Mercy Hospital Downtown
Mercy Hospital Southwest

Community Benefit 2020 Report and 2021 Plan

Adopted October 2020

Dignity Health
Mercy Hospitals

A message from

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

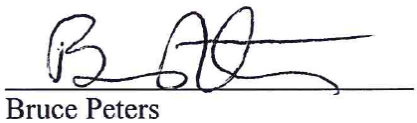
Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial 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 2020 Report and 2021 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.

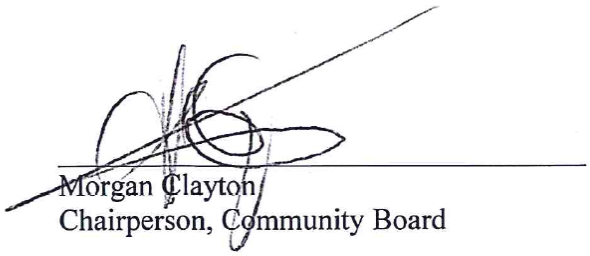
In fiscal year 2020 (FY20), Mercy Hospitals provided $46,382,022 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $30,028,888 in unreimbursed costs of caring for patients covered by Medicare.

The hospitals' Community Board reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its October 28, 2020 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 Winkley, 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

Community Served 	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, Lamont, Shafter and Taft.
Economic Value of Community Benefit 	$46,382,022 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $30,028,888 in unreimbursed costs of caring for patients covered by Medicare.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Access to health care • Alzheimer's disease • Chronic diseases • Overweight and obesity • Preventive practices • Social determinants of health/basic needs
FY20 Programs and Services 	The hospital delivered several programs and services to help address identified significant community health needs. These included: • Community Health Initiative - The Community Health Initiative of Kern County works with more than 50 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.
FY21 Planned Programs and Services 	The hospitals will continue their FY20 programs with the following changes: • Health insurance assistance will be provided telephonically and by mail. • Educational program activities will be conducted virtually until in-person classes and workshops can be conducted.

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.Corona@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 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 Hospital Downtown is also home to the area's only inpatient oncology unit.

Mercy Hospital Southwest is a 78-bed facility adjacent to California State University and includes a 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 Hospital Southwest also includes a 43-bed Medical and Surgical Unit. The hospital has 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.

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

Description of the Community Served

Mercy Hospitals serve 12 ZIP Codes representing 4 cities in Kern County.

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.

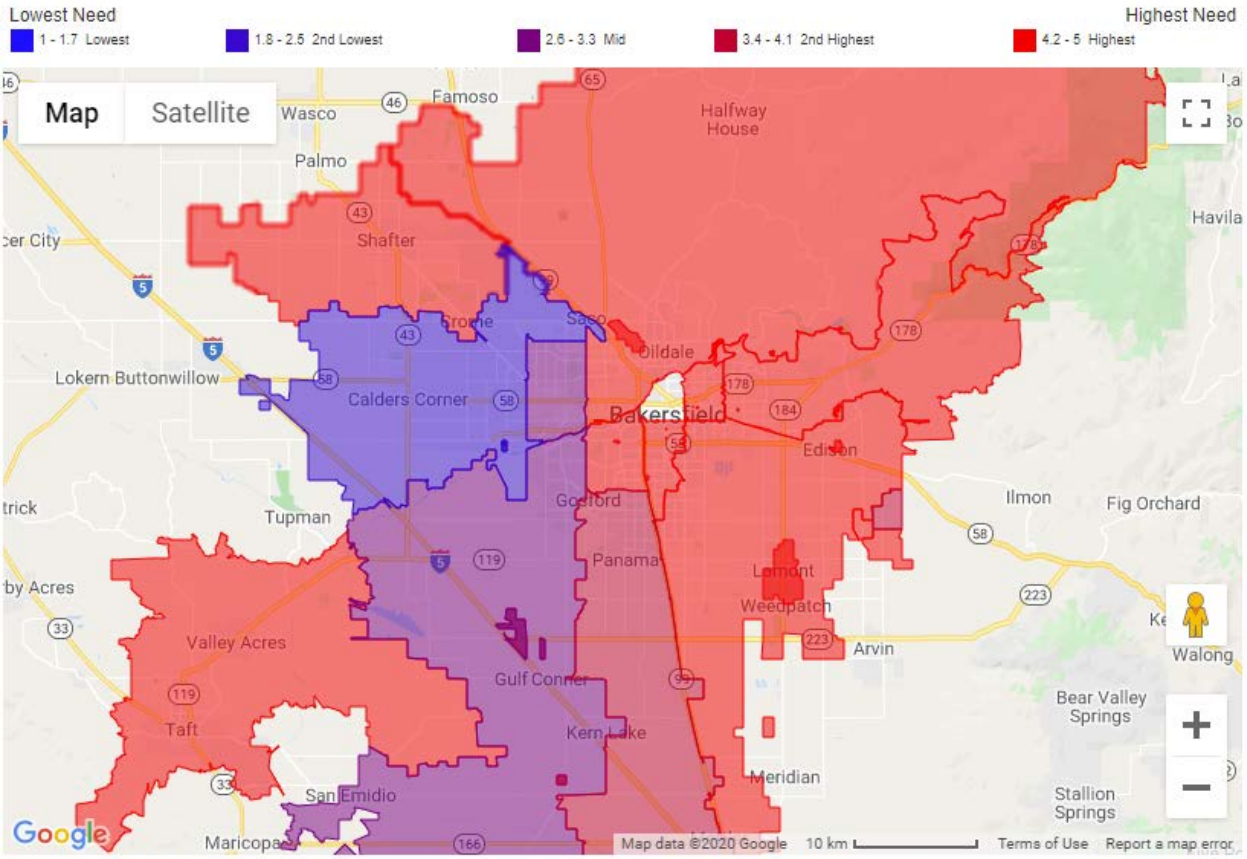
Total Population	599,835
Race	
White - Non-Hispanic	30.7%
Black/African American - Non-Hispanic	5.0%
Hispanic or Latino	56.1%
Asian/Pacific Islander	5.5%
All Others	2.7%
Total Hispanic & Race	100.0%
% Below Poverty	16.4%
Unemployment	9.5%
No High School Diploma	23.9%
Medicaid (households)	11.4%
Uninsured (households)	6.0%
Source: Claritas Pop-Facts® 2020; 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.



Mean(zipcode): 4.2 / Mean(person): 4.2 CNI Score Median: 4.7 CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
93263	5	21166	Shafter	Kern	California
93268	5	19126	Taft	Kern	California
93304	5	49047	Bakersfield	Kern	California
93305	5	37409	Bakersfield	Kern	California
93306	4.8	69719	Bakersfield	Kern	California
93307	4.8	90706	Bakersfield	Kern	California
93308	4.4	55349	Bakersfield	Kern	California
93309	4.6	57051	Bakersfield	Kern	California
93311	3	49951	Bakersfield	Kern	California
93312	2.8	62841	Bakersfield	Kern	California
93313	3.6	54993	Bakersfield	Kern	California
93314	2.4	32477	Bakersfield	Kern	California

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 health implementation strategy 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 assessment[1] identified the following significant community health needs:

- **Access to health care** – In Kern County, 35.8% of the population has employment-based health insurance. 35% are covered by Medi-Cal and 11% of the population has coverage that includes Medicare.
- **Alzheimer's disease** – The mortality rate from Alzheimer's disease in the service area was 61.8 per 100,000 persons. This is higher than the Kern County rate (50.5) and the state rate (35.5 per 100,000 persons).
- **Birth indicators** – Infant mortality reflects deaths of children under one year of age. The infant death rate in Kern County was 6.8 deaths per 1,000 live births. This rate is higher than the California rate of 4.6 and the Healthy People 2020 objective of 6.0 deaths per 1,000 live births.
- **Chronic diseases** – Heart disease, cancer and lung disease are the three leading causes of death in the service area. The cancer death rate in the service area is 177.5 per 100,000 persons, higher than the Healthy People 2020 objective (161.4 per 100,000). The age-adjusted mortality rate for ischemic heart disease in the service area was 146.3 deaths per 100,000 persons. This rate of heart disease death exceeded the Healthy People 2020 objective of 103.4 per 100,000 persons.
- **Dental care** – 2.4% of Kern County residents have never been to a dentist and 11.8% have not visited a dentist for five or more years. 25.3% of adults rated the condition of their teeth as fair to poor. 17.2% of

[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.

Kern County children, ages 3 to 11, have never been to a dentist.

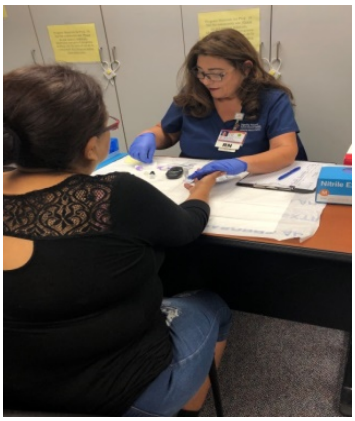
- **Economic insecurity** – Within Kern County unemployment was 9.2% in 2017. Areas with high unemployment were: Taft Heights (12.7%) and Taft (10.3%). Bakersfield (93305) has the highest percentage of children in poverty (58.6%).
- **Environmental pollution** – In 2016, Kern County had 78 days with ground-level ozone concentrations above the U.S. standard of 0.070 parts per million, compared to 22 days of high ozone concentrations in the state for the year.
- **Food insecurity** – Among the population in Kern County, 13.6% experienced food insecurity during the past year. Among children in Kern County, 25% lived in households that experienced food insecurity at some point in the year. The rate of food insecurity was higher in Kern County than in the state.
- **Housing and homelessness** – In Kern County, there was a spike of 9% in homelessness from 2017 to 2018, and a 46% increase in the number of unsheltered homeless. Among children, 3.7% of public school enrollees in Kern County were recorded as being homeless at some point during the 2015-2016 school year.
- **Mental health** – Mortality from suicide was higher in the service area (13.8 per 100,000 persons) than in the state (11.0 per 100,000 persons). The service area rate for suicide does not meet the Healthy People 2020 objective for suicide (10.2 deaths per 100,000 persons).
- **Overweight and obesity** – In Kern County, 34.8% of adults, 21.6% of teens, and 23.4% of children are overweight. This is a larger percentage of overweight children and teens than in the state. In Kern County, 40.7% of adults, ages 20 and older, are obese. 20.6% of county teens are obese.
- **Preventive practices** –The Healthy People 2020 objective is for 70% of the population to receive a flu shot. 44.1% of Kern County adults received a flu shot. Among Kern County seniors, 69.7% had received a flu shot. Among Kern County children, 6 months to 17 years, 47.7% received the flu shot.
- **Sexually transmitted infections** – Rates of STIs are climbing rapidly in Kern County. The rate for chlamydia in Kern County in 2017 was 763.1 diagnosed cases per 100,000 persons. The Kern County rate of gonorrhea was 251.6 cases per 100,000 persons.
- **Substance use and misuse** – The Healthy People 2020 objective for cigarette smoking among adults is 12%. In Kern County, 14.6% of adults smoke cigarettes. The rate of opioid prescriptions in Kern County was 772.1 per 1,000 persons. This rate is higher than the state rate of opioid prescribing (508.7 per 1,000 persons).
- **Unintentional injuries** – The age-adjusted death rate from unintentional injuries in the service area was 55.1 per 100,000 persons. This rate was higher than for Kern County (51.6 deaths per 100,000 persons). The death rate from unintentional injuries in the service area exceeds the Healthy People 2020 objective of 36.4 deaths for unintentional injuries per 100,000 persons.
- **Violence and injury prevention** – Violent crime rates increased from 2014 to 2017 in Bakersfield. Property crime rates increased from 2014 to 2017 in Bakersfield and Shafter. In Kern County the rate of children, under 18 years, who experienced abuse or neglect, was 11.8 per 1,000 children. This was higher than the state rate of 7.7 per 1,000 children.

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.

2020 Report and 2021 Plan

This section presents strategies and program activities the hospitals intend to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional 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 and California's shelter-in-place order affected many of the programs provided by the Department of Special Needs and Community Outreach. Community classes and in-person enrollment assistance were postponed. 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. 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, children at home all day, and grocery stores with empty shelves. To meet the needs of residents in southeast Bakersfield, the Learning and Outreach Centers expanded their emergency food basket and hot meals programs. The department will continue to help alleviate pandemic-induced needs in FY21 by providing emergency food and assisting clients telephonically with health insurance.

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 FY20	Planned FY21
Financial assistance	The hospitals will provide financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.	☐	☒
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.	☒	☒
Coordinated Care Network Initiative	Through the CCNI, hospital care coordination and community partner agencies will work together to	☒	☒

(CCNI)	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 FY20	Planned FY21
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 FY20	Planned FY21
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.	☒	☒
Smoking Cessation Program	Facilitates Freedom From Smoking®, an eight session seminar, to help encourage participants to work on the process and problems of quitting.	☒	☒

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), and motivating individuals to quit smoking and improve the length and quality of life.

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

Health Need: Overweight and Obesity

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
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. Offers community fitness classes.	☒	☒
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 FY20	Planned FY21
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.	☒	☒
Smoking Cessation Program	Facilitates Freedom From Smoking®, an eight session seminar, to help encourage participants to work on the process and problems of quitting.	☒	☒
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 FY20	Planned FY21
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.	☒	☒
Coordinated Care Network Initiative	Addresses the social determinants of health and ultimately links referred patients to appropriate and needed community-based services.	☒	☒

Art and Spirituality Center	Provides opportunities for artistic expression, 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.	☒	☒

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 FY20, Mercy and Memorial Hospitals awarded the grants below totaling $365,318. 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	$25,000
Bakersfield Homeless Center	Housing is Healthy	$25,000
Bakersfield Recovery Services	Mommy and Me Re-Envisioning Project	$50,000
Catholic Charities Diocese of Fresno of Bakersfield	Let's Not Sugarcoat Diabetes	$60,000
Grimm Family Education Foundation	Edible Schoolyard Kern County Mobile Kitchen Classroom	$35,318
Links for Life	Comprehensive Breast Health Program Expanded	$25,000
St. Vincent de Paul Stores and Center (SVDP)	The Homeless Assistance Program	$70,000
Wounded Heroes Fund	Empowering Veterans of Kern County	$75,000

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	☑ Access to care ☑ Alzheimer's disease ☑ Chronic diseases ☑ Overweight and obesity ☑ Preventive practices ☑ 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 2020 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 objectives as a result of grants 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	The Dignity Health Community Grants Program award $365,318 in grant funds to 8 community organizations. The following projects were funded in FY20: • Alzheimer's Disease Association of Kern County: Alzheimer's and Dementia Care Force • Bakersfield Homeless Center: Housing is Healthy • Bakersfield Recovery Services: Mommy and Me Re-Envisioning

	Project • Catholic Charities Diocese of Fresno of Bakersfield: Let's Not Sugarcoat Diabetes • Grimm Family Education Foundation: Edible Schoolyard Kern County Mobile Kitchen Classroom • Links for Life: Comprehensive Breast Health Program Expanded • St. Vincent de Paul Stores and Center (SVDP): The Homeless Assistance Program • Wounded Heroes Fund: Empowering Veterans of Kern County
Hospital's Contribution / Program Expense	The total FY20 expense was $365,318. Other hospital contributions include grant administration.
FY 2021 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	☑ Access to care ☐ Alzheimer's disease ☑ Chronic diseases ☑ Overweight and obesity ☑ Preventive practices ☐ Social determinants of health/basic needs
Program Description	The Healthy 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 2020 Report	
Program Goal / Anticipated Impact	By offering evidence-based Healthy 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)	• Provide 25 Healthy Living seminars in Kern County areas with a Community Needs Index (CNI) score of 3 or above to ensure that underserved persons throughout the county will have access to the seminars. • 90% of all participants with chronic diseases who complete Healthy Living-Chronic Disease and Healthy Living-Diabetes 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. • Provide 3 new locations in Kern County for Healthy Living seminars in order to expand our services.
Intervention Actions for Achieving Goal	• 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 Healthy 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, health care providers, health plans, senior centers, and family resource centers.
Performance / Impact	• Provided 23 Healthy Living seminars in areas of Kern County with a Community Need Index (CNI) score of 3 or higher to ensure that underserved persons throughout the county had access to the seminars. • 100% of all completers decreased admissions to the hospital or emergency department for the three months following their participation in the program. • Provided 9 new locations in Kern County for Healthy Living.

Hospital's Contribution / Program Expense	The total FY20 expense was $76,558. Of this amount, $16,594 was grant dollars and $59,964 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, facility expenses, evaluation, fundraising support, educational materials, liability insurance, bookkeeping, and human resource support for the program.
FY 2021 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)	• 75% of participants who register for Healthy Living seminars will complete the seminar by attending 4 out of 6 classes. • 90% of participants with a chronic disease who complete Healthy 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	• 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 Healthy Living Self-Management Programs provide quality service.
Planned Collaboration	Key partners include community health centers, churches, school districts, health care providers, health plans, senior centers, and family resource centers.
Community Wellness Program	
Significant Health Needs Addressed	☑ Access to care ☐ Alzheimer's disease ☑ Chronic diseases ☑ Overweight and obesity ☑ Preventive practices ☐ Social determinants of health/basic needs
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. The Community Wellness Program encompasses programs that address prevention, screening for cancer, cardiovascular disease, asthma, diabetes, overweight and obesity, and smoking cessation.
Community Benefit Category	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
FY 2020 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)	• Provide 25,000 blood pressure, cholesterol, glucose, and hemoglobin screenings in Kern County. At least 75% of participants who attend monthly health screenings and at least 2 health education classes, at targeted health screening sites, will show improved blood sugar results at the end of six months. • Provide 1,000 flu immunizations for residents of Kern County. • 80% of children who attend six of the eight classes in Healthy Kids in Healthy Homes will demonstrate improved physical fitness. • 90% of participants will have a better understanding of how to live a healthy lifestyle after attending a health education class, workshop or program. • Offer 3 Freedom from Smoking® clinics. • Plan and deliver quarterly cancer education or screening events.
Intervention Actions for Achieving Goal	• Ongoing collection of health screening results in a database. • Provide 125 community health education classes that focus on the following priorities – obesity, diabetes, asthma, and cardiovascular disease. • Provide community health education classes at 5 new locations. • Provide 15 nutrition education classes. • Further develop collaborative relationships with community-based organizations to provide health education throughout Kern County. • Strengthen educational opportunities at the Community Wellness Center in the form of classes and events.
Collaboration	Our program will collaborate with community health centers, churches, school districts, health care providers, health plans, and family resource centers.
Performance / Impact	• Provided 18,479 blood pressure, cholesterol, glucose, and hemoglobin screenings throughout Kern County. 64% of participants who attended monthly health screenings and health education classes, at targeted health screening sites, showed improved blood sugar results at the end of six months. • Provided 1,200 flu immunizations for residents of Kern County. • 74% percent of children who attended six of the eight Healthy Kids

	in Healthy Homes classes demonstrated improved physical fitness. • 96% percent of health education participants had a better understanding of how to live a healthy lifestyle after attending a health education class, workshop or program. • 3 Freedom from Smoking® clinics were offered. • Provided 1 cancer education or screening event per quarter.
Hospital's Contribution / Program Expense	The total FY20 expense for the Community Wellness Program was $898,846. Of this amount, $77,625 was grant dollars, and $821,221 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, fundraising support, bookkeeping, and human resource support for the program.
FY 2021 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)	• 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	• 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.
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	✓ Access to Care ❑ Alzheimer's Disease ❑ Chronic Disease ❑ Overweight and Obesity ❑ Preventive Practices ❑ Social Determinants of Health (Basic Needs Services)

Program Description	The Community Health Initiative of Kern County works with more than 50 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.
Community Benefit Category	A3-d Health Care Support Services - Enrollment Assistance
FY 2020 Report	
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)	• 700 individuals will be enrolled or renewed in Medi-Cal or Covered California and receive information to increase their understanding of their coverage and how to access care. • 85% of individuals served will receive assistance in choosing a health plan. • 50% of clients enrolled in a health insurance plan will schedule a primary care visit within the first 6 months of enrollment. • Provide 6 trainings to Certified Application Assisters (CACs) to maintain a strong county-wide network of assisters. • Train 15 community residents on the Promotora model. • Hold 4 events aimed at reducing stigma in accessing mental health services.
Intervention Actions for Achieving Goal	• Partner with school districts and community-based organizations to encourage client referrals for health insurance enrollment assistance and advocacy. • Train Promotoras as Health Access Assisters. • Train Promotoras as support group facilitators (mental health) • Support Promotoras to provide outreach, education and work within their communities. • Hold outreach events in outlying areas of Kern County. • Meet monthly with agency representatives to coordinate county-wide outreach, enrollment and education efforts. • Review “Path to Good Health” booklet with every client who receives application assistance to help them understand programs and coverage. • Make follow-up utilization calls to those individuals who are assisted with health insurance enrollment. • Coordinate the Outreach, Enrollment, Retention and Utilization Committee (OERUC). • Coordinate quarterly Certified Application Counselor (CAC)

	network.
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, community-based organizations, churches, Promotoras and other private and public stakeholders.
Performance / Impact	• 1,314 individuals were enrolled or renewed in Medi-Cal or Covered California and received information to increase their understanding of their coverage and how to access care. • 87% of individuals served received assistance in choosing a health plan. • 45% of clients enrolled in a health insurance plan scheduled a primary care visit within the first 6 months of enrollment. • Provided 9 trainings to Certified Application Assisters (CACs) to maintain a strong county-wide network of assisters. • 15 community residents were trained on the Promotora model. • Held 5 events aimed at reducing stigma in accessing mental health services.
Hospital's Contribution / Program Expense	The total FY20 expense for the Community Health Initiative was $397,870. Of this amount, $397,462 was grant dollars and $408 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 2021 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)	• 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	• 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 health plan, primary care physician and have scheduled their first appointment.
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	☐ Access to care ☐ Alzheimer's disease ☐ Chronic diseases ☐ Overweight and obesity ☑ Preventive practices ☑ Social determinants of health/basic needs
Program Description	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, shelter, 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. The Art and Spirituality Center provides opportunities for artistic expression, meditation, relaxation, and creativity to improve quality of life and reduce stress.
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 2020 Report

Program Goal / Anticipated Impact	Increase access to health and social services to help residents of Kern County stay healthy.
Measurable Objective(s)	• 35,000 individuals will be assisted with basic living necessities at the

with Indicator(s)	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. • 94% of Art and Spirituality Center participants will feel a reduction in stress and report an improved quality of life.
Intervention Actions for Achieving Goal	• 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, including community health centers and other private and public stakeholders. Some partners include: community clinics, churches, school districts, food banks, and family resource centers.
Performance / Impact	• 40,721 individuals were assisted with basic living necessities at the Learning and Outreach Centers. • 94% of the students who participated in the Homework Club and After School Club achieved a grade point average of 2.0 or above. • 3,557 participants took part in programs at the Art and Spirituality Center. • 98.5% of Art and Spirituality Center participants surveyed reported feeling a reduction in stress and an improved quality of life.
Hospital's Contribution / Program Expense	The total FY20 expense for the Learning and Outreach Centers and the Art and Spirituality Center was $460,859. Of this amount, $30,641 was grant dollars and donations, and $430,218 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, fundraising support, bookkeeping, and human resources support.
FY 2021 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)	• 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 feel a reduction in stress and report an improved quality of life.

Intervention Actions for Achieving Goal	• 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.
Planned Collaboration	Our programs collaborate with several local community organizations to achieve its goals, including community health centers and other private and public stakeholders. Some partners include: community clinics, churches, school districts, food banks, and family resource centers.

Homemaker Care Program

Significant Health Needs Addressed	☑ Access to care ☑ Alzheimer's disease ☐ Chronic diseases ☐ Overweight and obesity ☐ Preventive practices ☑ Social determinants of health/basic needs
Program Description	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 dementia and Alzheimer's disease.
Community Benefit Category	A3-h Health Care Support Services - General/Other F5-c Leadership Dev/Training for Community Members - Career development

FY 2020 Report

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)	• Improve the quality of life for 100% of clients, as measured by our FY2020 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 4, 4-week training sessions with a target of 32 graduates. • 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	• 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 resources. • 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	• 100% of clients reported an improvement in their quality of life. • Client satisfaction ratings achieved were 94.8% in December 2019 and 95% in June 2020. • Conducted 3, 4-week training classes, graduating 28 students. • 93% of the graduated students reported an increase in their confidence levels and 100% increased their skills and knowledge, by an average of 70.4%, as determined by pre and post examinations.
Hospital's Contribution / Program Expense	During FY20, expenses for the Homemaker Care Program were $387,210. Of this amount, $64,064.28 was grant dollars, $232,521 was fee for service, and $90,624.72 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 2021 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)	• Improve the quality of life for 100% of clients, as measured by our FY2021 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 sessions 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	• 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 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 7/1/2019 through 6/30/2020

	Persons	Net Benefit	% of Expenses
Benefits for Poor			
Financial Assistance	**7,208**	**6,351,632**	**1.9%**
Medicaid	**53,788**	**37,069,225**	**10.9%**
Community Services			
A - Community Health Improvement Services	19,154	984,374	0.3%
C - Subsidized Health Services	49	518,588	0.2%
E - Cash and In-Kind Contributions	17,476	363,369	0.1%
F - Community Building Activities	1,033	173,422	0.1%
G - Community Benefit Operations	158	639,711	0.2%
Totals for Community Services	**37,870**	**2,679,464**	**0.8%**
Totals for Poor	**98,866**	**46,100,321**	**13.5%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	2,293	166,678	0.0%
B - Health Professions Education	0	6,723	0.0%
E - Cash and In-Kind Contributions	0	29,229	0.0%
G - Community Benefit Operations	1,879	79,071	0.0%
Totals for Community Services	**4,172**	**281,701**	**0.1%**
Totals for Broader Community	**4,172**	**281,701**	**0.1%**
Totals - Community Benefit	**103,038**	**46,382,022**	**13.6%**
Medicare	**23,816**	**30,028,888**	**8.8%**
Totals with Medicare	**126,854**	**76,410,910**	**22.4%**

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

Sandra Serrano
Retired, Education

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

Morgan Clayton
Tel-Tec Security

Felicia Corona
Mercy and Memorial Hospitals

Paula De La Riva
First 5 Kern

Danny Edwards
Community Member

Steve Flores
The Naina and Ravi Patel Foundation

Rita Flory
Mercy and Memorial Hospitals

Julie Franks
State Farm Insurance Company

Toni Harper
Friends of Mercy Foundation

Mikie Hay
Jim Burke Ford

Pam Holiwell
Kern County Department of Human Services

Louie Iturruria
Kern Health Systems

Beth Miller
Bakersfield Memorial Hospital

Gloria Morales
Mercy Housing

Sr. Judy Morasci
Mercy Hospitals of Bakersfield

Genie Navarro
Mercy Housing

Robin Robinson
CityServe

Leonardo Ruiz
Univision

Patty Salazar
Mercy Hospitals of Bakersfield

Caryl Schweitzer
Bakersfield Memorial Hospital Foundation

Michele Shain
Bakersfield Memorial Hospital

Morgan Topper
Mercy Hospitals of Bakersfield

Kevin Truelson
Kern County Network for Children

Amanda Valenzuela
Alzheimer's Association, Kern County

Joan Van Alstyne
Mercy Hospitals of Bakersfield

Michelle Willow
Dignity Health Central California Service Area

Donna Winkley
Mercy and Memorial Hospitals

Financial Assistance Policy Summary

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 250% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 250-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

Bakersfield Memorial Hospital 420 34th St., Bakersfield, CA 93301 | **Financial Counseling** 661-327-4647 ext 4692
Patient Financial Services 866-397-9272 | www.dignityhealth.org/bakersfieldmemorial/paymenthelp

Mark Twain 768 Mountain Ranch Rd, San Andreas, CA 95249 | **Financial Counseling** 209-754-2622
Patient Financial Services 866-397-9272 | www.dignityhealth.org/marktwainmedical/paymenthelp

Mercy Hospital Downtown 2215 Truxtun Ave, Bakersfield, CA 93301 | **Financial Counseling** 661-327-1792 ext 4692
Patient Financial Services 866-397-9252 | www.dignityhealth.org/mercy-bakersfield/paymenthelp

Mercy Hospital Southwest 420 34th St, Bakersfield, CA 93301 | **Financial Counseling** 661-327-4647 ext 4692
Patient Financial Services 866-397-9252 | www.dignityhealth.org/bakersfieldmemorial/paymenthelp

Mercy Medical Center 333 Mercy Ave, Merced, CA 95340 | **Financial Counseling** 209-564-5105
Patient Financial Services 866-626-6583 | www.dignityhealth.org/mercymedical-merced/paymenthelp

St. Joseph's Behavioral Health Center 2510 North California St, Stockton, CA 95204 | **Financial Counseling** 209-461-2000
Patient Financial Services 866-397-9252 | www.dignityhealth.org/stjosephsbehavioral/paymenthelp

St. Joseph's Medical Center 1800 North California St, Stockton, CA 95204 | **Financial Counseling** 209-461-5281
Patient Financial Services 866-397-9272 | www.dignityhealth.org/stjosephs-stockton/paymenthelp

Central California_CA2016

Dignity Health.