Dignity Health
Memorial Hospital

Bakersfield Memorial Hospital

Community Benefit 2015 Report and 2016 Plan

A message from

Jon Van Boening, president and CEO of Memorial Hospital, and Robert Noriega, Chair of the Dignity Health Memorial Hospital Community Board.

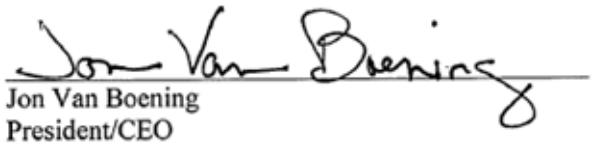
The **Hello humankindness** campaign launched by Dignity Health is a movement ignited by and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. Dignity Health's comprehensive approach to community health improvement includes multi-pronged initiatives directed at significant health needs, partnering with others in the community working to improve health, and investing in efforts that address social determinants of health.

Memorial Hospital shares a commitment to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2015 Report and 2016 Plan describe much of this work. This report meets requirements of not-for-profit hospitals in the Patient Protection and Affordable Care Act to adopt a community health Implementation Strategy at least every three years, and in California state law (Senate Bill 697) to produce an annual community benefit report and plan. Dignity Health complies with both mandates in all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospitals deliver, and are pleased to report to our community.

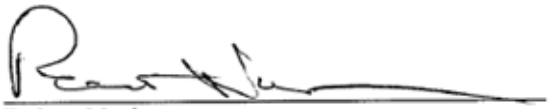
In fiscal year 2015 (FY15), Memorial Hospital provided $9,046,452 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital's total community benefit expense was $18,715,477.

Dignity Health's Memorial Hospital Board of Directors reviewed, approved and adopted the Community Benefit 2015 Report and 2016 Plan at its October 28, 2015 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (661) 632-5467.



Jon Van Boening
President/CEO



Robert Noriega
Chairperson, Board of Directors

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EXECUTIVE SUMMARY

Memorial Hospital serves all of Kern County, including Bakersfield (the county seat) and outlying rural communities such as Lost Hills, Taft, and Wasco. The county covers more than 8,100 square miles, making it the geographically third largest county in the state. The landscape is diverse, ranging from high desert to mountains to vast expanses of rich agricultural flatlands. According to the 2010 United States Census, Kern County's population was 839,631. Additional community facts and details can be found in the Description of Community Served section on page 8.

The significant community health needs that form the basis of this report and plan were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at www.healthykern.org. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The 10 significant community health needs identified are:

- Heart Disease and Stroke*
- Cancer
- Diabetes*
- Preventive Screenings*
- Cancer Screenings
- Access to Health Care*
- Low Birth Weight/Infant Mortality
- Asthma*
- Women's Health Screenings
- Sexually Transmitted Diseases (STDs)

Memorial Hospital further prioritized these 10 needs to five focus areas that are indicated by the * symbol. In FY15, we took numerous actions to help address identified needs. These included:

- Breast Health Program
- Preventive Health Screenings and Flu Clinics
- In-Home Health Education
- Health Education Classes/Seminars
- Community Health Initiative Program
- Chronic Disease Self-Management and Diabetes Self-Management Seminars
- Prescription Program
- Homemaker Care Program
- Outpatient Navigator Program

For FY16, Memorial Hospital will continue responding to the above mentioned community needs. We will also develop an Asthma Management Program and healthy cooking classes to be scheduled through the new kitchen classroom located at our Community Wellness Center.

The economic value of community benefit provided by Memorial Hospital in FY15 was $9,046,452, excluding unpaid costs of Medicare in the amount of $9,669,025.

Memorial Hospital maintains its strong, mission-based commitment to caring for Medi-Cal enrollees and all members of the community. The hospital served 65,257 Medi-Cal patients in FY15, compared to 53,439 in FY14, an 18% percent increase.

This report and plan is publicly available at http://www.dignityhealth.org/bakersfieldmemorial/.

MISSION, VISION AND VALUES

Our Mission

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

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

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

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

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

OUR HOSPITAL AND OUR COMMITMENT

Hospital Description

As Bakersfield's largest acute care facility, Memorial Hospital opened its doors to the public in 1956 to serve the growing needs of the community. Located in the heart of a re-energized downtown, the campus has received numerous awards and recognition for its quality care.

When the ground was turned on this community treasure 65 years ago, no one could know then how Memorial Hospital would grow. But through the leadership and heart of Larry Carr, the 112 bed community hospital grew into more than 400 and thousands of lives were changed. Today, Memorial is home to the Sarvanand Heart and Stroke Center, the Lauren Small Children's Medical Center, and soon, the new Robert A. Grimm Children's Pavilion for Emergency Care.

Memorial Hospital has many features designed to make patients and visitors feel comfortable and welcomed. The Einstein Pavilion, built in honor of Dr. Hans E. Einstein, is an architectural monument to the warmth and grace that defined its namesake. A landscaped plaza and covered entryway form an oasis from the outside world. Inside, waterfalls and lush plant life define a space of natural beauty and harmony.

Memorial Hospital offers a large variety of health services including an Accredited Chest Pain Center, da Vinci Surgical System®, Diabetes Clinic, Certified Stroke Center, the area's only Pediatric Intensive Care Unit, and the Wound Healing, Hyperbarics, and Amputation Prevention Center. Memorial Hospital is home to the Ronald McDonald House and is a member of Children's Miracle Network Hospitals.

Our Commitment

Rooted in Dignity Health's mission, vision and values, Memorial Hospital is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource. Memorial Hospital's president is committed to the Community Benefit process and accountable to Dignity Health system leadership.

A Community Benefit Committee of the Board assists the Department of Special Needs and Community Outreach in prioritizing programs that are in line with the hospital's strategic plan. Committee members include representatives of the hospital Executive Management Team, the business community, social service agencies, community volunteers, board members, and employees. This group meets four times annually to help ensure that our outreach services respond to identified community needs and are effectively working to improve the overall health status of the community. The Committee provides input, advice, and approval for the Community Benefit Plan. The approved plan is then submitted to the board of Memorial Hospital for final approval. During FY 2015, the Community Benefit Committee lost three members and gained five new members. A roster of current Committee members is attached as Appendix A.

Caring for the community beyond the hospital walls led to the founding of the Department of Special Needs and Community Outreach in 1991. In response to identified unmet health-related needs in the community, today the department operates more than 45 programs in Bakersfield, Arvin, Shafter, McFarland, Delano, Lost Hills, Ridgecrest, Taft, Wasco, and other outlying communities in Kern County where there is limited access to health care and related services.

With 38 employees and an annual budget of $2,960,154 (including both Mercy and Memorial Hospitals), the department's programs target low-income, uninsured, or underinsured individuals, as well as Kern County citizens with unmet health needs, including migrant farm workers and other disenfranchised populations. The department's leaders include Debbie Hull, Regional Director; Felicia Corona, Community Benefit CBISA Coordinator; Rita Flory, Programs and Projects Coordinator; Edgar Aguilar, Manager, Community Health Initiative; Judith Harniman, Manager, Community Wellness Program; Freddy Hernandez, Supervisor, Learning and Outreach Centers; David Mazone, Supervisor, Homemaker Care Program; and Donna Tirp, Manager, Art and Spirituality Center. The department frequently collaborates with more than 100 public, private, and nonprofit organizations.

The three Dignity Health hospitals in Bakersfield (Mercy Hospital Downtown, Mercy Hospital Southwest, and Memorial Hospital) are the largest providers of health services in the Southern San Joaquin Valley, serving a diverse population of urban and rural residents. Combining resources, Mercy and Memorial Hospitals respond to identified unmet health-related needs throughout Kern County in a unified way through four Outreach Centers:

Learning Center
631 E. California Avenue, Bakersfield, CA 93307, (661) 325-2995

Outreach Center
1627 Virginia Avenue "C", Bakersfield, CA 93307, (661) 325-2995

Community Wellness Center
2634 G Street, Bakersfield, CA 93301, (661) 861-0852

Art and Spirituality Center
2215 Truxtun Avenue, Bakersfield, CA 93301 (661) 632-5357

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

DESCRIPTION OF THE COMMUNITY SERVED

Memorial Hospital serves all of Kern County, including Bakersfield (the county seat) and outlying rural communities such as Lost Hills, Taft, and Wasco. We further define the community served by the hospitals' primary service area. This is based on the percent of discharges. Nearly two-thirds of Kern County's residents—and most of its major health care providers—are clustered in and around Bakersfield. In addition to Memorial Hospital, other health providers in Bakersfield include: Mercy Hospital Downtown, Mercy Hospital Southwest, Kern Medical Center, Kaiser Permanente, San Joaquin Community Hospital, The Heart Hospital, Good Samaritan Hospital, Clinica Sierra Vista and Omni Family Health. The service area for these providers is also Kern County. Whenever possible, an effort is made for community-based collaboration to solve problems and ensure sustainable health programs over the long term to populations that need it the most.

Many of Bakersfield's poorest residents are concentrated in the city's southeast quadrant, the site of two of our community outreach centers. The population is largely African American and Hispanic/Latino, with a high concentration of limited-English speaking individuals (many undocumented), elevated youth gang activity, and a high unemployment rate. These neighborhoods include rundown motels that house a transient homeless population, including many families with children.

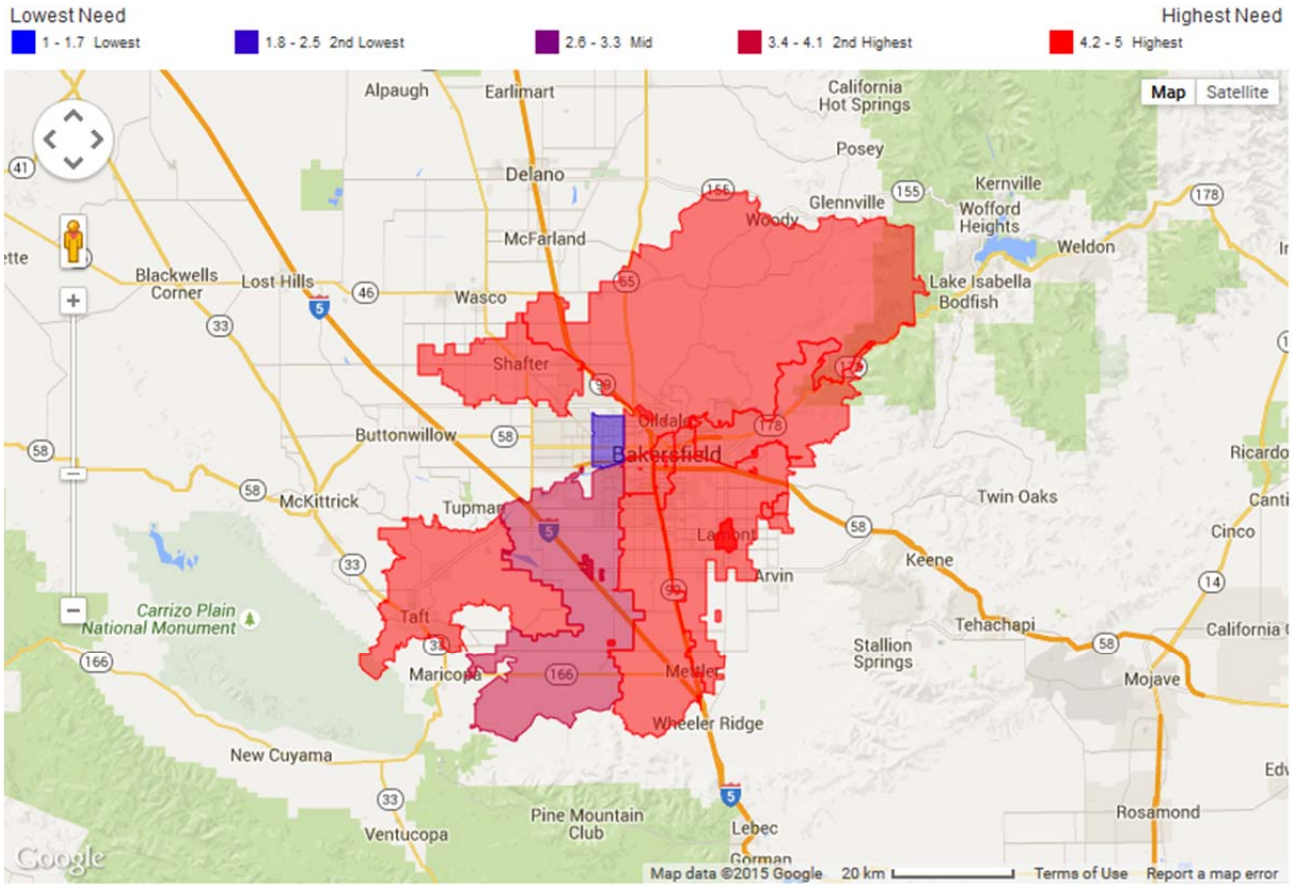
Most of these residents have not received health services or assistance because of poverty, chronic substance abuse, language barriers, lack of transportation, a strong mistrust of established institutions, or lack of knowledge about accessing and using available services. For many low-income individuals and families living in the outlying rural communities of Kern County, geographic isolation heightens these barriers to health care and other services.

Demographic indicators using 2015 Truven Health Analytics and Nielson Company estimates:

Total Population: 583,150
Hispanic or Latino: 53.6%
Race: 33.7% White, 5.4% Black/African American, 4.4% Asian/Pacific Islander, 0.7% American Indian/Alaska Native, 0.2 % Other, 2.0% Two or More Races
Median Income: $51,126
Uninsured: 11.4%
Unemployment: 8.8%
No HS Diploma: 27.9%
CNI Score: 4.6
Medicaid Population*: 35.4%
Other Area Hospitals: 8
Medically Underserved Areas or Populations: Yes

*Does not include individuals dually-eligible for Medicaid and Medicare.

Community Needs Index (CNI) Map



Mean(zipcode): 4.4 / Mean(person): 4.3 CNI Score Median: 4.6 CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
93241	5	17837	Lamont	Kern	California
93263	4.6	20965	Shafter	Kern	California
93268	4.8	19143	Taft	Kern	California
93301	5	12649	Bakersfield	Kern	California
93304	5	49870	Bakersfield	Kern	California
93305	5	37773	Bakersfield	Kern	California
93306	4.6	67944	Bakersfield	Kern	California
93307	5	89240	Bakersfield	Kern	California
93308	4.2	54377	Bakersfield	Kern	California
93309	4.4	58201	Bakersfield	Kern	California
93311	3.4	45539	Bakersfield	Kern	California
93312	2.4	61315	Bakersfield	Kern	California
93313	4.2	48297	Bakersfield	Kern	California

COMMUNITY BENEFIT PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the Community Benefit Committee and other stakeholders in the development and annual updating of the community benefit plan.

Community Health Needs Assessment Process

The 2012-2013 Kern County community health needs assessment process was initiated by the Kern County Community Benefit Collaborative in July 2012. The Collaborative is comprised of Delano Regional Medical Center, Dignity Health (Mercy and Memorial Hospitals), Kaiser Permanente, and San Joaquin Community Hospital.

The Kern County Community Benefit Collaborative along with its Steering Committee guided the study. The Steering Committee met numerous times over the course of the process to provide guidance on the components of the Kern County community health needs assessment. The collaborative met with community and hospital/health leaders in November 2012 to review and prioritize the community needs.

In an effort to examine the health related needs of the residents of Kern County, the Steering Committee and consulting team employed both qualitative and quantitative data collection and analysis methods. The report development was completed in March 2013.

The Steering Committee members and consulting team made significant efforts to ensure that all areas of the county, all socio-demographic groups and all underrepresented populations were included in the study. This objective was addressed by conducting two surveys and identifying key stakeholders that represented various subgroups within the community. In depth interviews were conducted with these stakeholders to identify needs and priorities. In addition, the process included public health participation and input, both through extensive use of California Department of Public Health data, as well as through the participation of the local department of health representatives in the prioritization process.

The quantitative secondary data collection process included a comprehensive collection and review of health and quality of life data, collected and analyzed through the use of the Health Communities Network system, a web-based community health data platform developed by the Healthy Communities Institute. The system is hosted on the Healthy Kern website at HealthyKern.org.

The qualitative primary data collection process included a Needs Assessment Survey with a total of 970 participants. The survey was conducted by consulting team Strategy Solutions. A total of 27 individual interviews were conducted with key stakeholders in the community to gather a personal perspective from those who have insight into the health of a community or the region. The interviews were designed to gain insights from diverse community groups and underrepresented populations.

The Community Assets section in the CHNA lists existing health care facilities and resources within the community that are available to respond to the health needs of the community. The complete CHNA report can be found at www.HealthyKern.org and on the Memorial Hospital website at http://www.dignityhealth.org/bakersfieldmemorial.

CHNA Significant Health Needs

With support from the Healthy Communities Institute and Strategy Solutions, members of the Community Benefit Collaborative undertook a structured approach to review public health data and conduct interviews of city and county residents and public health officials. This assessment resulted in a list of 40 health needs which were discussed at a community prioritization meeting.

Community Benefit Collaborative members came to agreement on a set of criteria to evaluate the 40 health needs identified through the assessment process. In order to determine community needs, each of the 140+ indicators on HealthyKern.org were analyzed on the following criteria: (1) How does Kern County perform compared to other counties in the state or nation? (2) Does Kern County meet national Healthy People 2020 goals? (3) Was there an apparent "health disparity"? and (4) Does historic data show that Kern County is trending in a negative direction?

The prioritization process identified 10 priority issues for the community:

1. Heart Disease and Stroke
2. Cancer
3. Diabetes
4. Preventative Screenings
5. Cancer Screenings
6. Access to Health Care
7. Low Birth Weight/Infant Mortality
8. Asthma
9. Women's Health Screenings
10. Sexually Transmitted Diseases (STDs)

Memorial Hospital is addressing all of these needs with one or more community benefit programs, with the exception of low birth weight and infant mortality. This issue is addressed in the community by entities and organizations other than our three hospitals.

Community Benefit Plan Development Process

As a matter of Dignity Health policy, the hospital's community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- **Disproportionate Unmet Health-Related Needs**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance**: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Memorial Hospital's Community Benefit Plan and Implementation Strategy was developed based on the findings and priorities established by the 2012-2013 Kern County Community Health Needs Assessment and review of the hospital's existing community benefit activities.

Each year Department employees present progress reports to the Community Benefit Committee. The Committee concentrated on program expansions and service quality. The Committee, as well as management and executive employees of each hospital, provide input and, as a result, make adjustments to programs, services, and the Community Benefit Plan. The Plan is then submitted to the board for final

approval. Each initiative in the Community Benefit Plan for Memorial Hospital relates directly to one or more needs identified in the Community Assessment.

Other stakeholders involved in the selection of priority areas of focus are those organizations with which our hospitals co-sponsor community benefit programs and outreach activities. Some include the Kern County Public Health Services Department, Greater Bakersfield Legal Assistance, Clinica Sierra Vista, United Way of Kern County, Community Action Partnership of Kern, Kern Family Health Care, Kern County Department of Human Services, Omni Health Services, Kern County Network for Children, First 5 Kern, and St. Vincent de Paul.

Planning for the Uninsured/Underinsured Patient Population

In keeping with its mission, the hospital offers patient financial assistance (also called charity care) to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay. The hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. The amount of financial assistance provided in FY15 is listed in the Economic Value of Community Benefit section of this report on page 29.

Brochures announcing financial assistance are located in each Emergency Department, patient registration area and various locations throughout each facility for patient and family review. Every patient is given a financial assistance brochure upon admission. If admitted in an emergent manner, the patient information binder contains the financial assistance information. Each facility also has financial counselors on site to assist patients and their families upon discharge with bill resolution and applications for government sponsored insurance services.

Individuals with financial capacity to purchase health insurance are encouraged to do so as a means of assuring access to health care services. Additionally, through grants from First 5 Kern, Kern County Public Health Services Department and The California Endowment, Mercy and Memorial Hospitals coordinate the County's Community Health Initiative. It uses monthly meetings, outreach, a strong network of partner agencies, and other methods to enroll and renew adults and children in health insurance through the Affordable Care Act. They minimize or eliminate barriers to enrollment. The Community Health Initiative of Kern County conducts outreach to inform and enroll hard to reach individuals into health insurance, and to build awareness and support in the community at large. The Community Health Initiative also works to develop new ways that residents might access health care outside of an insurance program so that all Kern County residents might have a medical home.

2015 REPORT AND 2016 PLAN

This section presents programs and initiatives the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It includes both a report on activities for FY15 and planned programs with measurable objectives for FY16.

SUMMARY

Below are the major initiatives and key community-based programs of Memorial Hospital. These programs were developed in response to the 2012-2013 Kern County Community Health Needs Assessment and are guided by the following five core principles:

- Focus on Populations with Disproportionate Unmet Health-Related Needs
  Seeking to accommodate the needs of communities with disproportionate unmet health-related needs.
- Emphasize Primary Prevention
  Addressing the underlying causes of persistent health problems.
- Build a Seamless Continuum of Care
  Emphasizing evidence-based approaches by establishing a link between clinical services and community health improvement services.
- Increase Community Capacity
  Targeting charitable resources to mobilize and build the capacity of existing community assets.
- Strengthen Collaborative Governance
  Engaging diverse community stakeholders in the selection, design, implementation, and evaluation of program activities

Major Initiatives

Asthma Management – provides Kern County families with a new level of asthma education and management using state of the art technology.

Chronic Disease Self-Management Program/Diabetes Self-Management Program – provides patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health.

Community Health Initiative of Kern County (CHI) – increases access to health insurance and health care for hard to reach individuals in Kern County.

Community Wellness Program - provides personalized in-home health education and monitoring, community health screening clinics, health education classes, and referrals to other local health care and social service resources.

Homemaker Care Program - provides homemaker services to frail elderly and disabled adults by helping them live independently for as long as possible. This program also provides job training to unemployed/hard to employ individuals by helping them learn marketable skills and transition into the work force.

Memorial Hospital is a key player when it comes to building a healthier Kern County. This is demonstrated by several on-going programs including:

Breast Health Program - provides qualifying individuals who are poor and uninsured with a mammogram free of charge for preventive health care and when necessary, a breast ultrasound or a breast needle biopsy.

Prescription Program - purchases necessary medications in emergency situations for people who must have the medicines for their health but have no money to buy them.

The hospital evaluated all current Community Benefit programs and their relation to the selected primary health needs. In many instances the structure was in place for existing programs to address the selected primary health needs. Where there was a deficiency, new programs or practices were developed. This process resulted in the development of the implementation plan described below. New programs that the hospital plans to deliver in 2016 are denoted by *. Other programs and non-quantifiable benefits can be found in Appendix B.

Access to Health Care

- Breast Health Program
- Charity Care for uninsured/underinsured and low income residents
- Community Health Initiative
- Enrollment Assistance/Government Programs
- Flu Clinics
- Guidance and Referrals to Community Services
- Health Fairs
- Homemaker Care Program - In-Home Care
- Prescription Purchases for Indigents

Preventive Screenings

- Health Screenings

Heart Disease and Stroke

- Health Education Seminars and Classes
- Chronic Disease Self-Management Program

Diabetes

- Healthy Kids in Healthy Homes
- In-Home Health Education
- Diabetes Self-Management Program

Asthma*

- Asthma Program

Anticipated Impact

The anticipated impact of specific program initiatives, including goals and objectives, are stated in the Program Digests on pages 16 to 29. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create

conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Community Benefit Committee, hospital executive leadership, Community Board, Dignity Health System Office and department employees receive and review program updates. In addition, the hospital evaluates impact and sets priorities for its community benefit program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

The hospital works with over 100 local community organizations to achieve its goals, including community health centers, public health services, social services, school districts, and other private and public stakeholders.

This community benefit plan specifies significant community health needs that the hospital plans to address in whole or in part, in ways consistent with its mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in other community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

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.

PROGRAM DIGESTS

Community Wellness Program	
Significant Health Needs Addressed	☒ Preventive Screenings ☒ Diabetes ☒ Asthma ☒ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Program Description	The Community Wellness Program is focused on preventive health care by providing on-site screenings and health and wellness education classes on relevant topics for residents throughout Kern County.
Planned Collaboration	Our programs work with dozens of local community organizations to achieve its goals, including community health centers, public health, social services, school districts, and other private and public stakeholders.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops A1-c Community Health Education - Individual health ed. for uninsured/under insured A2-d Community Based Clinical Services - Immunizations/Screenings
FY 2015 Report	
Program Goal / Anticipated Impact	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2015 were: • Provide 33,000 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. • Provide 12,000 clients with health education through in-home visits and classes/seminars including Empowerment-Chronic Disease and Diabetes. • Achieve an average evaluation score of 4 or higher from attendees at Community Health Education Classes. • Add one monthly Community Screening Clinic in a new rural county location. Enhancement strategies were: • Provide mini-education sessions to encourage participation of screening clients in Community Health Education Classes and Empowerment Seminars.
Baseline / Needs Summary	According to HealthyKern.org: • 30.8% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2011-2012). • The age-adjusted diabetes death rate in Kern County for the 2010 to 2012 measurement period is 33 per 100,000 compared to the State value of 20.6per 100,000. • The age-adjusted diabetes hospitalization rate in Kern County for the 2011 to 2013 measurement period is 25.1 per 100,000 population.
Intervention Actions for Achieving Goal	Intervention actions were: • Enhance our work with Mercy & Memorial Hospital's Case Management Department and other health care entities to implement a model continuum of care. • Improve tracking mechanisms that will enhance monitoring, follow-up, and retention of Community Clinic participants. • Demonstrate the impact on hospital utilization patterns by expanding the environment of seamless continuum of care between the hospital, the provider and the Community Wellness Program.

Program Performance / Outcome	During FY 15, the Community Wellness Program accomplished the following: • Provided 31,130 health screenings. (Goal: provide 33,000 screenings) • Provided 13,385 clients with health education. (Goal: Educate 12,000 clients) • Achieved an average evaluation score of 4.75 from attendees at Community Health Education Classes. (Goal: Score 4 or higher) • Added one monthly Community Screening Clinic in Tehachapi. (Goal: Add one new clinic in a rural county location) Enhancement strategies completed: • Provided multiple team approaches in providing mini-education sessions with screening clients, followed by scheduled Health Education Classes and Empowerment Seminars in nearby locations.
Hospital's Contribution / Program Expense	The total FY 2015 expense for the Community Wellness Program was $783,092. Of this amount, $159,348 was grant dollars, and $623,744 was contributed by Mercy and Memorial Hospitals. Capital funding used for the Community Wellness Center renovations was $115,942. All of the capital amounts were paid through grants and donations. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program and program's clinic van, bookkeeping, and human resource support for the program.
FY 2016 Plan	
Program Goal / Anticipated Impact	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2016 are: • Provide 32,000 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. • Provide 11,000 clients with health education through in-home visits and classes/seminars including Empowerment-Chronic Disease and Diabetes. • Provide 150 Community Health Education classes across the county. • Add one monthly Community Screening Clinic in a new rural county location. • Add 5 new locations for Community Health Education classes. • Provide 10 cooking classes through the Kitchen Classroom. Enhancement strategies are: • Promote kitchen classroom through collaborative meetings, Community Wellness Programs, and other events. • Meet with head of Bakersfield College Culinary Arts program to establish instructor recruitment.
Baseline / Needs Summary	According to HealthyKern.org: • 30.8% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2011-2012). • The age-adjusted diabetes death rate in Kern County for the 2010 to 2012 measurement period is 33 per 100,000 compared to the State value of 20.6per 100,000. • The age-adjusted diabetes hospitalization rate in Kern County for the 2011 to 2013 measurement period is 25.1 per 100,000 population.
Intervention Actions for Achieving Goal	Intervention actions are: • Improve collection of health screening data by utilizing technology that will be available on-site at health screening clinics. • Develop methods to track utilization by clients across all Community Wellness programs that will track outcomes.

Chronic Disease Self-Management Programs	
Significant Health Needs Addressed	☒ Preventive Screenings ☒ Diabetes ☒ Asthma ☒ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Program Description	Our comprehensive Chronic Disease Self-Management Programs (Empowerment-Chronic Disease and Empowerment-Diabetes) are designed to provide patients who have diabetes and other chronic illnesses with the knowledge, tools and motivation needed to become proactive in their health. Each program seminar consists of six (6) weekly classes covering a variety of topics including nutrition, exercise, use of medications, communication with doctors, stress management, and evaluating new treatments.
Planned Collaboration	Our program works with over a dozen local community organizations to achieve its goals, including community health centers and other private and public stakeholders.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops
FY 2015 Report	
Program Goal / Anticipated Impact	By offering evidence-based chronic disease self-management (CDSM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).
Measurable Objective(s) with Indicator(s)	The objectives for FY 2015 were: • Provide 20 Empowerment-Chronic Disease and Empowerment-Diabetes seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above to ensure that underserved persons throughout the county will have access to the Seminars. • 85% of all participants with chronic diseases who complete Empowerment-Chronic Disease and Empowerment-Diabetes seminars will remain healthier after their seminars, as measured by those who avoid admissions to the hospital or emergency department for the six months following their participation in the program. • Establish a regular system referring hospital-discharged patients to Empowerment seminars. Enhancement strategies were: • Expand access to Empowerment-Chronic Disease and Empowerment-Diabetes self-management education to residents of two new Kern County communities with a Community Need Index (CNI) score of 3 or above or to new high-risk communities. • Test the use of a Session Zero before Empowerment Seminars to determine impact on retention of participants.
Baseline / Needs Summary	According to HealthyKern.org: • The age-adjusted diabetes death rate in Kern County for the 2010 to 2012 measurement period is 33 per 100,000 compared to the State value of 20.6 per 100,000. Kern has the second highest diabetes death rate in the State. • The age-adjusted diabetes hospitalization rate in Kern County for the 2011 to 2013 measurement period is 25.1 per 100,000 population. • 33.2% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2011-2012). • Kern County has the highest death rate in the State due to Coronary Heart Disease.

Intervention Actions for Achieving Goal	Intervention actions were: • Engage clinical health professionals to guide program improvement. • Focus on the uninsured and populations covered by Medicaid, Medicare/Medicaid. • Expand awareness and access of Empowerment-Chronic Disease and Empowerment-Diabetes Self-Management Programs by increasing partnership with community organizations serving residents with chronic conditions, i.e., Arthritis Foundation, MS Society, etc. • Encourage and support continuing education for staff development to ensure quality service is offered by the Empowerment Self-Management Programs.
Program Performance / Outcome	During FY 2015, Empowerment accomplished the following: • Completed 27 Empowerment-Chronic Disease and Empowerment-Diabetes Seminars in Kern County (Goal 20 seminars). A total of 11 seminars were for Diabetes Self-Management, and 16 seminars were for Chronic Disease Self-Management. • 98.9% of participants with chronic diseases who completed the Empowerment-Chronic Disease and Empowerment-Diabetes seminars avoided admissions to the hospital or emergency department for the three months following their participation in the program. (Goal 85%) • 197 participants completed Empowerment-Chronic Disease and Empowerment-Diabetes seminars. • Referrals are received from hospital Care Managers for hospitalized patients who can benefit from Empowerment Seminars. Enhancement strategies completed: • Expanded access with Empowerment-Chronic Disease and Empowerment-Diabetes self-management seminars provided in Wasco, and four new locations in Bakersfield with a Community Needs Index (CNI) score of 3 or above, including Central Church and Bessie Owens Elementary School. • Session Zero was tested on three Diabetes Self-Management Seminars and two Chronic Disease Self-Management Seminars. There was no difference seen in retention by using Session Zero in any of the seminars. However, it did save time during Session One. It also signals the leaders when a seminar needs to be split because of a large turnout.
Hospital's Contribution / Program Expense	Expenses in FY 2015 have been $71,931. Mercy and Memorial Hospitals contributed 100% of the funding to the Chronic Disease Self-Management Programs' annual budget. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance, bookkeeping, and human resource support for the program.
FY 2016 Plan	
Program Goal / Anticipated Impact	By offering evidence-based chronic disease self-management (CDSM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).

Measurable Objective(s) with Indicator(s)	The objectives for FY 2016 are: • Provide 20 Empowerment-Chronic Disease and Empowerment-Diabetes seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above to ensure that underserved persons throughout the county will have access to the Seminars. • 85% of all participants with chronic diseases who complete Empowerment-Chronic Disease and Empowerment-Diabetes seminars will remain healthier after their seminars, as measured by those who avoid admissions to the hospital or emergency department for the three months following their participation in the program. • Provide 2 new locations in Kern County for Empowerment-Chronic Disease and Empowerment- Diabetes Seminars in order to expand our services. Enhancement strategies are: • Create a method to monitor each certified Empowerment leader at least annually to ensure that Stanford Leader Standards are being faithfully followed by all leaders. We expect this program fidelity practice to provide support in adhering to the strict Stanford method of leading among our lay leaders. • Train 10 new leaders for Empowerment-Chronic Disease in English to ensure that an adequate number of seminars will be available for the community.
Baseline / Needs Summary	According to HealthyKern.org: • 30.8% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2011-2012). • The age-adjusted diabetes death rate in Kern County for the 2010 to 2012 measurement period is 33 per 100,000 compared to the State value of 20.6per 100,000. • The age-adjusted diabetes hospitalization rate in Kern County for the 2011 to 2013 measurement period is 25.1 per 100,000 population.
Intervention Actions for Achieving Goal	Intervention actions are: • Engage clinical health professionals to guide program improvement. • Focus on the uninsured and populations covered by Medicaid, Medicare/Medicaid. • Encourage and support continuing education for leader development to ensure quality service is provided by the Empowerment Self-Management Programs.

Asthma Management	
Significant Health Needs Addressed	☐ Preventive Screenings ☐ Diabetes ☒ Asthma ☐ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Program Description	The Asthma Management project's goal is to bring a new level of asthma education and management to Kern County families, and to reduce repeated hospitalizations due to uncontrolled asthma. Certified Asthma Educators provide education to individuals and small groups throughout our county. Education is supported by state of the art technology that monitors a client's usage of both rescue and controller medications. This technology also notifies our educators when direct intervention is needed to help a client avoid an asthma crisis.
Planned Collaboration	Our program partners with Kern Health Systems, the American Lung Association and several local community organizations to achieve its goals.
Community Benefit Category	A1 – Community Health Education
FY 2015 Report	
Program Goal / Anticipated Impact	An Asthma Management pilot project will be established as a part of the Community Wellness Program, and 20 clients will be monitored and supported for the one-year project period.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2015 were: • Three employees of the Community Wellness Program (CWP) will become Certified Asthma Educators. • 20 clients will be enrolled into the pilot project. • Protocols for monitoring and intervention will be established. Enhancement strategies were: • Partner with community organizations to identify potential clients for pilot project. • Outcomes will be carefully monitored and compared with other Propeller Health client companies and Dignity Health hospitals that have used the technology.
Baseline / Needs Summary	According to the California Department of Public Health, 111,000 children and adults in Kern County (13.9% of the population) have been diagnosed with asthma in their lifetime, and 9.2% currently have active asthma. Asthma diagnoses, deaths, Emergency Department visits and hospitalizations occur at a higher rate in Kern than in California as a whole. Asthma is considered to be a manageable condition with appropriate medical intervention and consistent use of medication. Unfortunately, one-third of diagnosed Kern residents (32.3%) have not received a written self-management plan from a health care provider. (Source: 2009 California Health Interview Survey) According to HealthyKern.org the adult asthma age-adjusted hospitalization rate in Kern County for the 2011 to 2013 measurement period is 49.1 per 10,000 population.
Intervention Actions for Achieving Goal	Intervention actions were: • An agreement will be made with Propeller Health to utilize their proprietary technology monitoring system. • Communication will be established between CWP employees and appropriate hospital personnel to identify patients who are candidates for the pilot project.

Program Performance / Outcome	• Our employees are unable to become Certified Asthma Educators at this point. This certification requires a minimum of 1,000 hours of providing or receiving asthma education. Program staff is compiling information about their qualifying hours. • An agreement with Propeller Health was signed in March 2015. • Clients will be enrolled through a partnership with Kern Health Systems. Discussions are underway to implement the pilot project. • Protocols have not yet been started.
Hospital's Contribution / Program Expense	No expense was incurred during FY 2015.
FY 2016 Plan	
Program Goal / Anticipated Impact	An Asthma Management pilot project will be established as a part of the Community Wellness Program, and 20 clients will be monitored and supported for the one-year project period.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2016 are: • A structured plan will be in place for three Community Wellness Program employees to achieve the 1,000 hours needed to become Certified Asthma Educators. • 20 clients will be enrolled into the pilot project. • Protocols for monitoring and intervention will be established. Enhancement strategies are: • Work with Kern Health Systems to identify potential clients for pilot project. • Outcomes will be carefully monitored and compared with other Propeller Health client companies and Dignity Health hospitals that have used the technology.
Baseline / Needs Summary	According to the California Department of Public Health, 111,000 children and adults in Kern County (13.9% of the population) have been diagnosed with asthma in their lifetime, and 9.2% currently have active asthma. Asthma diagnoses, deaths, Emergency Department visits and hospitalizations occur at a higher rate in Kern than in California as a whole. Asthma is considered to be a manageable condition with appropriate medical intervention and consistent use of medication. Unfortunately, one-third of diagnosed Kern residents (32.3%) have not received a written self-management plan from a health care provider. (Source: 2009 California Health Interview Survey) According to HealthyKern.org the adult asthma age-adjusted hospitalization rate in Kern County for the 2011 to 2013 measurement period is 49.1 per 10,000 population.
Intervention Actions for Achieving Goal	Intervention actions are: • Community Wellness personnel will work together with Kern Health Systems' employees on technology training and monitoring protocols. • Communication will be established between CWP employees and appropriate KHS providers and personnel to identify patients who are candidates for the pilot project.

Community Health Initiative	
Significant Health Needs Addressed	☐ Preventive Screenings ☐ Diabetes ☐ Asthma ☐ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Program Description	The Community Health Initiative (CHI) of Kern County is a grant-funded project which works with more than 50 public, private and non-profit organizations to enroll children and adults into health insurance programs and educate them on how to utilize insurance. The CHI endeavors to provide access to health care for Kern County residents for whom no insurance program is available. The county-wide effort is further enhanced by providing training to Certified Enrollment Counselors (CECs) and by working with local and state stakeholders to streamline the sometimes-burdensome process of navigating the public health system.
Planned Collaboration	Our program works with dozens of local organizations to reach the different populations residing in Kern County. Partners include: community health centers, public health, social services, school districts, community-based organizations and other private and public stakeholders.
Community Benefit Category	A3-d Health Care Support Services - Enrollment Assistance
FY 2015 Report	
Program Goal / Anticipated Impact	With a coalition of Kern County organizations, educate and enroll uninsured adults and children into a health insurance plan through an innovative new plan.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2015 were: • Enroll 5,000 individuals in health insurance through Medi-Cal and Covered California. 2,000 enrollments will be made by Dignity Health employees, and 3,000 will be verified as enrolled or renewed by partner agencies. • Provide enrollment assistance in five new locations throughout the county, and eight locations previously supported. • Provide Outreach and Enrollment support at six events sponsored by Dignity Health Marketing. • Develop utilization strategies and education methods that result in 20% of assisted clients scheduling their first doctor appointment within six months of enrollment. • 100% of clients who receive enrollment assistance by CHI employees will be offered annual renewal assistance. Enhancement strategies were: • Expand the county's network of partner agencies providing enrollment services. • Provide ongoing training and support for the new enrollment practices of Covered California.
Baseline / Needs Summary	The California Health Interview Survey (CHIS) describes Kern County with a high percentage of children enrolled in health insurance. The indicators for Kern County, based on 2014 data, show that 93% of children have health insurance. However, 25% of adults ages 19-64 are uninsured, according to the same survey (based on 2012 data). The Affordable Care Act (ACA) is providing new opportunities for low-income adults to have access to health insurance. The partner agencies of the Community Health Initiative are already putting the collective expertise developed over the past 10 years to good use in developing new, innovative methods to reach these adult populations.

Intervention Actions for Achieving Goal	Intervention actions were: • Continue development of continuous flow of funding for program sustainability. • Provide outreach and enrollment services to populations that have been hard-to-reach through our traditional channels. • Continue to work at local, state and federal levels to eliminate barriers and streamline application processes.
Program Performance / Outcome	During FY 15, the Community Health Initiative accomplished the following: • Verified enrollment of 1,164 children and adults into health insurance programs by CHI staff. • Provided enrollment assistance in 25 new locations throughout the county and 42 locations previously supported. • Provided Outreach and Enrollment support at 48 events in collaboration with Dignity Health Marketing. • The "My Path to Good Health" Booklet was created as an education tool for Certified Enrollment Counselors and a resource for clients who were provided application assistance. Confirming the scheduling of clients' first doctor appointment within six months of enrollment did not begin this year. • 100% of clients who received enrollment assistance by CHI employees were offered renewal assistance. Enhancement strategies completed: • One additional agency became a Certified Enrollment Entity associated with the Community Health Initiative. • Conducted 11 partner trainings, with 398 partner agency personnel trained, on the new enrollment practices of Covered California.
Hospital's Contribution / Program Expense	The total FY 2015 expense for the Community Health Initiative was $683,700. The full $683,700 was secured though grant dollars. Hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program, bookkeeping, and human resource support for the program.
FY 2016 Plan	
Program Goal / Anticipated Impact	With a coalition of Kern County organizations, educate and enroll uninsured adults and children into a health insurance plan through innovative approaches.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2016 are: • Enroll or renew 2,500 individuals in health insurance through Medi-Cal and Covered California. 1,000 enrollments/renewals will be made by CHI employees, and 1,500 will be verified as enrolled or renewed by partner agencies. • Provide enrollment assistance in five new locations throughout the county, and 15 locations previously supported. • Provide Outreach and Enrollment support at 10 events in collaboration with Dignity Health Marketing. • Develop utilization strategies and education methods that result in 50% of assisted clients selecting a primary care provider and 20% scheduling their first doctor appointment within six months of enrollment. • 100% of clients who receive enrollment assistance by CHI employees will be offered annual renewal assistance. Enhancement strategies are: • Incorporate Promotoras in outreach, enrollment and utilization efforts to reach the Latino community. • Expand the county's network of partner agencies providing enrollment services. • Provide ongoing training and support on outreach, retention, enrollment and utilization practices.

Baseline / Needs Summary	The California Health Interview Survey (CHIS) describes Kern County with a high percentage of children enrolled in health insurance. The indicators for Kern County, based on 2014 data, show that 93% of children have health insurance. However, 25% of adults ages 19-64 are uninsured, according to the same survey (based on 2012 data). The Affordable Care Act (ACA) is providing new opportunities for low-income adults to have access to health insurance. The partner agencies of the Community Health Initiative are already putting the collective expertise developed over the past 10 years to good use in developing new, innovative methods to reach these adult populations.
Intervention Actions for Achieving Goal	Intervention actions are: • Continue development of continuous flow of funding for program sustainability. • Provide outreach and enrollment services to populations that have been hard-to-reach through our traditional channels. • Continue to work at local, state and federal levels to eliminate barriers and streamline application processes.

Homemaker Care Program	
Significant Needs Addressed	☒ Preventive Screenings ☒ Diabetes ☐ Asthma ☒ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Program Description	• TRAINING: The Homemaker Care Program provides a two-week comprehensive employment readiness skills training focusing on individuals transitioning from unemployment into the workforce. Participants are trained in many senior-related subjects in preparation of providing competent and reliable in-home supportive services to the ever growing senior population. We additionally provide soft-skills training in preparation for any other available work opportunities and collaboration with other entities to assist in their job searches. • SENIOR CARE: The Homemaker Care Program provides in-home supportive services to seniors, as well as adults with disabilities (both referred to as "clients"). Case management is conducted by an initial assessment, then with on-going, regular wellness checks and documented home visits by Homemaker Care Attendants. The mission is to provide low-income and needy clients that are at risk of losing their independence of living at home, with assistance in safety, nutrition, environmental cleanliness, and personal hygiene.
Planned Collaboration	Collaboration with many community-based organizations is essential to our ultimate success. Among the major collaborators, are: America's Job Center, Department of Human Services, Community Wellness Program, Mercy Hospital's Education Department, Garden Pathways, Kern Senior Network, UC Cal Fresh, Partners in Care Foundation, Dress for Success Bakersfield and BARC.
Community Benefit Category	E3-d In-kind Assistance - Basic services for individuals F5-c Leadership Dev/Training for Community Members - Career development
FY 2015 Report	
Program Goal / Anticipated Impact	• The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce. • The Homemaker Care Program will provide in-home support services to low-income seniors and disabled adults allowing them to remain in their homes.

Measurable Objective(s) with Indicator(s)	The objectives for FY 2015 were: • Achieve an overall grade among program graduates of 90% or more on total competency exam scores • Verify that 65% of program graduates apply for three jobs within one month following completion of training • Provide 14,000 hours of in-home supportive services to senior and disabled clients • Increase full pay hours to 45% of total hours served Enhancement strategies: • Establish agreements with America's Job Center and Dress for Success to assist training graduates with career coaching, resume building and interview skills • Ensure sustainability of the program through advertising and by researching grant funding that will support senior services and the training program and by marketing to full pay clients
Baseline / Needs Summary	According to HealthyKern.org: • In 2013, Kern County's Annual unemployment rate was 10.4% compared to 9.1% in the state. One effect of high unemployment is that the labor force is not able to supply appropriate skills to employers. • In 2012, Kern County's high school dropout rate was 5.1%. Students who do not finish high school are more likely to lack the basic skills required to function in an increasingly complicated job market and society. • In 2012, 10.4% of Kern County seniors 65 years or older were living in poverty compared to 10% in the state. A senior who lives in poverty faces a higher risk of losing his or her ability to live independently due to physical limitations, medical needs, and reliance on low fixed income.
Intervention Actions for Achieving Goal	Intervention actions were: • Provide opportunities for trainees to conduct on-line applications utilizing the resources at the Community Wellness Center • Track employment rate and retention • Enhance marketing tools for both the training program and in-home supportive services • Conduct continuous recruitment of qualified in-home care attendants to hire into the program • Conduct monthly meetings with In-Home Care Attendants to discuss providing safety and quality service to each client

Program Performance / Outcome	During FY 2015, the Homemaker Care Program accomplished the following: TRAINING: • Achieved an overall grade of 90% or more on total competency exam scores (Goal: Score of 90% or more) • Verified that 72% of 50 graduates applied for a minimum of three jobs post completion (Goal: 65% or more). SENIOR CARE: • Provided 15,828 hours of in-home supportive services to at-risk seniors and disabled adults (Goal: Provide 14,000 hours) • Increased full pay hours to 59% of total hours served (Goal: Increase full pay hours to 45%) Enhancement Strategies: • Established agreements with America's Job Center and Dress for Success to assist training graduates with career coaching, resume building and interview skills • Through FY 2015 we continued to research grant funding opportunities and market to full pay clients.
Hospital's Contribution / Program Expense	During FY 2015, expenses for the Homemaker Care Program were $296,222. Of this amount, $60,088 was grant dollars, $183,752 was fee for service, and $52,382 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, human resource support, office space, fundraising support, bookkeeping, strategic planning, and evaluation support for the program.
FY 2016 Plan	
Program Goal / Anticipated Impact	• The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce. • The Homemaker Care Program will provide in-home support services to low-income seniors and disabled adults allowing them to remain in their homes.
2016 Objectives Measure/Indicator of success	The objectives for FY 2016 are: TRAINING: • Conduct four 2-week training sessions • Graduate a total of 40 participants with an overall grade of at least 80% • Ensure 100% of the graduates meet their primary objective for participating in this training within 3 months of completion SENIOR CARE: • Conduct 17,410 hours of in-home supportive services • Increase private pay revenues to $205,300 • Provide in-home supportive services to a monthly average of 67 households

Baseline / Needs Summary	TRAINING: • The unemployment rate for Bakersfield was 10% in May 2015, compared to the national average of 5.7% (Bureau of Labor Statistics, U.S. Department of Labor). • The MDRC (formerly stood for and known as "Manpower Demonstration Research Corporation") suggests the rates are more than double that for "individuals with criminal records, workers without postsecondary education, and other groups that have difficulty finding jobs even when economic conditions are good." SENIOR CARE: • The 2013 U.S. Census Bureau estimated that in 2010, 8.4% of Bakersfield's population was aged 65 years or older. Based on 2014 data of total population, the extrapolated senior population is 31,000. • Between 2009 and 2013, 20.4% of the total population of Bakersfield was below the poverty level (U.S. Census Bureau, 2013). • The Administration on Aging (US Dept. of Health and Human Services) estimates that the senior population (age 65 and older) will grow by over 26% between the years 2013 and 2020. • The Administration on Aging estimates that over 70% of seniors will need some form of long-term care during their lives (Genworth Cost of Care Study 2013). The Administration on Aging estimates the current (2013) average annual costs of Homemaker Services in California to be between $46,412 and $56,056 (Genworth Cost of Care Study 2013).
Intervention Actions for Achieving Goal	Intervention Actions are: TRAINING: • Collaborate with other organizations, both public and private, to identify candidates for our Homemaker Care Program training, and to assist in providing quality presentations and training relating to senior care. • Provide on-going assistance to graduates by providing on-line resources at the Community Wellness Center. • Track success of the graduates achieving their primary goal for taking the training course. SENIOR CARE: • Transition to a quality scheduling software allowing much greater flexibility, delivery of a higher quality service and a much more efficient system. • Collaborate with other senior-related and healthcare related companies, organizations and public agencies to make them aware of our low-cost and subsidized services.

ECONOMIC VALUE OF COMMUNITY BENEFIT

324 Bakersfield Memorial Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2014 through 6/30/2015

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Living in Poverty						
Financial Assistance	**10,847**	**3,522,329**	**0**	**3,522,329**	**0.9**	**0.8**
Medicaid	**65,257**	**168,390,552**	**165,818,043**	**2,572,509**	**0.7**	**0.6**
Community Services						
A - Community Health Improvement Services	22,457	652,242	361,401	290,841	0.1	0.1
E - Financial and In-Kind Contributions	22,891	2,148,903	92,485	2,056,418	0.5	0.5
F - Community Building Activities	3,295	73,596	39,103	34,493	0.0	0.0
G - Community Benefit Operations	0	475,972	71,718	404,254	0.1	0.1
Totals for Community Services	**48,643**	**3,350,713**	**564,707**	**2,786,006**	**0.7**	**0.6**
Totals for Living in Poverty	**124,747**	**175,263,594**	**166,382,750**	**8,880,844**	**2.3**	**2.0**
Benefits for Broader Community						
Community Services						
A - Community Health Improvement Services	12,177	90,926	8,475	82,451	0.0	0.0
E - Financial and In-Kind Contributions	227	78,700	0	78,700	0.0	0.0
F - Community Building Activities	0	2,322	0	2,322	0.0	0.0
G - Community Benefit Operations	0	2,135	0	2,135	0.0	0.0
Totals for Community Services	**12,404**	**174,083**	**8,475**	**165,608**	**0.0**	**0.0**
Totals for Broader Community	**12,404**	**174,083**	**8,475**	**165,608**	**0.0**	**0.0**
Totals - Community Benefit	**137,151**	**175,437,677**	**166,391,225**	**9,046,452**	**2.4**	**2.0**
Medicare	**18,315**	**84,086,084**	**74,417,059**	**9,669,025**	**2.5**	**2.2**
Totals with Medicare	**155,466**	**259,523,761**	**240,808,284**	**18,715,477**	**4.9**	**4.2**

The method for calculating costs is cost accounting methodology.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

Bakersfield Memorial Hospital
Board of Directors
2015

1. Robert Noriega, *Chair*

2. Stephen T. Clifford, *Vice Chair*

3. Brad Hannink, *Secretary/Treasurer*

4. Jon Van Boening, *BMH President and CEO*

5. John R. Findley, MD

6. Donald McMurtrey

7. Susan Helper, MD

8. Bruce Peters, President - Mercy Hospitals of Bakersfield

9. Javier Miro, MD

10. Stephen Helvie, MD

11. Sandra Serrano

12. Susie Small

Mercy and Memorial Hospitals
Department of Special Needs and Community Outreach

Community Benefit Committee
Membership

Justin Cave, Executive Director, Advanced Center for Eyecare

Morgan Clayton, President, Tel-Tec Security

Felicia Corona, Community Benefit CBISA Coordinator, Mercy & Memorial Hospitals

Tom Corson, Executive Director, Kern County Network for Children

Rita Flory, Community Benefit Coordinator, Mercy & Memorial Hospitals

Judith Harniman, Community Member

Mikie Hay, Director of Community Affairs, Jim Burke Ford

Tyler Hedden, COO, Mercy Hospitals of Bakersfield

Rosario Hernandez-Ortiz, Public Relations Coordinator, Mercy & Memorial Hospitals

Della Hodson, President, United Way Kern County

Pam Holiwell, Assistant Director, Kern County Department of Human Services

Debbie Hull, Regional Director, Special Needs and Community Outreach, Mercy & Memorial Hospitals

Louis Iturriria, Director of Marketing and Member Services, Kern Health Systems

Gloria Morales, Services Coordinator, Mercy Services Corp.

Sr. Judy Morasci, Vice President, Mission Integration, Mercy Hospitals of Bakersfield

Genie Navarro, Property Manager, Mercy Services Corp.

Eddie Paine, President, Foundation Financial, Inc.

Michelle Pearl-Krizo, Coordinator, Kern County Public Health Services Department

Norma Rojas-Mora, Executive Director, Housing Authority of the County of Kern

Sandra Serrano, Chancellor, Kern Community College District

Bhavna Sharma, Lead Coordinator, Global Family Care Network

Joan Van Alstyne, Director, Quality Management, Bakersfield Memorial Hospital

Stephanie Weber, Vice President, Philanthropy, Mercy Hospitals of Bakersfield

Jonathan Webster, Executive Director, Brotherhood Alliance

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

Community Programs

- **Art for Healing** – provides patients, families and community members an opportunity to experience the healing benefits that may come from creative expression.
- **Breakfast Club** – provides a wholesome warm dinner meal to the homeless, disadvantaged individuals and families residing in the southeast community of Bakersfield twice a week.
- **Dinner Bell Program** – provides a wholesome warm dinner meal to the homeless, disadvantaged individuals and families residing in the southeast community of Bakersfield twice a week.
- **Guidance and Referrals to Community Services** – provides individuals and families in need with referrals to community partners who provide assistance with basic needs.
- **Holiday Food Baskets** – provides a holiday food basket from St. Philips Parish to individuals and families in need.
- **Hygiene/Diaper Program** – provides personal hygiene education and personal hygiene items to residents of homeless shelters, children in schools, and community outreach centers. The diaper distribution program provides a supply of diapers to families in need of immediate assistance.
- **Emergency Food Baskets** – provides food baskets to families, seniors, and individuals at our Learning Center. Emergency food baskets are provided to families and individuals who periodically require help with meeting their nutritional needs.
- **The Homework Club and Afterschool Club** – provide an academically structured after school program for underserved students attending Kindergarten through sixth grade. The program focuses on providing a safe environment for children to work on homework and other academic skills.
- **Operation Back to School** – provides poor and underserved school-age children with the necessary clothes and school supplies to return to school in August/September.
- **Shared Christmas** – provides low-income families with Christmas presents through donations from Dignity Health staff and other community partners.

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Executive Leadership, the Community Board and the Dignity Health System Office receive updates on program performance and news.

Every year, Memorial Hospital contributes to a fund for the Dignity Health Community Grants Program. This program awards grants to nonprofit organizations in Kern County whose proposals respond to the priorities identified in the health assessment and community benefit plan for Memorial Hospital. Dignity Health grant funds are used to provide services to underserved populations. During FY 2015, the following grants were awarded to community non-profit organizations:

Advanced Center for Eyecare - $75,000
Alpha House - $50,000
American Lung Association - $37,571
Garden Pathways - $75,000
Westside Community Resource Center - $30,500

Non-Quantifiable Benefits

Working collaboratively with community partners, the hospital provides leadership and advocacy, stewardship of resources, assistance with local capacity building, and participation in community-wide health planning. Employees of the Department of Special Needs and Community Outreach participate and chair a variety of collaborative committees throughout Kern County, including the Kern County Promotoras Network, Kern Comprehensive Cancer Awareness Partnership and Kern County Community Health Needs Assessment Committee. Each quarter hospital exempt employees report the names of the community organizations, neighborhood groups, and related community health activities in which they participate. Our participation as a collaborative partner provides an opportunity to share information, resources and ideas, solve problems, identify options, and evaluate the success of our efforts. Hospital funds are important to leveraging improvements throughout our entire county. The money and effort we invest in our outreach provides the opportunity to acquire grants and donations to supplement our funding as well as develop partnerships to extend the reach of our mission.

During FY 15, the following grants were secured from other sources to support our community health programs:

Community Health Initiative

- The California Endowment (Promotoras) - $50,000
- First 5 Kern - $161,633
- Kern County Public Health-Successful Application Stipend - $96,670
- The California Endowment (Affordable Care Act) - $239,091
- Medi-Cal Administrative Activities - $47,755

Community Wellness Program

- Kaiser Permanente (Kitchen Classroom) - $10,000
- The Bakersfield Californian (Kitchen Classroom) - $50,000
- Friends of Mercy Foundation Spirit of Giving Employee Campaign - $69,000
- Kern Health Systems - $138,873
- Friends of Mercy Foundation Community Care Initiative - $100,000

Homemaker Care Program

- Jim Burke Endowment - $18,000

Also, in May 2015, the Community Health Initiative Program received a Beautiful Bakersfield Award from the Bakersfield Chamber of Commerce for the work of their Outreach, Enrollment, Retention and Utilization Committee and the significant impact they are having on the health of residents throughout Kern County. This Committee developed the “My Path to Good Health” booklet. It is a customizable toolkit that helps newly enrolled health insurance consumers know what their coverage entails and how best to utilize these benefits.

In June 2015, Mercy and Memorial Hospitals received the Achievement Citation Award from the Catholic Health Association for “Beyond the Walls,” the 45 programs and services for Kern County residents that the department offers. This is CHA’s annual award for an original, bold, innovative program that delivers measurable results for communities served. Its antipoverty programs advance population health by positively impacting social determinants of health including educational attainment, food security, economic opportunities and the fabric of neighborhoods.