
Hospital's Contribution / Program Expense	
FY 2023 Plan	
Program Goal / Anticipated Impact	1. Increased enrollment in the program by 5% baseline for FY 2022 was 42. 2. Increase participation among medical providers by 2% baseline for FY 2022 was 54. 3. Extend program rotations to include the nursing profession. 4. Hold one Career Day : Medical field event at a local middle school.
Planned Activities	1. Increase outreach to high school, colleges and alternative schools throughout the Central Coast service area. 2. Contact high school and college counselors asking them for student referrals to the program. 3. Increase recruitment of local physicians and obtain referrals to gain participation. 4. Collaborate with the hospital department managers, directors, and administration to gain participation of the patient care nurses. 5. Highlight program in the Community Health electronic newsletter which is distributed to community partners including medical facilities throughout the central coast area. 6. Outreach to one middle school to pilot the Career Day: Medical field event. 7. Coordinate with the residency program on the format of the Career Day: Medical field event.

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.

- Health Professions 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; and
  - partners with local community college by donating money so the college could disperse funding as needed for the 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.

- 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.

- Human Trafficking (Suspected Abuse Task Force) – 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 annual training, training of all new employees, and training to other hospital departments. Since the launch the task force has decided to include and address all types of suspected abuse. The task force includes Marian, Arroyo Grande, and French Hospitals. The manager of community health represents the hospital at the county human trafficking task force acting as their community liaison.

- Substance Use Navigation Program: Marian, Arroyo Grande, and French Hospitals started a Substance Use Navigation in 2020. This program focuses on providing increased support through dedicated social workers to patients presenting with Substance Use Disorders. The primary goal of the provider is to provide assessment, intervention, and support while in hospital care, but also to link to appropriate resources with the flexibility to follow patients post-acutely as needed. Identified patients who are seen by providers after hours may also receive a follow up call from social work to coordinate care if/when appropriate. Naloxone Distribution Programs were also launched at all 3 hospital sites through the support of this program.

- Dignity Health announced that is has introduced the Medical Safe Haven (MSH) program at The Family Medicine Center at Marian Regional Medical Center, an area highly impacted by human trafficking. Within the Family Medicine Center, the Marian Family Medicine Residency Program - a three-year post-graduate program for physicians – offers training in the broad spectrum of family medicine. Resident physicians will now be trained to recognize and treat trafficked patients.The MSH program creates a safe space where medical providers can offer ongoing care

for victims and survivors of human trafficking, sex and/or labor, through the use of survivor-informed practices that help to minimize further trauma. This integrated-care model offers survivors the full spectrum of health services, including: primary care, prenatal and obstetrical care, newborn, pediatric and adolescent care, mental health support, vaccinations, STI testing and treatment, PrEP, telehealth, and other essential services. MSH will be serving victims and survivors of human trafficking, sex and/or labor in both Santa Barbara and San Luis Obispo counties.

- 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 2,327 lactation consultations for FY 2022.

- San Luis Obispo County Housing Trust Fund (HTF)
  HTF has two loans with Dignity Health. The first loan for $500,000 was approved in 2011 and the 2nd loan for $500,000 was approved in November 2015. Funds to HTF help the organization respond to increased demand for local affordable housing projects. Preference is given to projects that benefit women and children, and can include single-family ownerships as well as multifamily rental units. Special-needs housing may include transitional housing and group and supportive housing. HTF provides financing and technical assistance for local affordable housing projects, and advocates for affordable housing legislation, programs, and projects at the local, state, and federal levels.

- Employees donated to the following drives: Salvation Army Angel Tree and Vitalant Blood drives.

- 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 FY2022 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, Cal Poly Prevention Committee, Latino Health Coalition of SLO County, ACTION: For Healthy Communities, SLO County Human Trafficking Task Force, and Promotores Collaborative of SLO County

Economic Value of Community Benefit

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.

366 French Hospital Medical Center					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2021 through 6/30/2022					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Poor					
Financial Assistance	**4,535**	**1,472,984**	**0**	**1,472,984**	**0.8%**
Medicaid	**17,377**	**30,899,977**	**14,559,664**	**16,340,313**	**8.3%**
Community Services					
A - Community Health Improvement Services	8,196	988,097	30,552	957,545	0.5%
E - Cash and In-Kind Contributions	2	120,286	0	120,286	0.1%
F - Community Building Activities	0	165	0	165	0.0%
G - Community Benefit Operations	0	70,920	0	70,920	0.0%
Totals for Community Services	**8,198**	**1,179,468**	**30,552**	**1,148,916**	**0.6%**
Totals for Poor	**30,110**	**33,552,429**	**14,590,216**	**18,962,213**	**9.7%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	5,448	606,687	13,035	593,652	0.3%
B - Health Professions Education	155	226,221	0	226,221	0.1%
G - Community Benefit Operations	0	21,145	0	21,145	0.0%
Totals for Community Services	**5,603**	**854,053**	**13,035**	**841,018**	**0.4%**
Totals for Broader Community	**5,603**	**854,053**	**13,035**	**841,018**	**0.4%**
Totals - Community Benefit	**35,713**	**34,406,482**	**14,603,251**	**19,803,231**	**10.1%**
Medicare	**51,709**	**79,841,400**	**58,296,827**	**21,544,573**	**11.0%**
Totals with Medicare	**87,422**	**114,247,882**	**72,900,078**	**41,347,804**	**21.1%**

Hospital Board and Committee Rosters

French Hospital Medical Center

Community Board FY 23

Anita Robinson
Chair of the Board
Banking Executive, Retired

Terrance L Harris
Vice-Chair
Assistant Vice Provost of Admissions & Enrollment Development, CPSU, SLO

Boyd G Carano
Secretary
Of Counsel, Vinson & Elkins

Alan Iftiniuk
President & CEO, French Hospital Medical Center

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

Luke Faber, MD
Surgeon, CC Cardiothoracic Surgical Assoc.

Charlene Rosales
Deputy Director, Mission Community Services Corp

Mike Ryan, MD
Internist, Central Coast Chest Consultants

Craig Canfield, MD
Urologist, Chief of Staff

Wayne Simon
Attorney-at-Law

Antonia Torrey, PhD, RN
Nurse Educator, Retired

Ke-Ping Tsao, MD
Retired physician

Ermina Karim
Past CEO, SLO Chamber of Commerce

Tom Lebens
Atty-at-Law
Foundation Board Chair

Bianca Lin, MSN, RN
Retired Nursing Director

Wyatt Mello
President & CEO and EVP, Mello Group

Thomas L Miller, MD
Radiologist, Radiology Associates of SLO

Sister Jeanne Rollins, OSF
Educator

John Ronca
Attorney-at-Law

French Hospital Medical Center
Community Benefit Committee FY2022

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

Fr. Russell Brown
Pastor, SLO Old Mission Church

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

John Dunn
Retired SLO City Manager

Alan Iftiniuk
President & CEO, French Hospital Medical Center

Sister Jeanne Rollins, OSF
Educator

Charlene Rosales
Director of Governmental Affairs

Shannon D Acquisto
Hearst Cancer Resource Center–
FHMC Program Coordinator

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

Patricia Herrera, MS
Manager of Community Health
California Central Coast Market Area

Calandra Parks, RN
Perinatal Mental Health Program Coordinator
FHMC Program Coordinator

Jean Raymond, RN,GCNS-BC
Faith Community Nursing/Health Ministry 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
California Central Coast Market Area

Debbie Wettlaufer
Chief Financial Officer
French Hospital Medical Center