French Hospital Medical Center

2019 Community Health Implementation Strategy

Adopted October 2019

Dignity Health™
French Hospital Medical Center

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At-a-Glance Summary

Community Served 	The primary service area for French Hospital Medical Center (FHMC) encompasses the areas of the City 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.
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
Strategies and Programs to Address Needs 	The hospital intends to take several actions and to dedicate resources to these needs, including: • Access to primary health care, dental care, and behavioral health o Improved outreach into the community by medical professionals targeting most vulnerable populations o Community grants program will address access. • Aging, more mature population o Emergency department rooms specialized for geriatric patients o Community grants program will address aging needs. • Chronic disease prevention and management o Increased community educational programming, including bilingual o Promotores de Salud o Improve community access to free screening programs
Anticipated Impact 	These programs will bring medical professionals out of the hospital and clinics and into the community where they will be able to encounter the most underserved population that is least likely to access a traditional clinic or hospital. Programs will also allow the aging population to age well in place as long as possible. Educational programs will continue to provide community health education at low or no cost.
Planned Collaboration	Every program identified will engage multiple community non-governmental community organizations to execute the planned strategy/program.

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 in San Luis Obispo, CA 93401 or by email to CCSAN-CHNA@dignityhealth.org.

Our Hospital and the Community Served

About French Hospital Medical Center

French Hospital Medical Center (FHMC) 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. 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, cardiologist, 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

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

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

Financial Assistance for Medically Necessary Care

French Hospital Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary and other materials are on the hospital's web site.

Description of the Community Served

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. A summary description of the community is below. Additional details can be found in the CHNA report online.

FHMC service area is home to over 184,000 individuals, of which approximately 71% consider themselves Caucasian and 20% 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, with the vast unincorporated areas, striking natural beauty, and thriving communities'. Behind the striking natural beauty are geographically isolated communities, that may host one of the 766 homeless individuals in the area. Within FHMC 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 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 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.

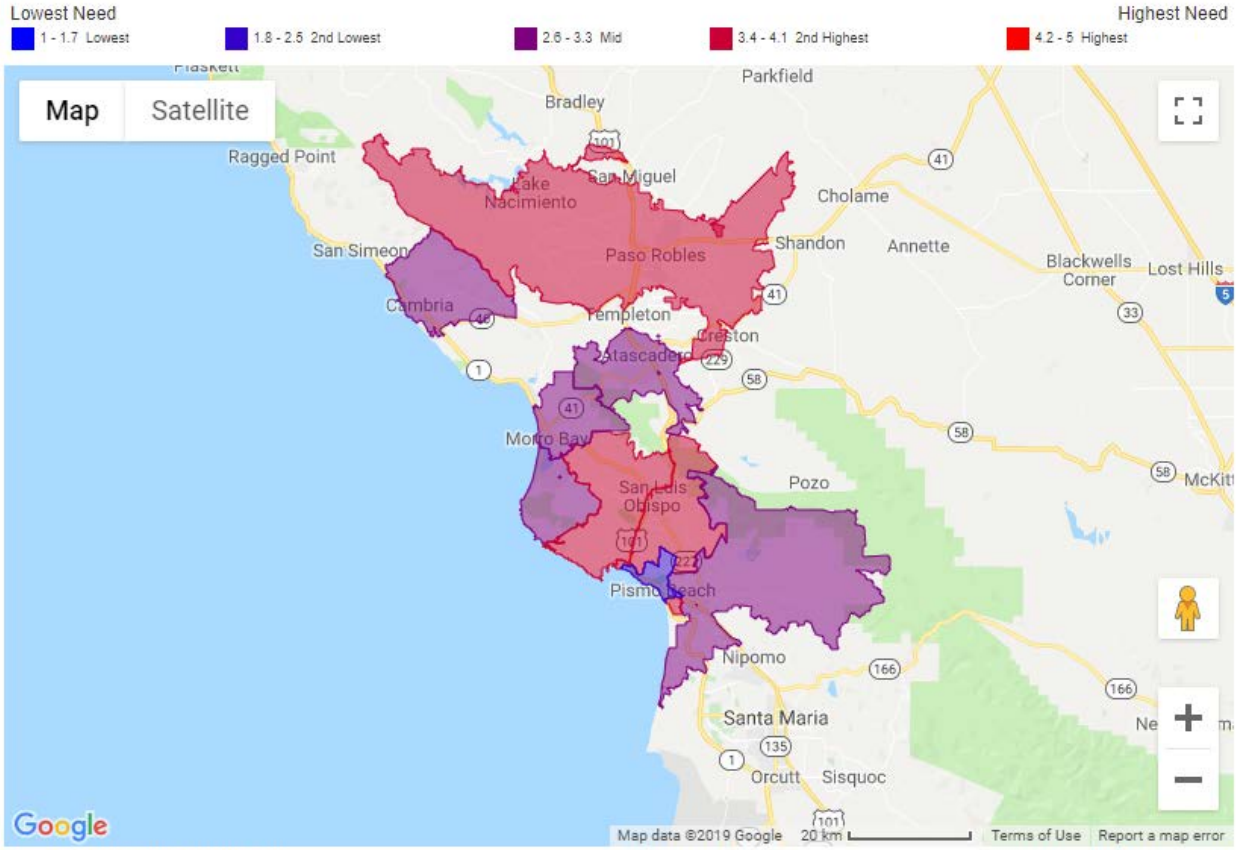
Demographic information for the FHMC primary service area taken from 2018 The Claritas Company, © Copyright IBM Corporation provides data on the following:

- Total Population: 187,235
- Hispanic or Latino: 20.6%
- Race: 69.7% White, 2.0% Black/African American, 4.1% Asian/Pacific Islander, 3.6% All Others
- Median Income: $67,694
- Uninsured: 8.2%
- Unemployment: 2.9%
- No HS Diploma: 9.7%
- CNI Score: 3.1
- Medicaid Population: 22.5%
- Other Area Hospitals: 2
- Medically Underserved Areas or Populations: Yes

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): 3.1 / Mean(person): 3.2 CNI Score Median: 3.1 CNI Score Mode: 2.8,3.6

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 health implementation strategy 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 detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/-/media/cm/media/documents/CHNA/CHNA-French.ashx?la=en&hash=5CAF08B6216DEFEA0AB2B6307D2306C658844070 or upon request at the hospital's Community Health office.

Significant Health Needs

The 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.
- 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.
- Chronic disease prevention and management 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.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

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 Implementation Strategy

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.

The development of this Community Health Implementation Strategy began with a review of current programs already offered by FHMC and the newly identified needs in the CHNA. Program planning for the next three years included input from members of the Community Benefit Committee, senior leadership, clinical experts, and program owners. External community organizations were also

approached and discussions were held regarding collaborative efforts to address needs. Existing activities were reviewed for effectiveness, the need for continuation, or the need for enhancement. New programs have been developed and existing programs have been enhanced based upon feedback from internal and external stakeholders. Program development includes a plan for monitoring for performance and quality to find areas of improvement to facilitate their success.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned 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
Dignity Health Community Grants	Fund Accountable Care Communities (ACC) in FY2020 that offer free or sliding scale health and dental care to adults.
Transitional Care (TCM) Management Program	The TCM program fosters external partnerships and community linkages to promote continuity of care.
Financial Assistance Programs	Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.
Street Medicine Outreach Program	A community health manager will attend a Street Medicine Training to better understand the necessary steps to develop a program.
Behavioral Health Master Plan	In collaboration with San Luis Obispo County Public Health Department a county wide behavioral health coalition will be developed.
Marian Family Medicine Resident Outreach	The family medicine outreach program will provide residents at community events.
Emergency Department Expansion	Additional exam rooms are being added to the emergency department facilitating quicker access to care, including a specialized geriatric room.
Promotores de Salud	The Promotores Community Health Outreach program utilizes a robust network of culturally competent community health workers, that are members of their communityfurthering health education in the community.

Anticipated Impact: Increase access to free medical care and resources to provide early detection, prevention, and management of illness. Increase smooth transitions for discharged patients by providing access to "medical homes" and pharmaceutical patient assistance programs.

Planned Collaboration: SLO Noor free medical and dental clinics, FHMC Care Coordination and Social Work Departments, Alliance for Pharmaceutical Assess (APA Inc), Hearst Cancer Resource Center, FHMC Community Health Department, and San Luis Obispo County Public Health Department.

Health Need: Aging, More Mature Population

Strategy or Program Name	Summary Description
Dignity Health Community Grants Program	Fund Accountable Care Communities (ACC) in FY2020 that support adult based health care programs and/or a long term care solution for those seniors facing hospice.
Transitional Care (TCM)Management Program	The TCM program fosters external partnerships and community linkages to promote continuity of care.
Financial Assistance Programs	Financial assistance programs to cover basic needs, hospital bills, transportation vouchers, hotel vouchers.
Faith Community Nurse Program	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.
Dignity Health Wellness Programs	Free evidence based self-management disease workshops.

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

Planned Collaboration: Planned collaboration with Dignity Heath's Home Health, Care Coordination, Care Transitions, Social Work, Family Service Agencies, Meals on Wheels, SB Foodbank, APA Inc., and Area on Aging Agency, Hearst Cancer Resource Center.

Health Need: Chronic Disease Prevention and Management

Strategy or Program Name	Summary Description
Dignity Health Wellness programs	Provide community education classes focused on evidence based self-management disease workshops.
Bilingual Support Groups	Free cancer, diabetes, stroke, and grief support groups offered.
Transitional Care Management Program	The CT program fosters external partnerships and community linkages to promote continuity of care.
Free Screening Mammogram clinics	Cancer Care program offers free screening mammograms to women who are uninsured or underinsured.
Colon Cancer Screening Program	Colon cancer free screening program for the under insured and uninsured.
Lung Cancer Screening Program	Evaluate the capacity to implement a community no cost lung cancer screening program.
Homeless Chronic Disease Education and Navigation Program	Develop an educational program targeted to those residing in poverty (homeless or otherwise). Program will also connect individuals to community organizations to also address needed social determinants.

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

Planned Collaboration: Planned Collaboration with the Latino Health Coalition, SLO Noor Free Clinic, Community Clinics of the Central Coast, Pacific Central Coast Health Centers, and SLO County Public Health Department.

Program Digests

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

 **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 free of charge, their families and loved ones that include consultations with oncology nurse, social worker, certified cancer exercise trainer and registered dietician.
Community Benefit Category	A1e-Community Health Improvement Services; A1-Health Care Support Services; A2- Community Based Clinical Services; E3-Financial and In-Kind Donations
Planned Actions for 2019 - 2021	
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 FHMC 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% annually (Year 1, 2, 3). 2. Increase the number of free mammograms provided to the community by 10% annually (Year 1, 2, 3). 3. Spanish Cancer Support Group: Increase cancer patient attendance by 15% annually (Year 1, 2, 3). 4. Offer three Medical Professional community lectures in Spanish annually (Year 1, 2, 3). 5. Offer 12 Spanish presentation by the Community Cancer Educator annually (Year 1, 2, 3).
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 FHMC health fairs.

Cancer Prevention and Screenings

	3. Increase outreach to north county schools, churches, vineyards, health fairs, and medical clinics. 4. Continue to provide cancer awareness information and community resources to target populations. 5. Expand promotion of free breast cancer screening clinics to the broader community. 6. Schedule regular meeting with the breast cancer screening health community collaborators for continued promotion and awareness of free clinics. 7. Grow the collaboration with Spanish radio for public service 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. Create a Spanish language cancer awareness flyers and distribute to all Spanish speaking new patients and to predominately Spanish speaking areas in community. 11. Conduct a survey to determine the cancer related topics request by the medically underserved Spanish population.
Planned Collaboration	FHMC Women Imaging Center, La "M" radio, Community Health Centers of the Central Coast, SLO Noor Foundation (SLO & PR), Community Action Partnership of San Luis Obispo County, Peoples Self Help Housing, San Luis Obispo County Health Department, North County Catholic Churches, schools in the SLO County school district Los Osos Cares, Inc. and collaborative grant partners of Dignity Health/ FHMC.

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 (CT) 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. The CT program fosters external partnerships and community linkages to promote continuity of care.
Community Benefit Category	A3- Health Care Support Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	The Care Transition (CT) program provides consistent telephonic patient follow-up and education to better help participants manage their COPD, diabetes, pneumonia, cardiac event, sepsis and heart failure. Program with focus on the following populations – Seniors, Hispanic, Underserved, regardless of insurance coverage.
Measurable Objective(s) with Indicator(s)	1. 95% of participants enrolled in the program will verbalize they take their medications as prescribed on on-going basis (Year 1, 2, 3) 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 (Year 1, 2, 3). . 3. Utilizing available communication tools (Octavia) send at least 50% of patients not enrolled in the CT program to community education for ongoing support (Year 1, 2, and 3). 4. 70% of CT participants referred to community education will complete at least one program, increasing 5% annually, and 5% will register for ongoing programs, increasing to 10% by year 3 (Year 1, 2, 3). 5. Assess participtants' for social determinant needs and refer to community programs including social support, health literacy, and food and housing security.
Intervention Actions for Achieving Goal	1. Patients referred to CT during hospital discharge will be called to enroll in the program and a nurse will identify any problems or symptoms 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.

Care Transitions	
	3. Identify effective practice patterns to ensure that patients with limited or no insurance can receive services specific to their needs. 4. Identify patients who are having difficulty with physician follow-up and assist in locating MD and schedule appointment. 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.
Planned Collaboration	Planned collaboration with Dignity Heath's Home Health, Care Coordination, Care Transitions, Social Work, Family Service Agencies, Meals on Wheels, SB Foodbank, APA Inc., and Area on Aging Agency.

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	The cardiovascular disease and stroke program at FHMC will provide risk assessments and education to community members to improve their health self-efficacy and facilitate medical follow-up for any identified risk factors.
Community Benefit Category	A1- Community Health Education; A2- Community Based Clinical Services; A1-Community Health Education: Support Group

Planned Actions for 2019 - 2021

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% at target population health fair events annually (Year 1, 2, 3). 2. 80% of participants deemed at-risk 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 (Year 1, 2, 3). 3. Increase number of participants in the Healthier Living and the Diabetes Empowerment Education Program (DEEP) by 5% annually (Year 1, 2, 3). 4. Provide 4 FAST Friday events for target populations (Spanish and elderly) (Year 1, 2, 3). 5. Present Explaining Stroke 101 class twice annually, increasing 50% Year 1, 33% Year 2, 25% Year 3 to an elderly population.
Intervention Actions for Achieving Goal	1. All screened participants will be referred to 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.
Planned Collaboration	Dignity Health Hospital Departments: Cardiovascular, Stroke and Community Education. Local partner invitations for health fair events.

Diabetes Prevention and Self-Management

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	A1.- Community Health Education: Individual Health Education for uninsured/under insured

Planned Actions for 2019 - 2021

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% annually. Include the homeless population as a potential group to target (Year 1, 2, 3). 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 (Year 1, 2, 3). 3. Complete 12 one-on-one individual sessions per quarter from the Noor Clinic and referrals from FHMC patient care coordinator. If the waitlist at Noor Clinic exceeds five clients, an additional dietitian visit to Noor will be provided monthly until the waitlist is completed (Year 1, 2, 3). 4. The goal for diabetes quarterly support meeting attendance is 32 individuals, and increase attendance 5% annually (Year 1, 2, 3).
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. 4. Offer ongoing support through quarterly educational group events. 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 encourage those patients to attend ongoing community health promotion classes. 7. Work with Prado Day to provide DEEP classes on-site.
Planned Collaboration	Pacific Central Coast Health Centers, SLO Noor, CAPSLO, Alliance for Pharmaceutical Access, Inc., Central Coast Patient Care Coordinators, CenCal, CHCCC, Central Coast Endocrinology, 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 CHNA. 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
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Grant funds will be awarded to organizations in FHMCs service area to the "Accountable Care Community (ACC)" who serve areas aligning with FHMC's CHNA.
Measurable Objective(s) with Indicator(s)	1. Provide grant writing workshops in the Spring of each calendar year (Year 1, 2, 3). 2. Build richer ACC that are focused on multiple significant health needs (Year 1, 2, 3). 3. 100% of funded ACC will update local community benefit committees on their project (Year 1, 2, 3). 4. 100% of funded ACC will schedule at least quarterly meetings to ensure outcomes are attained (Year 1, 2, 3).
Intervention Actions for Achieving Goal	1. Community Education Coordinator will work closely with agencies to form a more succinct "Accountable Care Community" (ACC) for services the hospital is unable to address itself. 2. Coach ACC to provide more concise, comprehensive quarterly measurable outcomes. 3. All funded ACC will submit timely quarterly sustainability report to Community Benefit Committee. 4. Funded ACC will present at Community Benefit Committee meetings.
Planned Collaboration	SLO Noor Foundation, Community Counseling Center, Transitions Mental Health Association, and other community organization addressing the community health needs.

Hospital Board and Committee Rosters

French Hospital Medical Center Community Board
FY 2019

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Research Scholar in Residence, CPSU, SLO

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

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Mike Ryan, MD
Central Coast Chest Consultants

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Aaron Steed
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Liz Summer
Foundation Board Chair
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Antonia Torrey, RN, PhD
Nurse Educator, Cuesta College

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

French Hospital Medical Center
Community Benefit Committee FY2019

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FHMC Community Board Member

Fr. Russell Brown
Pastor, SLO Old Mission Church

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