

A message from

Bruce Peters, President and CEO of Mercy Hospitals, and Morgan Clayton, Chair of the Dignity Health Mercy Hospitals' Community Board.

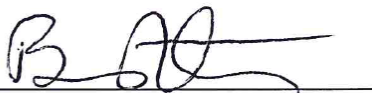
Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Mercy Hospitals shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

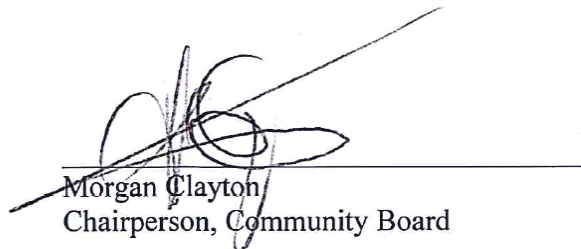
In fiscal year 2021 (FY21), Mercy Hospitals provided \$54,424,249 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred \$29,724,018 in unreimbursed costs of caring for patients covered by Medicare.

The hospitals' Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its October 27, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching to out to Donna Sharp, Regional Director for the Department of Special Needs and Community Outreach, at (661) 632-5467.



Bruce Peters
President/CEO







Morgan Clayton
Chairperson, Community Board

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At-a-Glance Summary

<p>Community Served</p> 	<p>Mercy has two hospitals, Mercy Hospital Downtown and Mercy Hospital Southwest, located in Bakersfield in Kern County. The hospitals' service area encompasses the cities of: Bakersfield, Shafter and Taft.</p>
<p>Economic Value of Community Benefit</p> 	<p>\$54,424,249 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits.</p> <p>\$29,724,018 in unreimbursed costs of caring for patients covered by Medicare.</p>
<p>Significant Community Health Needs Being Addressed</p> 	<p>The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:</p> <ul style="list-style-type: none"> • Access to health care • Alzheimer's disease • Chronic diseases • Overweight and obesity • Preventive practices • Social determinants of health/basic needs
<p>FY21 Programs and Services</p> 	<p>The hospital delivered several programs and services to help address identified significant community health needs. These included:</p> <ul style="list-style-type: none"> • Community Health Initiative - The Community Health Initiative of Kern County works with public, private and non-profit organizations to enroll individuals in health insurance programs. • Community Wellness Program - The Community Wellness Program is focused on preventive health care by providing on-site screenings as well as health and wellness education classes on relevant topics for residents throughout Kern County. • Chronic Disease Self-Management Programs - The Healthy Living Self-Management Programs (Chronic Disease and Diabetes) are designed for persons who have diabetes and other chronic illnesses, providing them with the knowledge, tools and motivation needed to become proactive in their health. • Homemaker Care Program - The Homemaker Care Program provides in-home supportive services to seniors ages 65 and older, as well as adults

with disabilities.

- Learning and Outreach Centers - The Learning and Outreach Centers provide referral services, food, clothing, shelter, education, and after school tutoring services to the most vulnerable and needy residents of the community.
- Art and Spirituality Center - The Art and Spirituality Center provides opportunities for artistic expression, meditation, relaxation, and creativity to improve quality of life and reduce stress.

FY22 Planned Programs and Services



The FY21 programs will continue with the following changes:

- Health insurance assistance will be provided telephonically and by mail until in-person services can be provided.
- The Community Wellness Program will discontinue its fitness programs and begin offering an evidence-based active living program for older adults.

This document is publicly available at <https://www.dignityhealth.org/central-california/locations/mercy-bakersfield/about-us/community-benefit-report-health-needs-assessment>. A paper copy is available for inspection upon request at the Mercy Hospital Downtown Administrative Office.

Written comments on this report can be submitted to the Special Needs and Community Outreach office at 2215 Truxtun Avenue, Bakersfield, California 93301 or by e-mail to Felicia.Boyd@DignityHealth.org.

Our Hospital and the Community Served

About Mercy Hospitals

Mercy Hospital Downtown and Mercy Hospital Southwest (Mercy Hospitals) are members of Dignity Health, which is a part of CommonSpirit Health. Mercy Hospital Downtown is located at 2215 Truxtun Avenue, Bakersfield, California 93301. Mercy Hospital Southwest is the only acute care hospital west of Highway 99 and is located at 400 Old River Road, Bakersfield, California 93311.

Mercy Hospital Downtown is an acute care hospital with 144 beds, including a 31-bed medical unit, a 31-bed surgical unit, a 31-bed telemetry unit, a 29-bed guarded care unit and a 20-bed adult ICU. The full range of medical and surgical services also includes; a 14-station, Level II Base-Station Emergency Department; six surgical suites; post anesthesia care unit; ambulatory and prep units; outpatient surgery and outpatient GI laboratory. Mercy Downtown is home to the area’s only inpatient oncology unit and the S.A. Camp Companies Robotic Surgical Center, specializing in minimally invasive surgery including robotic surgery with the da Vinci® Xi Robotic Surgery System.

Mercy Hospital Southwest has established a similar reputation for superior health care, since opening in 1992. This 78-bed facility adjacent to California State University, Bakersfield includes our respected Family Birth Center, which features an 18-bed labor delivery recovery postpartum unit (LDRP), an 11-bed postpartum unit, and a 9-bed NICU. Mercy Southwest has the first licensed OB Emergency Department in Kern County for 24/7 high-risk emergency obstetric care. In addition to exceptional maternity care, The Women’s Center at Mercy Southwest provides innovative and specialized care for women’s health issues.

The Southwest campus also includes a 43-bed Medical and Surgical Unit, a 14-bed Level II Emergency Department, an 8-bed ICU along with 10 tele beds, and 6 operating rooms, one of which is a state-of-the-art minimally invasive surgical video suite, offering patients the opportunity for surgery with less scarring and quicker recovery.

Mercy Hospitals are nationally recognized as Primary Stroke Centers and recently achieved five Centers of Excellence accreditations in Minimally Invasive, Robotic, Hernia, and Colorectal Surgeries and Minimally Invasive Gynecology. These distinctions from Surgical Review Corporation (SRC) recognize the hospital’s achievements in providing the highest quality of care as determined by an independent, external process of evaluation.



Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

Mercy Hospitals is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospitals' web site.

Description of the Community Served

Mercy Hospitals serve 12 ZIP codes representing four cities in Kern County. A summary description of the community is below. Additional details can be found in the CHNA report online.

Mercy Hospitals Service Area

Place	ZIP Code
Bakersfield	93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93314
Shafter	93263
Taft	93268

Kern County covers more than 8,100 square miles, geographically making it the third largest county in the state. The landscape is diverse, ranging from high desert to mountains to vast expanses of rich agricultural flatlands. Kern County consistently ranks among the top five most productive agricultural counties in the United States and is one of the nation's leading petroleum-producing counties. Seasonal and cyclical fluctuations in employment in the agriculture and petroleum industries drive Kern County's unemployment rate consistently well above the state average.

Total Population	599,835
Race	
White - Non-Hispanic	30.7%
Black/African American - Non-Hispanic	5.0%
Hispanic or Latino	56.1%
Asian/Pacific Islander	5.5%
All Others	2.7%
Total Hispanic & Race	100.0%
% Below Poverty	16.4%
Unemployment	9.5%
No High School Diploma	23.9%
Medicaid (households)	11.4%
Uninsured (households)	6.0%
Source: Claritas Pop-Facts® 2021; SG2 Market Demographic Module	

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

Community Assessment and Significant Needs

The hospitals engage in multiple activities to conduct its community health improvement planning process. These include, but are not limited to, conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospitals' community benefit plan and programs were identified in the most recent CHNA report, which was adopted in June 2019. The CHNA contains several key elements, including:

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

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at <https://www.dignityhealth.org/central-california/locations/mercy-bakersfield/about-us/community-benefit-report-health-needs-assessment> or upon request at the hospitals' Department of Special Needs and Community Outreach office.

Significant Health Needs

The community health needs assessment¹ identified the following significant community health needs:

- Access to health care
- Alzheimer's disease
- Birth indicators
- Chronic diseases
- Dental care
- Economic insecurity
- Environmental pollution
- Food insecurity
- Housing and homelessness
- Mental health
- Overweight and obesity
- Preventive practices
- Sexually transmitted infections
- Substance use and misuse
- Unintentional injuries
- Violence and injury prevention

¹ Additional information on these health needs and the associated data sources can be found in the Community Health Needs Assessment available at <https://www.dignityhealth.org/central-california/locations/mercy-bakersfield/about-us/community-benefit-report-health-needs-assessment>.

Significant Needs the Hospitals Do Not Intend to Address

Mercy Hospitals will not focus on the following needs identified in the CHNA: birth indicators, dental care, environmental pollution, mental health, sexually transmitted infections, substance use and misuse, unintentional injuries and violence and injury prevention. Taking existing community resources into consideration, Mercy Hospitals has selected to concentrate on those health needs that we can most effectively address given our areas of focus. The hospitals have insufficient resources to effectively address all the identified needs and in some cases, the needs are currently addressed by others in the community.

2021 Report and 2022 Plan

This section presents strategies and program activities the hospitals are delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide additional details on select programs.

This report specifies planned activities consistent with the hospitals' mission and capabilities. The hospitals may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospitals' limited resources to best serve the community.



The anticipated impacts of the hospitals' activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospitals anticipate that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospitals work to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

Mercy Hospitals are dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

The following criteria were used by the hospitals to determine the significant health needs they will address in the Implementation Strategy:

- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.

- Focus Area: Has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

The Special Needs and Community Outreach team participated in a facilitated meeting to discuss the identified health needs according to these criteria. The CHNA served as the resource document for the review of health needs as it provided statistical data on the severity of issues and also included community input on the health needs. As well, the community prioritization of the needs was taken into consideration. The Community Benefit Committee also engaged in the process to review the health needs and confirm priority health needs. As a result of the review of needs and application of the above criteria, Mercy Hospitals chose to focus on: access to care, Alzheimer’s disease, chronic diseases, overweight and obesity, preventive practices and social determinants of health/basic needs.

For each health need the hospitals plan to address, the Implementation Strategy describes: actions the hospitals intend to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospitals and other organizations. In most cases, the strategies identified to address the selected needs are based on existing programs that have evidence of success. For some strategies, Mercy Hospitals are part of a larger collaborative effort focused on addressing a countywide need.

Impact of the Coronavirus Pandemic


The impact of COVID-19 affected many of the programs provided by the Department of Special Needs and Community Outreach. The department adjusted its programs and continued to serve those who were most in need. Educational programs transitioned from in-person to online classes via Zoom, and insurance enrollment assistance was provided via telephone. Basic needs, including food insecurity, became a focus in Bakersfield and many of the outlying areas. The demand for food increased tremendously as many families found themselves without employment or with children at home all day. To meet the needs of residents in southeast Bakersfield, the Learning and Outreach Centers continued to provide its emergency food basket and hot meals programs.



Report and Plan by Health Need

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

They are organized by health need and include statements of the anticipated impact and any planned collaboration with other organizations in our community.

 Health Need: Access to Care			
Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Financial assistance	The hospitals will provide financial assistance to	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

	eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.		
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.	☒	☒
Connected Community Network (CCN)	Through the CCNI, hospital care coordination and community partner agencies will work together to identify vulnerable patients' health and health-related social needs, and electronically link health care providers to organizations that provide direct services.	☒	☒
Community Health Initiative	Increases access to health insurance and health care for hard to reach individuals in Kern County. Provides training for application assistance, and educates families on the importance of preventive care.	☒	☒
Homemaker Care Program	Provides in home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients.	☒	☒
Prescription Purchases for Indigents	Purchases necessary medications in emergency situations for people who must have the medicines for their health but have no money to buy them.	☒	☒

Impact: The initiatives addressing access to care are anticipated to result in: early identification and treatment of health issues, gains in public or private health care coverage, increased knowledge on how to access and navigate the health care system, and linkages to health care resources and social services that improve the quality of life for vulnerable clients.

Collaboration: Key partners include faith community, community clinics, and community-based organizations.



Health Need: Alzheimer's Disease

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.	☒	☒
Homemaker Care Program	Provides in home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients.	☒	☒

Impact: The initiatives addressing Alzheimer's disease are anticipated to result in: early identification of health issues related to Alzheimer's disease, education and training of caregivers to provide safe and

appropriate care for persons with Alzheimer’s disease.

Collaboration: Key partners include faith community, community clinics, community-based organizations, Alzheimer’s organizations and senior services agencies.



Health Need: Chronic Diseases

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.	☒	☒
Community Wellness Program: Chronic Disease/Diabetes Self-Management Program	Provides residents who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health through 6-week workshops.	☒	☒

Impact: The initiatives addressing chronic diseases are anticipated to result in: early identification of chronic health issues, avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (diabetes and Congestive Heart Failure).

Collaboration: Key partners include faith community, community clinics, and community-based organizations.



Health Need: Overweight and Obesity

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services which improve the health and well-being of vulnerable and underserved populations.	☒	☒
Community Wellness Program	Provides health education on nutrition, diabetes, cholesterol and hypertension.	☒	☒
Healthy Kids in Healthy Homes	The 8-session program provides information to children on the topics of nutrition, exercise, and lifestyle.	☒	☒

Impact: The initiatives addressing overweight and obesity are anticipated to result in: early identification of health issues related to obesity, increased knowledge on the factors that contribute to obesity and the health risks associated with obesity, increased knowledge on how to prevent obesity through nutrition and physical fitness and improve the length and quality of life.

Collaboration: Key partners include public health, community-based organizations, schools and

school districts.



Health Need: Preventive Practices

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.	☒	☒
Community Wellness Program	Provides community health screenings, as well as health education on a variety of prevention topics.	☒	☒
Community Health Initiative	Increases access to health insurance and health care for hard to reach individuals in Kern County. Provides training for application assistance, and educates families on the importance of preventive care.	☒	☒

Impact: The initiatives addressing preventive practices are anticipated to result in: early identification of health issues, increased knowledge on the factors that contribute to health risks and improved healthy lifestyles.

Collaboration: Key partners include public health, schools and school districts, faith community, community clinics and community-based organizations.



Health Need: Social Determinants of Health/Basic Needs

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.	☒	☒
Learning and Outreach Centers	In collaboration with other community service agencies, the centers provide referral services, food, clothing, and education to the most vulnerable and needy residents of the community. After school programs at the centers provide tutoring support to underserved youth.	☒	☒
Connected Community Network (CCN)	Addresses the social determinants of health and ultimately links referred patients to appropriate and needed community-based services.	☒	☒
Art and Spirituality	Provides opportunities for artistic expression,	☒	☒

Center	meditation, relaxation, and creativity to promote health and well-being, aiding in physical, mental, and emotional recovery, including relieving anxiety and decreasing the perception of pain.		
Homemaker Care Program	Provides in home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Impact: The initiatives addressing basic needs services are anticipated to result in: increased access to health and social services to help residents of Kern County stay healthy and to live a better quality of life.

Collaboration: Key partners include faith community, food bank/pantries, housing and homelessness agencies, community clinics, community-based organizations, and senior agencies.

Community Grants Program


One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY21, Mercy and Memorial Hospitals awarded the grants below totaling \$380,144. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Alzheimer's Disease Association of Kern County	Alzheimer's and Dementia Care Force	\$45,144
Bakersfield Pregnancy Center	Compassionate Care Services in Crisis Situations	\$25,000
Bakersfield, Arc Inc. (BARC)	Bakersfield, Arc Inc. Project	\$50,000
Casa Esperanza	Welcome Home Project	\$30,000
Catholic Charities	Teaching Young Parents More Than How to Fish	\$40,000
CityServe Network	CityServe Educational Collaborative	\$40,000
Grimm Family Education Foundation	Edible Schoolyard Kern County Small Farm Ecosystem	\$25,000
St. Vincent de Paul Stores and Center	The Homeless Assistance Program	\$75,000
Wounded Heroes Fund	Empowering Veterans of Kern County	\$50,000

Program Digests

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

 Dignity Health Community Grants Program	
Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input checked="" type="checkbox"/> Alzheimer’s disease <input checked="" type="checkbox"/> Chronic diseases <input checked="" type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input checked="" type="checkbox"/> Social determinants of health/basic needs
Program Description	Award grant funds to local non-profit organizations to be used to effect collective impact, addressing the health priorities established by the hospitals (based on the most recent Community Health Needs Assessment). Awards will be given to agencies with a formal collaboration and links to the hospitals.
Community Benefit Category	E1 – Cash Donation
FY 2021 Report	
Program Goal / Anticipated Impact	Increased access and reduced barriers to health care, preventive care, basic needs and chronic disease prevention and treatment for the medically underserved.
Measurable Objective(s) with Indicator(s)	100% of funded programs reported on their activities, services and achievement of objectives with grant funds on a semi-annual basis.
Intervention Actions for Achieving Goal	100% of awarded agencies worked with Special Needs and Community Outreach staff to ensure programs met the objectives stated in their grant proposals.
Collaboration	Non-profit community-based organizations, faith organizations, community clinics, senior care providers, food distribution agencies.
Performance / Impact	<p>The Dignity Health Community Grants Program award \$365,318 in grant funds to 8 community organizations.</p> <p>The following projects were funded in FY21:</p> <ul style="list-style-type: none"> Alzheimer’s Disease Association of Kern County <i>Alzheimer’s and Dementia Care Force, Social Safety Net Program</i> - \$45,144

	<ul style="list-style-type: none"> • Bakersfield Pregnancy Center <i>Compassionate Care Services in Crisis Situations</i> - \$25,000 • Bakersfield, Arc Inc. <i>BARC</i> - \$50,000 • Casa Esperanza <i>Welcome Home Project</i> - \$30,000 • Catholic Charities <i>Teaching Young Parents More Than How to Fish</i> - \$40,000 • CityServe Network <i>CityServe Educational Collaborative</i> - \$40,000 • Grimm Family Education Foundation <i>Edible Schoolyard Kern County Small Farm Ecosystem</i> - \$25,000 • Saint Vincent de Paul Center <i>Homeless Assistance Program</i> - \$75,000 • Wounded Heroes Fund <i>Empowering Veterans of Kern County 2021</i> - \$50,000
Hospital's Contribution / Program Expense	The total FY21 expense was \$380,144. Other hospital contributions include grant administration.
FY 2022 Plan	
Program Goal / Anticipated Impact	Increased access and reduced barriers to health care, preventive care, basic needs and chronic disease prevention and treatment for the medically underserved.
Measurable Objective(s) with Indicator(s)	Funding will be provided to implement programs that support hospital priorities and demonstrate strong collaboration with the hospitals. 100% of funded programs will report objectives as a result of grants on a semi-annual basis.
Intervention Actions for Achieving Goal	All awarded agencies will work with Special Needs and Community Outreach staff to ensure programs meet the objectives stated in their grant proposals.
Planned Collaboration	Non-profit community-based organizations, faith organizations, community clinics, senior care providers, food distribution agencies.



Chronic Disease/Chronic Pain/Diabetes Self-Management Programs

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input checked="" type="checkbox"/> Chronic diseases <input checked="" type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input type="checkbox"/> Social determinants of health/basic needs
Program Description	The Healthier Living Self-Management Programs (Chronic Disease, Chronic Pain and Diabetes) are designed for persons who have diabetes and other chronic illnesses, providing them with the knowledge, tools and motivation needed to become proactive in their health. Each program seminar consists of six weekly classes covering a variety of topics including nutrition, exercise, use of medications, and communication with doctors, stress management, and evaluating new treatments.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops
FY 2021 Report	
Program Goal / Anticipated Impact	By offering evidence-based Healthier Living 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)	<ul style="list-style-type: none"> • 75% of participants who register for Healthier Living will complete the seminar by attending 4 out of 6 classes. • 90% of participants with a chronic disease who complete Healthier Living seminars will remain healthier after their seminars, as measured by those who avoid admissions to the hospital or emergency department for three months following their participation in the program. • Outreach to 2 new communities in Kern County in order to expand our services.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Offer seminars that are six weeks in length that target persons with diabetes and other chronic diseases. • Focus seminars on the uninsured and populations who qualify for publicly funded health care plans. • Engage clinical health professionals and health plan providers to guide program improvement. • Encourage and support continuing education for leader development to ensure the Healthier Living Self-Management Programs provide quality service.
Collaboration	Our program will continue to collaborate with several local community

	organizations to achieve its goals, including community health centers and other private and public stakeholders. Some of the program's major partners include: churches, school districts, senior centers, and family resource centers.
Performance / Impact	<ul style="list-style-type: none"> 99% of participants who registered for Healthier Living will complete the seminar by attending 4 out of 6 classes. 100% of all completers decreased admissions to the hospital or emergency department for the three months following their participation in the program. Outreached to 2 new locations in Kern County for Healthier Living.
Hospital's Contribution / Program Expense	The total FY21 expense was \$23,722. The program received \$24,843 in grant revenue. Other hospital contributions include program supervision, facility expenses, evaluation, fundraising support, educational materials, liability insurance, bookkeeping, and human resource support for the program.
FY 2022 Plan	
Program Goal / Anticipated Impact	Decrease 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)	<ul style="list-style-type: none"> 75% of participants who register for Healthier Living will complete the seminar by attending 4 out of 6 classes. 90% of participants with a chronic disease who complete the Healthier Living seminars will avoid admission to the hospital or emergency department for three months following their participation in the program. Outreach to 2 new communities in Kern County in order to expand services.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> Offer seminars that are six weeks in length that target persons with diabetes and other chronic diseases. Focus seminars on the uninsured and populations who qualify for publicly funded health care plans. Engage clinical health professionals and health plan providers to guide program improvement. Encourage and support continuing education for leader development to ensure the Healthier Living Self-Management Programs provide quality service.
Planned Collaboration	Key partners include community health centers, churches, school districts, senior centers, and family resource centers.



Community Wellness Program

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input checked="" type="checkbox"/> Chronic diseases <input checked="" type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input type="checkbox"/> Social determinants of health/basic needs
Program Description	<p>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. The Community Wellness Program encompasses programs that address prevention, screening for cancer, cardiovascular disease, asthma, diabetes, and obesity.</p>
Community Benefit Category	<p>A1-a Community Health Education - Lectures/Workshops A2-d Community Based Clinical Services - Immunizations/Screenings A3-g Health Care Support Services - Case management post-discharge</p>
FY 2021 Report	
Program Goal / Anticipated Impact	<p>The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.</p>
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • 75% of health screening participants surveyed will report making a positive lifestyle change. • Provide 1,000 flu immunizations for residents of Kern County. • 80% of children who attend Healthy Kids in Healthy Homes workshops will complete the workshop by attending six out of eight classes. • 90% of health education participants surveyed will report having a better understanding of how to live a healthy lifestyle. • Plan and deliver quarterly cancer education or screening events.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Provide community health education classes that focus on the following priorities – obesity, diabetes, asthma, and cardiovascular disease. • Outreach to 2 new communities for health education classes. • Develop and strengthen educational opportunities at the Community Wellness Center and virtually in the form of classes and events.
Collaboration	<p>Our program will collaborate with community health centers, churches, school districts, health care providers, health plans, and family resource centers.</p>
Performance / Impact	<ul style="list-style-type: none"> • The pandemic resulted in closures of our health screening sites for most of the fiscal year. As a result, we did not survey participants to determine positive lifestyle changes. We provided 1,090 health

	<p>screenings.</p> <ul style="list-style-type: none"> • Provided 1,871 flu immunizations for residents of Kern County. • 100% of children who attended Healthy Kids in Healthy Homes workshops will attend six out of eight classes. • 100% of health education participants surveyed reported having a better understanding of how to live a healthy lifestyle. • Provided 33 cancer education classes. Cancer screenings were not scheduled due to the pandemic.
Hospital's Contribution / Program Expense	The total FY21 expense for the Community Wellness Program was \$734,941. Of this amount, \$113,278 was grant dollars, and \$621,663 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, fundraising support, bookkeeping, and human resource support for the program.
FY 2022 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)	<ul style="list-style-type: none"> • 75% of health screening participants surveyed will report making a positive lifestyle change. • Provide 1,000 flu immunizations for residents of Kern County. • 80% of children who attend Healthy Kids in Healthy Homes workshops will attend six out of eight classes. • 90% of health education participants surveyed will report having a better understanding of how to live a healthy lifestyle. • Plan and deliver quarterly cancer education or screening events.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Provide community health education classes that focus on the following significant health needs – obesity, diabetes, asthma, and cardiovascular disease. • Outreach to 2 new communities for health education classes. • Develop and strengthen educational opportunities throughout the community.
Planned Collaboration	Our program will collaborate with community health centers, churches, school districts, health care providers, health plans, and family resource centers.



Community Health Initiative

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input type="checkbox"/> Chronic diseases <input type="checkbox"/> Overweight and obesity <input type="checkbox"/> Preventive practices <input type="checkbox"/> Social determinants of health/basic needs
Program Description	<p>The Community Health Initiative of Kern County works with public, private and non-profit organizations to enroll individuals in health insurance programs. The Community Health Initiative works to provide access to health care for those for whom no insurance program is available. The Community Health Initiative provides training for Certified Enrollment Counselors and referrals to partner agencies, and works at the local and state levels to help streamline the sometimes burdensome process of navigating through the public health system.</p>
Community Benefit Category	A3-d Health Care Support Services - Enrollment Assistance
FY 2021 Report	
Program Goal / Anticipated Impact	<p>Kern County residents will have access to health care, will be able to navigate health insurance coverage to access care, and will utilize preventive care.</p>
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • At least 90% of individuals who present for health insurance enrollment will be assisted with a Medi-Cal or Covered California application. • 85% of individuals who enroll in health insurance will select a health plan. • 50% of enrolled individuals will schedule their first doctor visit within six months of enrollment. • 100% of clients who are assisted with health insurance enrollment will receive information to increase their understanding of their coverage and how to access care.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Work with and train Community Health Workers to provide outreach and education throughout Kern County. • Meet with agency representatives to coordinate county wide outreach, enrollment, and education efforts. • Review “Path to Good Health” booklet with every client to ensure they understand and know how to access care. • Make follow-up utilization calls to those individuals who are assisted with health insurance enrollment to ensure they have selected a health plan, primary care physician and have scheduled their first appointment.

Collaboration	Our program works with several of local organizations to reach the different populations residing in Kern County. Partnerships include: community health centers, public health, social services, school districts, churches, Promotoras and other private and public stakeholders.
Performance / Impact	<ul style="list-style-type: none"> • 100% of individuals who presented for health insurance enrollment were assisted with a Medi-Cal or Covered California application. • 96% of individuals who enrolled in health insurance selected a health plan. • 24% of enrolled individuals scheduled their first doctor visit within six months of enrollment. • 100% of clients who were assisted with health insurance enrollment received information to increase their understanding of their coverage and how to access care.
Hospital's Contribution / Program Expense	The total FY21 expense for the Community Health Initiative was \$326,014. Of this amount, \$172,864 was grant dollars and \$153,150 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, fundraising support, liability insurance, bookkeeping, and human resource support for the program.
FY 2022 Plan	
Program Goal / Anticipated Impact	Kern County residents will have access to health care, will be able to navigate health insurance coverage to access care, and will utilize preventive care.
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • 75% of individuals who begin the health insurance application process will complete enrollment. • 50% of enrolled individuals will schedule their first doctor visit within six months of enrollment. • 90% of individuals who enroll in health insurance will select a health plan.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Work with and train Community Health Workers to prescreen and collect necessary documents for health insurance enrollment. • Make follow-up utilization calls to those individuals who are assisted with health insurance enrollment to ensure they have selected a health plan, primary care physician and have scheduled their first appointment. • Review the “Path to Good Health” booklet with every client to ensure they understand and know how to access care.
Planned Collaboration	Our program will continue to work with several of local organizations to reach the different populations residing in Kern County. Partners will include: community health centers, public health, social services, school districts, community-based organizations, churches, Promotoras and other private and public stakeholders.



Basic Needs Services

Significant Health Needs Addressed	<input type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input type="checkbox"/> Chronic diseases <input type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input checked="" type="checkbox"/> Social determinants of health/basic needs
Program Description	<p>The Learning and Outreach Centers are located in economically depressed neighborhoods of southeast Bakersfield. These centers serve as strategic hubs of our community outreach efforts. In collaboration with other community service agencies, the centers provide referral services, food, clothing, education, and health screenings to the most vulnerable and needy residents of the community. The after school program provides tutoring support five days a week to underserved youth.</p> <p>The Art and Spirituality Center provides opportunities for artistic expression, meditation, relaxation, and creativity to improve quality of life and reduce stress.</p>
Community Benefit Category	E3-a In-kind Donations - Food E3-c In-kind Donations - Clothing/gifts E3-d In-kind Assistance - Basic services for individuals F3- Community Support
FY 2021 Report	
Program Goal / Anticipated Impact	Increase access to health and social services to help residents of Kern County stay healthy.
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • 35,000 individuals will be assisted with basic living necessities at the Learning and Outreach Centers. • 85% of the students who participate in the Homework Club, After School Club, and College Dream Program will achieve a grade point average of 2.0 or above. • 95% of Art and Spirituality Center participants will participate and create freely in a supportive and accepting environment.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • The Learning and Outreach Centers will provide basic need services to vulnerable residents living in underserved neighborhoods of southeast Bakersfield. • The Learning and Outreach Centers will offer after school programs that provide tutoring support and educational guidance to underserved youth. • The Art and Spirituality Center will offer programs in a variety of artistic classifications.

Collaboration	Our programs collaborate with several local community organizations to achieve its goals. Some partners include school districts, food banks, and family resource centers.
Performance / Impact	<ul style="list-style-type: none"> • 37,043 individuals were assisted with basic living necessities at the Learning and Outreach Centers. • 87% of the students who participated in the Homework Club and After School Club achieved a grade point average of 2.0 or above. • 97.2% of Art and Spirituality Center participants surveyed reported they were able to create freely in a supportive and accepting environment.
Hospital's Contribution / Program Expense	The total FY21 expense for the Learning and Outreach Centers and the Art and Spirituality Center was \$406,650. Of this amount, \$42,380 was grant dollars and donations, and \$364,270 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, fundraising support, bookkeeping, and human resources support.
FY 2022 Plan	
Program Goal / Anticipated Impact	Increase access to health and social services to help residents of Kern County stay healthy.
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • 35,000 individuals will be assisted with basic living necessities at the Learning and Outreach Centers. • 85% of the students who participate in the Homework Club, After School Club, and College Dream Program will achieve a grade point average of 2.25 or above. • 96% of Art and Spirituality Center participants surveyed will report feeling a general sense of well-being.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • The Learning and Outreach Centers will provide basic need services to vulnerable residents living in underserved neighborhoods of southeast Bakersfield. • The Learning and Outreach Centers will offer after school programs that provide tutoring support and educational guidance to underserved youth. • The Art and Spirituality Center will offer programs in a variety of artistic classifications, both in-person and virtually, to promote physical, emotional and spiritual healing and well-being.
Planned Collaboration	Our programs collaborate with several local community organizations to achieve its goals. Some partners include school districts, food banks, and family resource centers.



Homemaker Care Program

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input checked="" type="checkbox"/> Alzheimer’s disease <input type="checkbox"/> Chronic diseases <input type="checkbox"/> Overweight and obesity <input type="checkbox"/> Preventive practices <input checked="" type="checkbox"/> Social determinants of health/basic needs
Program Description	<p>The Homemaker Care Program provides in-home supportive services to seniors, ages 65 and older, as well as adults with disabilities. Case management for seniors is conducted in the form of wellness checks and home visits to assess client safety, nutrition, and program satisfaction. This education program also provides specialized training for care providers to increase community capacity. The training is a four-week, comprehensive employment readiness skills training focusing on individuals transitioning from unemployment into the workforce as home care providers. Additional and more comprehensive training courses are also offered for persons with Alzheimer’s disease.</p>
Community Benefit Category	<p>A3-h Health Care Support Services - General/Other F5-c Leadership Dev/Training for Community Members - Career development</p>
FY 2021 Report	
Program Goal / Anticipated Impact	<p>Provide employment readiness training for individuals transitioning from unemployment into the workforce, and provide in-home support services to low-income seniors and disabled adults allowing them to remain in their homes.</p>
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • Improve the quality of life for 100% of clients, as measured by our Client Impact Survey. • Obtain an overall client satisfaction rate of at least 90% for excellence in maintaining dignity and quality of service received, as compiled from the compilation of a semi-annual survey. • Conduct 3 Homemaker Care vocational training classes with 80% of the graduates obtaining post-assessment scores of at least 70%. • Improve the knowledge, skill, and confidence level of 100% of the graduates in being prepared to seek employment in the healthcare industry, as disclosed by a post-course survey.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Collaborate with senior-related and health care related companies, organizations and public agencies to increase our ability to advocate for our clients and help all seniors advocate for themselves. • Provide services to increase access to care for vulnerable seniors and disabled clients. • Link underserved clients to needed health care and social service

	<p>resources.</p> <ul style="list-style-type: none"> Collaborate with other organizations to identify candidates for the training program.
Collaboration	Our program will continue to collaborate with assisted living facilities, non-profits, and several local community organizations to achieve its goals.
Performance / Impact	<ul style="list-style-type: none"> Improved the quality of life for 100% of clients responding, as measured by our Client Impact Survey. Obtained an overall average client satisfaction rate of 94% for excellence in maintaining dignity and quality of service received, as compiled from the compilation of a semi-annual survey. Conducted 3 Homemaker Care vocational training classes with 100% of the graduates obtaining post-assessment scores of at least 70%. Improved the knowledge, skill, and confidence level of 100% of the graduates in being prepared to seek employment in the healthcare industry, as disclosed by a post-course survey.
Hospital's Contribution / Program Expense	During FY21, expenses for the Homemaker Care Program were \$360,175. Of this amount, \$18,081 was grant dollars, \$197,082 was fee for service, and \$145,012 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include human resource support, office space, fundraising support, bookkeeping, strategic planning, and evaluation support for the program.
FY 2022 Plan	
Program Goal / Anticipated Impact	Provide employment readiness training for individuals transitioning from unemployment into the workforce, and 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)	<ul style="list-style-type: none"> Improve the quality of life for 100% of clients, measured by our Client Impact Survey. Obtain an average, overall client satisfaction rating of 90% for excellence in maintaining dignity and quality of service received, as compiled from two semi-annual Client Satisfaction surveys. Conduct four, Homemaker Care vocational training classes with 80% of the graduates obtaining post-assessment scores of at least 70%. Improve the knowledge, skill and confidence level of 100% of the graduates in being prepared to seek employment in the healthcare industry, as disclosed by our post-course survey.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> Collaborate with senior-related and health care related companies, organizations and public agencies to increase our ability to advocate for our clients and help all seniors advocate for themselves. Provide services to increase access to care for vulnerable seniors and

	<p>disabled clients.</p> <ul style="list-style-type: none"> • Link underserved clients to needed health care and social service resources. • Collaborate with other organizations to identify candidates for the training program.
Planned Collaboration	Our program will collaborate with assisted living facilities, senior services, and local community organizations to achieve its goals.

Other Programs and Non-Quantifiable Benefits

The hospitals deliver 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 hospitals' mission and our commitment to improving community health and well-being.

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

Prescription Program - The Prescription Purchase for Indigent Program purchases necessary medications in emergency situations for people who must have the medicines for their health but have no money to purchase them. The hospital's social workers identify patients in need of medication and request the medication from Komoto Pharmacy.

Homemaker Care Program: Hospital to Home Stat – This program provides a solution to meet the frequent challenges our case managers face with discharging a patient to home, safely. These patients are those that require immediate, non-medical assistance at home to avoid readmission to the hospital, to provide safety and support for improved patient experiences and to once again become independent in their homes.

Community Committees and Boards - Hospital staff serves on many community committees and boards in the service area such including the Alzheimer's Disease Association of Kern County, CBCC Infusion Center Family Centered Care Advisory Committee, Outreach Enrollment Retention Utilization Committee, Kern County Cancer Fund Patient Eligibility Committee Meeting, Kern Coalition Against Human Trafficking, Binational Health Week Task Force and the Dignity Health Community Grants Committee.



Economic Value of Community Benefit

322 Mercy Hospitals of Bakersfield					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2020 through 6/30/2021					
	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	5,014	5,099,320	0	5,099,320	1.4%
Medicaid	49,046	150,184,776	103,800,000	46,384,776	12.4%
Community Services					
A - Community Health Improvement Services	9,131	1,013,185	212,049	801,136	0.2%
C - Subsidized Health Services	40	484,837	0	484,837	0.1%
E - Cash and In-Kind Contributions	16,501	638,556	16,892	621,664	0.2%
F - Community Building Activities	593	130,948	1,614	129,334	0.0%
Totals for Community Services	0	659,939	864	659,075	0.2%
Totals for Community Services	26,265	2,927,465	231,419	2,696,046	0.7%
Totals for Poor	80,325	158,211,561	104,031,419	54,180,142	14.5%
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	44	133,404	0	133,404	0.0%
B - Health Professions Education	10	2,046	0	2,046	0.0%
E - Cash and In-Kind Contributions	2	21,976	0	21,976	0.0%
G - Community Benefit Operations	1,771	88,795	2,114	86,681	0.0%
Totals for Community Services	1,827	246,221	2,114	244,107	0.1%
Totals for Broader Community	1,827	246,221	2,114	244,107	0.1%
Totals - Community Benefit	82,152	158,457,782	104,033,533	54,424,249	14.5%
Medicare	22,289	104,389,736	74,665,718	29,724,018	7.9%
Totals with Medicare	104,441	262,847,518	178,699,251	84,148,267	22.5%

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

Hospital Board and Committee Rosters

Mercy Hospitals Community Board

A.J. Antongiovanni
President, Mission Bank

Sarupinder Bhangoo, MD
Physician (Chief of Staff)

Dana Brennan
Director of Corporate/Government Affairs,
Grimmway Farms

Pat Campbell
Retired, Marketing

Morgan Clayton - Chair
President, Tel-Tec Security

Sr. Patricia Creedon
Executive Director, Religious Order of the Sacred
Heart Oakwood Community

John R. Findley, MD
Physician

Ken Keller
President, Bakersfield Memorial Hospital

Geoffrey King
Partner, Barbich Hooper King Dill Hoffman,
Accountancy

Donald McMurtrey
Retired, Business Owner

Robert Noriega
Attorney, Young & Woolridge

Bruce Peters
President, Mercy Hospitals of Bakersfield

Evelyn Young Spath, EdD
Retired, Education

Jay Tamsi
President, Kern County Hispanic Chamber of
Commerce

Jigisha Upadhyaya, MD
Physician

Jon VanBoening
President, Dignity Health Central California
Division

Community Benefit Committee

Felicia Boyd
Mercy and Memorial Hospitals

Morgan Clayton
Tel-Tec Security
Board Member, Mercy Hospitals

Paula De La Riva
First 5 Kern

Danny Edwards
Community Member

Steve Flores
The Naina and Ravi Patel Foundation

Toni Harper
Friends of Mercy Foundation

Mikie Hay
Jim Burke Ford

Pam Holiwell
Kern County Department of Human Services

Louie Iturruria
Kern Health Systems

Adrianna Kessler
Kern County Department of Human Services

Beth Miller
Bakersfield Memorial Hospital

Gloria Morales
Mercy Housing

Sr. Judy Morasci
Community Member

Genie Navarro
Mercy Housing

Robin Robinson
CityServe

Leonardo Ruiz
Univision

Patty Salazar
Mercy Hospitals of Bakersfield

Michele Shain
Bakersfield Memorial Hospital

Donna Sharp
Mercy and Memorial Hospitals

Alexis Shaw
Kern County Network for Children

Caryl Schweitzer
Bakersfield Memorial Hospital Foundation

Morgan Topper
Mercy Hospitals of Bakersfield

Amanda Valenzuela
Alzheimer's Association, Kern County

Frenchy Valenzuela
Mercy and Memorial Hospitals

Joan Van Alstyne
Mercy Hospitals of Bakersfield

Michelle Willow
Dignity Health Central California Service Area

Evelyn Young-Spath
Board Member, Mercy Hospitals