2025 Community Health Implementation Strategy and Plan

Adopted October 2025

French Hospital Medical Center

Dignity Health®
A member of CommonSpirit

Table of Contents

At-a-Glance Summary

Community Served	French Hospital Medical Center (FHMC) serves approximately 180,000 residents from northwestern San Luis Obispo County, including the communities of Atascadero , Cambria, San Luis Obispo, Los Osos, Morro Bay, Paso Robles, Avila Beach, and Templeton, California.
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 the hospitals intends to address with strategies and programs are: • Priority 1: Culturally sensitive and accepting healthcare • Priority 2: Readily available healthcare and navigation assistance in patients' spoken language • Priority 3: Unmet Vital Conditions • Priority 4: Access to Improved Behavioral Health including substance use disorder treatment and navigation of services
Strategies and Programs to Address Needs	The Hospital intends to take several actions and to dedicate resources to these needs, including: *Priority 1:* • Colibrí Project: Cultural Awareness Training • Schwartz Rounds • Healthcare Humility Series • Peer to Peer Support *Priority 2:* • Heritage Language Identifier Tool • Dignity Health Interpreter Certification Program *Priority 3:* • Community Health Improvement Grant Program • Financial Assistance Programs • Patient Transportation *Priority 4:* • Behavioral Wellness Support Groups • Behavioral Wellness Center (Crisis Stabilization Unit) • Substance Use Navigation Program • Community Health Improvement Grant program

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the hospital Manager of Community Health at 1911 Johnson Ave., San Luis Obispo, CA 93401 or by e-mail to CHNA-CCSAN@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

French Hospital Medical Center is a member of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

The French Hospital Medical Center is a state-of-the-art, 98-bed acute care facility located 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.

The Hospital'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, San Luis Obispo's premier cardiac center, providing the latest cardiac and imaging technology, and the Hearst Cancer Resource Center offering free education, resources and support to cancer patients and their families. FHMC has received 27 Straight A's in hospital safety from the Leapfrog Group and a CMS 5-Star hospital rating.

Our Mission

The Hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

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

The Hospital serves residents from the Northwestern San Luis Obispo County communities of Atascadero, Cambria, San Luis Obispo, Los Osos, Morro Bay, Paso Robles, and Templeton, California. A summary description of the community is below, and additional details can be found in the CHNA report online.

The community served by the hospital includes the following zip codes and zip code tabulation areas which are shown on Figure 1 below:

- 93401 and 93405 (San Luis Obispo),
- 93402 (Los Osos),
- 93422 (Atascadero),
- 93424 (Avila Beach),
- 93428 (Cambria),
- 93442 (Morro Bay),
- 93446 (Paso Robles),
- 93465 (Templeton),

To accurately report U.S. Census information, the following Zip Code Tabulation Areas (ZCTAs) 2020 (within zip code 93405) were also included in the community served analysis:

- ZCTA 93407 and 93410 (California Polytechnic State University);
- ZCTA 93409 (California Men's Colony)

Figure 1. Communities Served by the Hospital

According to the American Community Survey (2019-2023, 5-Year Estimate), the FHMC community is home to 187,261 residents, with nearly 68% of the community identifying as White alone, not Hispanic or Latino(a). Approximately one in five (21.7%) community members identify themselves as Hispanic or Latino(a). The communities with the most individuals that identify themselves as Hispanic or Latino(a) are Paso Robles (93446) (13,895) and Atascadero (93422) (7,258). The Asian community accounts for 3.8% of the total population, there are 2,249 Black community members (1.2%), and nearly 5% of the community identifies themselves as two or more races.

Excluding ZCTA 93407, 93410, and 93409, approximately one in five individuals within the FHMC community (18.3%) reside in poverty, exceeding county (13.5%) and state (12.0%) rates. This accounts for approximately 6% of families and 13% of individuals in the community who are living below 100% of the federal poverty level. Over 35% of the residents of the community have public health insurance coverage. One in four San Luis Obispo County residents is covered by Medi-Cal/CenCal, and about 6% of community members have no health insurance coverage. Nearly one-third (32.3%) of the community is age 55 and older, and many reside in the more geographically isolated communities. Approximately half of the community members in each of the following locations are age 55 and older: Morro Bay (93442), Cambria, (93428), and Avila Beach (93424).

Approximately 20,000 18 to 24-year-olds within the community can be attributed to California Polytechnic State University. The campus has been assigned ZCTAs 93407 and 93410, which are located within zip code 93405.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

- Description of the community assessed consistent with the hospital's service area;
- Description of the assessment process and methods;
- Data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

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 or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Culturally sensitive and accepting healthcare trusted by the community.	Provide health care services that acknowledges the patient's culture and traditions to enhance trust among provider and patient.	•
Readily available healthcare and navigation assistance in the patients' spoken language.	Provide interpretation services, forms and literature in the patients' preferred language.	•
Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare.	Barriers to basic needs can affect an individual's health in all aspects: body, mind, and spirit.	•
Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.	Developing low barrier criteria to behavioral health and substance abuse disorder treatments to most neediest.	•

2025 Implementation Strategy and Plan

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, including resources for and anticipated impacts of these activities.

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 Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included 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, Trauma Program Services, Quality, 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 meeting 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 2025 CHNA report, and Healthy People 2030 was 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 Central Coast Community Benefit Committee, Dignity Health California Region Central Coast Hospitals Leadership Team, their Community Board and the national CommonSpirit Health community health system office (Dignity Health) receive regular program updates.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

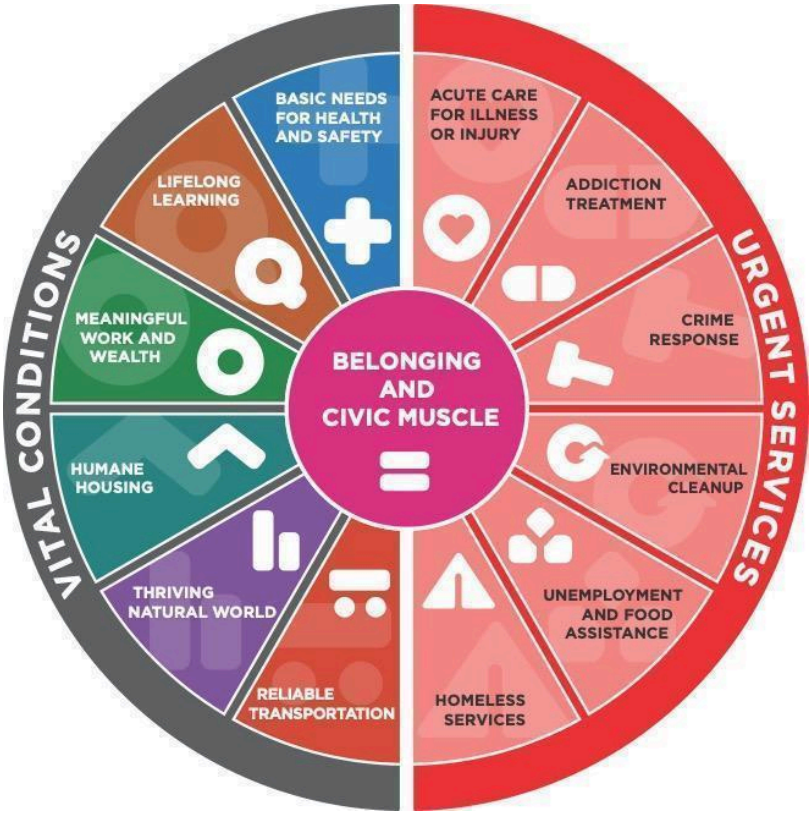
Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.



Well-Being Portfolio in this Strategy and Plan
The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need No. 1:	Culturally sensitive and accepting health care trusted by the community.				
Population(s) of Focus:	FHMC Most Vulnerable Populations				
Strategy or Program	**Summary Description**	**Strategic Alignment**			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Colibrí Project: Cultural Awareness Training	Training will equip clinicians with: ● Cultural knowledge and tools to be utilized when caring for our non-English speaking population; ● Increase patient-provider trust; and, ● Decrease moral distress in caregiver staff that occurs when medically necessary options are declined.		●	●	VC: Lifelong Learning and Meaningful Work and Wealth US: Acute Care for Illness or Injury = Belonging & Civic Muscle
Schwartz Rounds	Schwartz Rounds provides a regular open forum to discuss the psychosocial and emotional aspects of working in healthcare and will provide an opportunity for caregivers to: ● Appreciate the roles and contributions of colleagues from different disciplines; ● Decrease feelings of stress and isolation, ● Increase insight into the social and emotional aspects of patient care, and ● Increase feelings of compassion.		●	●	VC: Lifelong Learning and Meaningful Work and Wealth US: Acute Care for Illness or Injury = Belonging & Civic Muscle

Health Need No. 1:	Culturally sensitive and accepting health care trusted by the community.				
Peer to Peer Support	A peer to peer support program for staff to decrease anxiety, depression, stress, and burnout.		●	●	VC: Lifelong Learning and Meaningful Work and Wealth = Belonging & Civic Muscle
Healthcare Humility Series	A series to increase awareness and cultural humility about the different subpopulations that exist in the community.			●	VC: Lifelong Learning = Belonging & Civic Muscle
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Herencia Indígena, hospital administration, and other hospital departments.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve patient trust, health outcomes, and healthcare experiences by sharing cultural, historical, and language differences when serving the community.	• 80% of the Colibrí Project training attendees will be able to identify 2 cultural norms on their post survey • Schwartz Round self-assessments indicate growth or improvement	• Pre & post test results; • Self-reflective evaluation; and, • Tracking of participation in Peer to Peer Support

Health Need No. 2:	Readily available health care and navigation assistance in patients' spoken language				
Population(s) of Focus:	FHMC Most Vulnerable Populations				
Strategy or Program	**Summary Description**	**Strategic Alignment**			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Heritage Language Identifier Tool	A map that can be used to pinpoint the area where the patient is from to match them with the correct interpreter.			●	VC: Basic Needs for Health and Safety US: Acute Care for Illness or Injury = Belonging & Civic Muscle
Dignity Health Interpreter Certification Program	Program that certifies bilingual staff who pass a written and oral exam to provide interpreter services to patients with limited English proficiency.			●	VC: Basic Needs for Health and Safety US: Acute Care for Illness or Injury = Belonging & Civic Muscle
Mixteco Interpreters	Herencia Indígena provides Mixteco interpreters both in the hospital and within the outpatient setting. The program also provides advocacy and navigation services for social/basic needs.	●		●	VC: Basic Needs for Health and Safety US: Acute Care for Illness or Injury = Belonging & Civic Muscle

Health Need No. 2:	Readily available health care and navigation assistance in patients' spoken language
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.
Planned Collaborators:	Hospital Administration, all hospital departments, and Pacific Central Coast Health Centers

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To improve patient communication between healthcare team and patient to enhance health outcomes and healthcare experiences.	• 40% of the hospital patient interfacing staff will report they use the language identifier tool most of the time. • Increase the number of staff that are certified to provide interpreter services by 25%.	• Tracking of hospital departments and staff using the language identifier tool • Interpreter Certification tracking

Health Need No. 3:	Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare				
Population(s) of Focus:	FHMC Most Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grant Program	Fund projects whose goal is to meet the vital condition(s) of: ● Basic needs; ● Housing; ● Transportation; and, ● Childcare.	●		●	VC: Basic Needs for Health and Safety, Humane Housing, and Reliable Transportation US: Homeless Services, Unemployment and Food Assistance, and Addiction Treatment
Financial Assistance Program	● Financial assistance programs are offered to medically underserved individuals to cover basic needs, hospital bills, transportation vouchers, and hotel vouchers. ● The Hearst Cancer Resource Center Basic Needs program provides financial assistance for basic needs (mortgage payment assistance, rent, gas cards) to community members affected by cancer.	●		●	VC: Basic Needs for Health and Safety, Humane Housing, and Reliable Transportation US: Homeless Services
Patient Transportation	The cancer centers provide vouchers for transportation. Transportation for discharged patients is also provided by a third-party through care coordination.	●		●	VC: Reliable Transportation

Health Need No. 3:	Unmet vital conditions, including transportation, finances, housing (including the unhoused population), education, the environment, and childcare
Planned Resources:	The hospital will provide financial assistance, registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.
Planned Collaborators:	Not for profit community partners, hospital care coordination team, transition care center, Mission Hope, Hearst Cancer Research Center and Pacific Central Coast Health Centers

Anticipated Impacts (overall long-term goals)	Measure	Data Source
To help address the unmet vital conditions among the most marginalized in the community.	• Community Grant awardee reporting metrics • Provide assistance to the most vulnerable community members as the need presents	• List of Community Health Grant awardees and projects • Tracking of the number of patients provided transportation to and from the hospital • Community benefit reporting

Health Need No. 4:	Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.				
Population(s) of Focus:	FHMC Most Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Behavioral Wellness Support Groups	Community support groups that provide mental health support to families and individuals that are impacted by: ● Perinatal mood and anxiety disorder (PMAD), ● Diabetes, and ● Other chronic illnesses.	●	●	●	VC: Basic Needs for Health and Safety and Lifelong Learning US: Acute Care for Illness or Injury = Belonging& Civic Muscle
Behavioral Wellness Center (Crisis Stabilization Unit)	The Behavioral Wellness Center provides a safe haven for those individuals experiencing a mental health crisis.		●	●	VC: Basic Needs for Health & Safety US: Acute Care for Illness or Injury
Community Health Improvement Grant Program	Fund projects whose goals are: ● To improve behavioral health; ● Offer substance use disorder treatment; and ● Navigation services.	●	●	●	US: Acute Care for Illness or Injury, Addiction Treatment, and Homeless Services

Health Need No. 4:	Access to improved behavioral health, including substance use disorder treatment, and navigation of services with a special emphasis on the unhoused population.				
Substance Use Navigation Program	A dedicated social worker assists patients presenting with Substance Use Disorder (SUD) to link with appropriate resources.			●	US: Acute Care for Illness & Injury, Addiction Treatment, and Homeless Services
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Hospital care coordination team, transition care center, behavioral wellness team, community health department, community homeless service providers, community substance use providers, and community mental health providers				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve access to behavioral health, substance use disorder treatments, and implementation of navigation services.	• Increase attendance by 5% at support groups • Improve self efficacy score by 5% between pre- and post assessments for Behavioral Wellness Support	• Support groups attendance logs • List of 2026 Community Grant awardees • Behavioral Wellness Support Groups pre- and post test results

Program Highlights

The FHMC community is unique due to its location on the Central Coast, with vast unincorporated areas, striking natural beauty, and thriving communities. Behind the striking natural beauty are geographically isolated communities, where marginalized individuals can be found residing in poverty, working in the shadows of the agriculture, tourism, or retail industry. The following paragraphs are a brief reflection of FHMC's commitment to improving community health, especially for the vulnerable, while advancing social justice for all.

The FHMC Community Health Department and Marian Family Residency Program have collaborated to expand their Street Medicine Program to the FHMC Community. The Street Medicine Program will provide very basic health and basic needs assessments to unsheltered individuals in the FHMC community. The Street Medicine team conducts regular outings to several homeless encampments in the community.

Health Professions Education at FHMC sponsors training for medical students, nurses, and other students in the healthcare field. Hundreds of hours each year are committed to providing a clinical setting for undergraduate training and internships for dietary professionals, technicians, physical therapists, social workers, pharmacists, and other health professionals from universities and colleges.

The Substance Use Navigation Program focuses on providing increased support through a dedicated social worker to patients presenting with Substance Use Disorders. The primary goal of the provider is to provide assessment, intervention, and support following hospital discharge care, but also to link to appropriate resources with the flexibility to follow patients post-acutely as needed.

The Behavioral Wellness Support Program provides mental health support through individualized and group support. The program aims 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.

FHMC is introducing a new program starting in FY 2026, the Health Equity: Healthcare on Their Terms Program. The goal of the program is to develop and increase trust among hospital staff, patients, and the community by offering new training and support to staff and implementing a new language tool for patients to more accurately match with interpreters.

FHMC also engages in a variety of essential community building activities as a means to further the mission of advocacy, partnership, and collaboration. Activities will include 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.