Dignity Health.
Memorial Hospital

Memorial Hospital
Bakersfield, California

Community Health Implementation Strategy
2016 – 2018

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EXECUTIVE SUMMARY

Dignity Health Memorial Hospital serves all of Kern County, including Bakersfield and outlying rural communities. The population of Kern County is 848,204. In the county, 30% of the population is children, ages 0-17. 60.8% of the population is adults and 9.2% are seniors. The community is primarily Hispanic or Latino, at 49.8%, followed by White at 37.8%. Black/African-Americans are 5.3% and Asians represent 5.3% of the population. Poverty rates in the county (22.9%) are higher than for California (15.9%). Of the population aged 25 and over, 27.5% do not have a high school diploma. (*Source: U.S. Census Bureau, American Community Survey, 2009-2013.)* On a positive note, rates of health insurance coverage are increasing. Health insurance coverage for children has increased from 90.6% in 2011 to 95.2% in 2014. *(Source: U.S. Census Bureau, American Community Survey accessed from www.healthykern.org.)*

The significant community health needs that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at http://www.dignityhealth.org/bakersfieldmemorial/dignity-health-in-kern-county/community-programs/community-benefit-report. Additional details about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report. As well, a description of program impact during the three years since the last Implementation Strategy can be found in the 2016 CHNA.

As part of the CHNA process, the significant community health needs were prioritized with input from the community, which yielded this prioritized list of significant health needs:

1. Overweight and obesity
2. Mental health
3. Access to care
4. Diabetes
5. Cardiovascular disease
6. Substance abuse
7. Asthma
8. Maternal and infant health
9. Cancer
10. HIV/AIDS/STD
11. Oral health
12. Environmental health

For the next three years, Memorial Hospital plans to address access to health care, chronic diseases and overweight and obesity through a number of initiatives and a commitment of resources. For example, the Community Wellness Program will focus efforts on addressing asthma, cancer, cardiovascular disease, smoking cessation, and overweight and obesity. The Chronic Disease Self-Management programs will focus on diabetes management. The Community Health Initiative will increase access to health insurance and health care for hard to reach individuals in Kern County. Basic needs and support

services, referrals, and health screenings will be available to the community through our three outreach centers. The Homemaker Care Program will provide homemaker services to frail elderly and disabled adults. A full listing of the programs and activities planned to meet the selected health needs is outlined in the pages that follow.

This is available to the public on the hospitals' website at: http://www.dignityhealth.org/bakersfieldmemorial/dignity-health-in-kern-county/community-programs/community-benefit-report. A paper copy is available for inspection upon request at Memorial Hospital's Administrative Office. Written comments on this report can be submitted to the Memorial Hospital's Administration Office at 420 34th Street, Bakersfield, California, 93301or by e-mail to Debbie.Hull@DignityHealth.org.

MISSION, VISION AND VALUES

Our Mission

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

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

Our Vision

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

Our Values

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

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

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

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

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

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

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

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

OUR HOSPITAL AND OUR COMMITMENT

As Bakersfield's largest acute care facility, Memorial Hospital opened its doors to the public in 1956 to serve the growing needs of the community. Located in the heart of a reenergized downtown, the campus has received numerous awards and recognition for its quality care. When the ground was turned on this community treasure 65 years ago, no one could know then how Memorial Hospital would grow. But through the leadership and heart of Larry Carr, the 112 bed community hospital grew into more than 400 and thousands of lives were changed. In 1996 Memorial Hospital affiliated with Dignity Health. The three Dignity Health hospitals in Bakersfield (Mercy Hospital Downtown, Mercy Hospital Southwest, and Memorial Hospital) are the largest providers of health services in the Southern San Joaquin Valley serving a diverse population of urban and rural residents.

Memorial Hospital is located at 420 34th Street, Bakersfield, California, 93301. Memorial has 426-licensed beds and includes a full-service Emergency Department with an Accredited Chest Pain Center and Nationally Certified Stroke Center. In addition, the hospital has a Family Care and Birthing Center, the Lauren Small Children's Center, which includes the area's only Pediatric Intensive Care Unit, a Level II NICU, the Sarvanand Heart and Stroke Center with Kern County's first Bi-Plane Interventional Suite, the Center for Wound Care and Hyperbarics, and many more services.

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

Memorial Hospital has a Board of Directors. The Board is responsible for ensuring that community health is one of the major goals in the strategic planning process. The Board of Directors is a diverse group that includes community members, physicians, faith-based representatives, and business health executives who provide a broad spectrum of perspectives on plans presented for their approval. Memorial Hospital's president is committed to the community benefit process and accountable to Dignity Health system leadership.

The Community Benefit Committee of the Board assists the Department of Special Needs and Community Outreach in prioritizing programs that are in line with the hospital's strategic plan. Committee members include representatives of the hospital Executive Management Team, the business community, social service agencies, community volunteers, board members, and employees. This group meets four times annually to help ensure that our outreach services respond to identified community needs and are effectively working to improve the overall health status of the community. The Committee provides input, advice, and approval for the Community Health Needs Assessment, Implementation Strategy, Community Benefit Plan, and program monitoring. Reports approved by the Community Benefit Committee are then submitted to the Board of Directors at Memorial Hospital for

final approval. A roster of current Community Benefit Committee members can be found in Appendix A.

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

With 33 employees the department's programs target low-income, uninsured, or underinsured individuals, as well as Kern County citizens with unmet health needs, including migrant farm workers and other disenfranchised populations. The department frequently collaborates with more than 100 public, private, and nonprofit organizations.

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

DESCRIPTION OF THE COMMUNITY SERVED

Memorial Hospital serves all of Kern County, including Bakersfield and outlying rural communities. Memorial determines the Primary Service Area by assigning zip codes based on patient discharges. Over 70% of inpatient discharges constitute the Primary Service Area (*Office of Statewide Health Planning and Development*).

The 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. Agriculture is the third largest industry in the county and accounts for 24% of private sector jobs. Seasonal and cyclical fluctuations in employment in the agriculture and petroleum industries drive Kern County's unemployment rate consistently well above the state average. A summary description of the community follows, and additional community facts and details can be found in the CHNA report online.

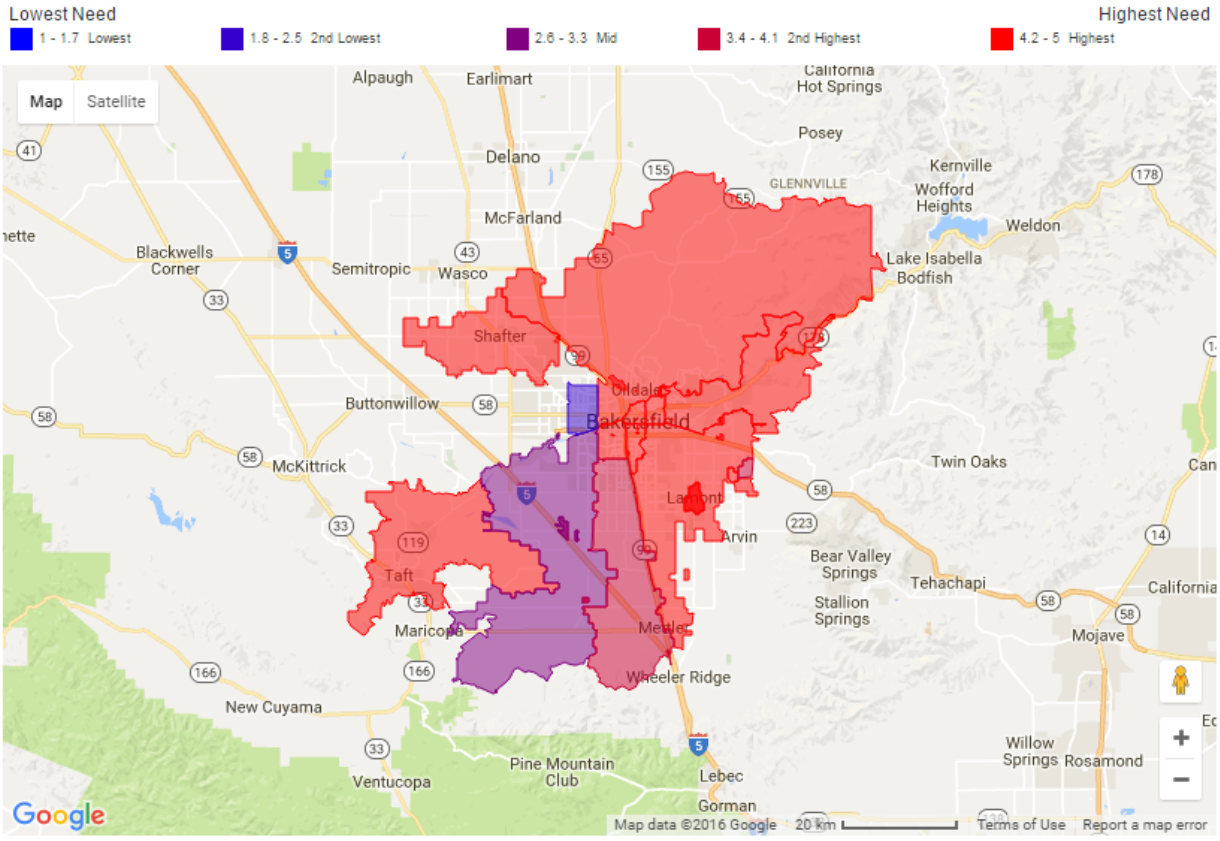
The following data is from Truven Health Analytics:

Total Population: 589,112
Race: 32.9% White – Non-Hispanic, 5.4% Black/African American, 54.3% Hispanic or Latino, 4.7% Asian/Pacific Islander, 2.7 % All Others
Median Income: $52,663
Unemployment: 7.9%
No HS Diploma: 25.8%
CNI Score: 4.6
Medicaid Population*: 32.3%
Uninsured: 8.7%
Other Area Hospitals: 8
Medically Underserved Areas or Populations: Yes

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

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. 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 Needs Index (CNI) Map



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

Zip Code	CNI Score	Population	City	County	State
93241	4.8	18020	Lamont	Kern	California
93263	4.6	21166	Shafter	Kern	California
93268	4.8	19280	Taft	Kern	California
93301	5	12531	Bakersfield	Kern	California
93304	5	49957	Bakersfield	Kern	California
93305	5	37640	Bakersfield	Kern	California
93306	4.6	68539	Bakersfield	Kern	California
93307	5	90052	Bakersfield	Kern	California
93308	4.2	55501	Bakersfield	Kern	California
93309	4.4	58195	Bakersfield	Kern	California
93311	3.2	46794	Bakersfield	Kern	California
93312	2.4	61889	Bakersfield	Kern	California
93313	4	49548	Bakersfield	Kern	California

Implementation Strategy Development Process

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

Community Health Needs Assessment Process

The most recently completed CHNA was adopted by the Memorial Hospital Board of Directors in April, 2016. The Community Health Needs Assessment process was overseen by the Kern County Community Benefit Collaborative. The Collaborative is comprised of Delano Regional Medical Center, Dignity Health (Mercy and Memorial Hospitals), Kaiser Permanente, and San Joaquin Community Hospital. Secondary data was collected from a variety of local, county, and state sources to present community demographics; social, economic and environmental factors; health access; maternal and infant health; leading causes of death; chronic disease; health behaviors; sexually transmitted infections; and mental health and substance abuse. Analysis of secondary data included an examination and reporting of health disparities for some health indicators. The report includes benchmark comparison data that measures Memorial data findings with Healthy People 2020 objectives. For the CHNA, information was obtained through a community survey, interviews with key community stakeholders, public health, service providers, members of medically underserved, low-income, and minority populations in the community and individuals or organizations serving or representing the interests of such populations.

Memorial Hospital makes the CHNA and its companion Implementation Strategy widely available to the public and welcomes comments on them. The CHNA report is available to the public on the hospital's website and a paper copy is available for inspection upon request at the Memorial Hospital Administrative Office. Written comments on this report can be submitted to the Memorial Hospital Administration Office at 420 34th Street, Bakersfield, California, 93301or on the website at http://www.dignityhealth.org/bakersfieldmemorial/dignity-health-in-kern-county/community-programs/community-benefit-report. Public comment was requested on the previous CHNA and Implementation Strategy. All written comments were reviewed and, where appropriate, are included in the CHNA.

CHNA Significant Health Needs

The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process helped to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, and ascertain community assets to address needs.

The following criteria were used to identify significant health needs:

1. The size of the problem (relative portion of population afflicted by the problem)
2. The seriousness of the problem (impact at individual, family, and community levels)

To determine size and seriousness of the problem, health indicators identified in the secondary data were measured against benchmark data, specifically California rates and Healthy People 2020 objectives, where available. Health indicators that performed poorly against one or more of these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources (interview and survey participants) were asked to identify and validate community and health issues; information gathered from these sources helped determine significant health needs.

Significant Health Needs

The following significant health needs were determined:

- Access to care – Health insurance coverage is considered a key component to accessing health care including regular primary care, specialty care and other health services that contributes to one's health status. In Kern County, 90.9% of residents are insured; however, there remain many barriers to accessing care. (*Source: California Health Interview Survey, 2014.)*
- Asthma – In Kern County 9.4% of the population has been diagnosed with asthma. (*Source: California Health Interview Survey, 2014.)* Asthma is a chronic disease and without proper disease management those that suffer with asthma have higher hospitalization and ER usage. (*Source: California Office of Statewide Health Planning & Development, 2014.)* Poor air quality in Kern County has been identified as an asthma trigger.
- Cancer – death rates for respiratory cancer are significantly higher in Kern County than in the state. (*Source: California Cancer Registry, Cancer Surveillance Section, California Department of Public Health, 2009-2013.)* Environmental factors such as pesticides and herbicides found in Kern County are identified as a potential cause of cancer. Many cancers are preventable by reducing risk factors such as: use of tobacco products, physical inactivity and poor nutrition, obesity, and ultraviolet light exposure. *(Source: Healthy People 2020.)*
- Cardiovascular disease – Cardiovascular disease includes conditions that impact the heart and vascular system. Conditions may include heart disease, stroke, high blood cholesterol and high blood pressure. For adults in Kern County, 9.4% have been diagnosed with heart disease and 40.3% of adults have been diagnosed with high blood pressure. (*Source: California Health Interview Survey, 2014.)* Kern County has high rates of hospitalization for Congestive Heart Failure. (*Source: California Office of Statewide Health Planning & Development, 2014.)*
- Dental health – Lack of access to dental health care can contribute to poor health status. 23% of children in Kern County have never been to the dentist. Community residents identify the need for more dental care resources. (*Source: California Health Interview Survey, 2007 & 2014.)*
- Diabetes – Diabetes is a costly chronic condition that can lead to disability, loss of productivity and premature death. 13.5% of adults have been diagnosed with pre-diabetes and 10.3% are diagnosed with diabetes. (*Source: California Health Interview Survey, 2014.)* Adults in Kern County have high rates of

hospitalization for complications of diabetes. (*Source: California Office of Statewide Health Planning & Development, 2014.)* Lack of physical activity and poor eating habits are contributors to diabetes.

- Environmental health (air quality and water safety) – The county experiences high amounts of air and water pollution from agricultural activities. (*Source: U.S. Environmental Protection Agency, Toxics Release Inventory Program, 2014.)* Coccidioidmycosis or Valley Fever is an illness caused by a fungus found in the soil. Kern County has high rates of Valley Fever. (*Source: California Department of Public Health, Center for Infectious Disease, Yearly Summaries of Selected General Communicable Diseases in California, 2011 – 2014.)*
- Lung disease – Chronic Lower Respiratory Disease is the third highest cause of death in Kern County and exceeds the state death rate. (*Source: California Department of Public Health, 2013.)* One contributing factor to lung disease is smoking. In the county, 10.1% of adults and 12.5% of teens smoke cigarettes. (*Source: California Health Interview Survey, 2014.)*
- Maternal and infant health – there were 12,712 births in Kern County in 2013, 66% of births were to Latinas. Kern County has high rates of teen births (10.9%) and infant deaths (7.0 per 1,000 live births). (*Source: California Department of Public Health, 2013.)* Community stakeholders noted Kern County has the highest rates of teen pregnancy in the state and higher rates of infant mortality among African Americans.
- Mental health – In Kern County, 17.1% of adults experienced serious psychological distress in the past year. 26.8% of adults received insufficient social and emotional support. Community stakeholders identified an ongoing stigma associated with having mental health issues. (*Source: California Health Interview Survey, 2014.)* A lack of mental health resources was identified as a barrier to accessing care in Kern County.
- Overweight and obesity – Being overweight is a precursor to many chronic diseases. In Kern County, 24.2% of the adult population reported being overweight, lower than the state (36.2%). 15.6% of teens and 18.2% of children in the county are overweight. Over half of county adults (50.4%) are obese. Adult overweight and obesity (combined) by race and ethnicity indicate rates among Latinos (87.7%) and Whites (75.9%) are higher than in the state. (*Source: California Health Interview Survey, 2014.)*
- Sexually Transmitted Infections – Rates of chlamydia and gonorrhea are higher in the county than found in the state. Community experts identified increasing rates of HIV among African American women and syphilis among pregnant women who had no prenatal care. (*Source: California Department of Public Health, 2014.)*
- Substance abuse (alcohol, drug, tobacco use) – Binge drinking among adults and teens in Kern County exceed the state rate. 10.1% of adults and 12.5% of teens smoke cigarettes. (*Source: California Health Interview Survey, 2014.)* Community stakeholders noted the increased rates of drug use in the county. Substance abuse was associated with mental illness and violence.

Significant Health Needs the Hospital will Address

The Kern County Community Benefit Collaborative hosted a community forum on January 19, 2016 in Bakersfield to prioritize the significant health needs. The forum engaged 38 community leaders in public health, government agencies, schools, and nonprofit organizations that serve the medically

underserved, low-income, and minority populations in the community. A review of the significant health needs was presented at the community forum.

The forum attendees were engaged in a process to prioritize the health needs using the Relative Worth method. The Relative Worth method is a ranking strategy where each participant received a fixed number of points they assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels).

The community input yielded this prioritized list of significant health needs:

1. Overweight and obesity
2. Mental health
3. Access to care
4. Diabetes
5. Cardiovascular disease
6. Substance abuse
7. Asthma
8. Maternal and infant health
9. Cancer
10. HIV/AIDS/STD
11. Oral health
12. Environmental health

After the community forum prioritized the health needs, the Director of the Department of Special Needs and Community Outreach convened a half-day meeting with the Department's program leaders. The staff used the following criteria to determine the significant health needs that Memorial Hospital will address in the Implementation Strategy:

- Organizational Capacity: Is there capacity to address the issue?
- Existing Infrastructure: Are there programs, systems, staff and support resources in place to address the issue?
- Established Relationships: Are there established relationships with community partners to address the issue?
- Ongoing Investment: Are there existing resources that are committed to the issue? Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: Have competencies and expertise been acknowledged to address the issue? Does the issue fit with the organizational mission?

After a thorough process that applied these criteria to the identified significant health needs, Memorial Hospital selected the following needs to address:

- Overweight and obesity
- Access to health care
- Chronic diseases
    - Asthma/lung disease
    - Cancer
    - Cardiovascular disease
    - Diabetes
- Basic needs services

Significant Health Needs the Hospital will Not Address

Taking existing hospital and community resources into consideration, Memorial Hospital will not directly address the remaining health needs identified in the CHNA including: dental health, environmental health, maternal and infant health, mental health, sexually transmitted infections and substance abuse. Memorial Hospital cannot address all the health needs present in the community; therefore, it will concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise.

Creating the Implementation Strategy

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

- **Focus on Disproportionate Unmet Health-Related Needs**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Emphasize Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Contribute to a Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Build Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Demonstrate Collaboration**: Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.

Planning for the Uninsured/Underinsured Patient Population

Memorial Hospital seeks to deliver compassionate, high quality, affordable health care and to advocate for those who are poor and disenfranchised. In furtherance of this mission, the hospitals offer financial assistance to eligible patients who may not have the financial capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language

summary of the hospitals' Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY16 is listed in the Economic Value of Community Benefit section of this report on page 32.

Memorial Hospital notifies and inform patients about the Financial Assistance Policy by offering a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process. At the time of billing, each patient is offered a conspicuous written notice containing information about the availability of the Policy.

Notice of the financial assistance program is posted in locations visible to the public, including the emergency department, billing office, admissions office, and other areas reasonably calculated to reach people who are most likely to require financial assistance from the hospital. The hospital provides brochures explaining the financial assistance program in registration, admitting, emergency and urgent care areas, and in patient financial services offices.

The Financial Assistance Policy, the Financial Assistance Application, and plain language summary of the Policy are widely available on the hospitals' web site, and paper copies are available upon request and without charge, both by mail and in public locations of the hospital. Written notices, posted signs and brochures are printed and available online in appropriate languages.

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

2016-2018 Implementation Strategy

This section presents strategies, programs and initiatives that Memorial Hospital intends to deliver, fund or collaborate with others to address the selected significant community health needs over the next three years. It includes summary descriptions, anticipated impacts, planned collaboration, and detailed "program digests" on select initiatives. The strategy specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

Strategy and Program Plan Summary

The following programs and initiatives address the significant health needs the hospital has chosen to address.

Access to Health Care

- **Financial Assistance** provides financial assistance through both free and discounted care for health care services, consistent with the hospital's financial assistance policy. During the past three years (FY13, FY14, FY15), Memorial Hospital provided over 403,000 persons with $52 million in financial assistance.
- **Breast Health Program** provides qualifying individuals who are poor and uninsured with a mammogram free of charge for preventive health care and when necessary, a breast ultrasound or a breast needle biopsy.
- **Community Health Initiative (CHI)** increases access to health insurance and health care for hard to reach individuals in Kern County. To assist in this effort, CHI collaborates with over 50 social service and health care organizations, community groups and agencies throughout Kern County. CHI provides training for application assistance and educates families on the importance of preventive care.
- **Homemaker Care Program** provides needed access to care for the frail elderly and disabled adults by helping them live independently for as long as possible. The Homemaker Care Program provides in home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients. This program also provides job training to unemployed individuals by helping them learn marketable skills and transition into the work force.
- **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.

Chronic Diseases

- **Community Wellness Program** provides community health education and in-home health education on a variety of prevention and treatment topics. Support groups are available for individuals with chronic diseases and their family members or caregivers. Health screenings for

cholesterol, blood pressure, blood sugar, and skin cancer are provided at a number of community sites, health fairs and community events. The Kitchen Classroom, located at the Community Wellness Center, provides participants with a "hands-on" classroom learning experience. Classes provide participants with an educational lecture, along with a "hands-on" cooking demonstration and food sampling. Classroom topics include: basic nutrition education, diabetic nutrition education, chronic disease management, as well as, classes for specialty populations. Classes are provided in English and Spanish typically lasting 90 minutes, comprising of a 45 minute lecture and a 45 minute cooking demonstration.

- **Chronic Disease Self-Management Program/Diabetes Self-Management Program** provides patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. The Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Program (DSMP), established by the Stanford School of Medicine, are part of a comprehensive program we call Empowerment. Each program seminar consists of six weekly classes covering a variety of topics including nutrition, exercise, use of medications, and evaluating new treatments.
- **Asthma Management Project** provides asthma education to individuals and small groups throughout the county. Education is supported by state-of-the-art technology that monitors a client's usage of both rescue and controller medications. This technology also notifies project educators when direct intervention is needed to help a client avoid an asthma crisis. The program partners with Kern Health Systems, Propeller Health the American Lung Association and several local community organizations to achieve its goals.
- **Smoking Cessation Program** offers Freedom From Smoking®, an eight session seminar, to help encourage participants to work on the process and problems of quitting, both individually and as part of a group.

Overweight and Obesity

- **In-Home Health Education** provides personalized in-home health education and monitoring on topics including nutrition, diabetes and hypertension.
- **Health Education and Screenings** provides health education on a variety of prevention and treatment topics. Health screenings for blood pressure, blood sugar, and BMI are provided at a number of community sites, health fairs and community events.
- **Healthy Kids in Healthy Homes** addresses the issue of childhood obesity through 8 seminar sessions for children. The program provides information on the topics of nutrition, exercise, and lifestyle. The program takes place at various schools throughout Kern County for children in 4th, 5th and 6th grades.

Basic Needs Services

- **Learning and Outreach Centers** provides basic need services to residents living in economically depressed neighborhoods of southeast Bakersfield. In collaboration with other community service agencies, the centers provide referral services, food, clothing, shelter, and education to the most vulnerable and needy residents of the community. After school programs

at the centers provide tutoring support five days a week to underserved youth. Services are provided in English and Spanish.

- **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.

Anticipated Impact

The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact and address the underlying causes of persistent health problems through health promotion and disease prevention. The Community Benefit Committee, hospital executive leadership, Board of Directors, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health programs by conducting Community Health Needs Assessments every three years.

Planned Collaboration

The Department of Special Needs and Community Outreach regularly collaborates with more than 100 community organizations and agencies to address the health needs of the community. Working collaboratively with community partners, the hospital provides leadership and advocacy, stewardship of resources, assistance with local capacity building, and participation in community-wide health planning. Employees of the Department of Special Needs and Community Outreach are members of a variety of collaborative committees throughout Kern County including the Kern County Promotoras Network, Kern Comprehensive Cancer Awareness Partnership and Kern County Needs Assessment Committee. Hospital employees serve on a number of different boards or committees that respond to a variety of community concerns including the Mercy Cancer Committee, Alzheimer's Association of Central California, Asthma Coalition of Kern County, Domestic Violence Advisory Council of Kern County, and Kern County Homeless Collaborative. Our participation as a collaborative partner provides an opportunity to share information, resources and ideas, solve problems, identify options, and evaluate the success of our efforts.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs identified in the most recent CHNA report.

Community Wellness Program	
Significant Health Needs Addressed	✓ Overweight and Obesity ✓ Access to Care ✓ Diabetes ✓ Cardiovascular Disease ✓ Asthma ✓ Cancer ❑ Basic Needs Services
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
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 and treatment for cancer, cardiovascular disease, asthma, overweight and obesity, and smoking cessation.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops A1-c Community Health Education - Individual health ed. for uninsured/under insured A2-d Community Based Clinical Services - Immunizations/Screenings
Planned Actions for 2016 - 2018	
Program Goal / Anticipated Impact	Increase access to preventive health services and reduce the impact of chronic diseases on health.
Measurable Objective(s) with Indicator(s)	• Provide 33,000 blood pressure, cholesterol, glucose, and BMI screenings throughout Kern County. Eighty percent of clients who attend seven or more screenings will see improved health screening results. • Provide 900 flu immunizations for residents of Kern County. • Provide 10,500 clients with health education through in-home visits and classes/seminars including Empowerment-Chronic Disease and Diabetes. • A representative random sample of clients educated will be selected, to determine effectiveness of in-home and classroom health education. Ninety-five percent will report increased knowledge on the importance of living a healthy lifestyle. • Eighty-five percent of children who attend six of the eight classes in Healthy Kids in Healthy Homes will demonstrate improved physical fitness. • Maintain 20 clients in the Asthma Program pilot project. Seventy percent of the clients will demonstrate a reduction in rescue inhaler usages.

Intervention Actions for Achieving Goal	1. Provide 175 Community Health Education classes that focus on the following community priorities – Obesity, Diabetes, Asthma, and Cardiovascular Disease. 2. Add 5 new locations for Community Health Education classes. 3. Further develop collaborative relationships with community based providers to provide health education throughout Kern County. 4. Identify and implement health education opportunities for specialty populations. 5. Provide 26 cooking classes through the Kitchen Classroom. 6. Provide nutrition education to participants in the National Youth Sports Program. 7. In coordination with community partners, host events at the Community Wellness Center.
Planned Collaboration	Our programs will continue to collaborate with dozens of local community organizations to achieve our goals, including community health centers, public health, social services, school districts, and other private and public stakeholders. Some of the program's major partners include: California State University Bakersfield, Women Infants and Children Program, school districts, health care providers, health plans, and family resource centers.

Chronic Disease Self-Management/Diabetes Programs	
Significant Health Needs Addressed	✓ Overweight and Obesity ✓ Access to Care ✓ Diabetes ✓ Cardiovascular Disease ✓ Asthma ✓ Cancer ❑ Basic Needs Services
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The Chronic Disease Self-Management Programs (Empowerment -Chronic Disease and Empowerment -Diabetes) are designed for persons who have diabetes and other chronic illnesses to provide 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, communication with doctors, stress management, and evaluating new treatments.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops
Planned Actions for 2016 - 2018	
Program Goal / Anticipated Impact	Evidence-based chronic disease self-management (CDSM) programs will decrease hospital admissions and ER use for persons with diabetes and Congestive Heart Failure.
Measurable Objective(s) with Indicator(s)	• Provide 25 Empowerment-Chronic Disease and Empowerment-Diabetes seminars in those areas of Kern County with a Community Need Index (CNI) score of 3 or higher to ensure that underserved persons throughout the county have access to the seminars. • 85% of all participants with chronic diseases who complete Empowerment-Chronic Disease and Empowerment-Diabetes seminars will decrease admissions to the hospital or emergency department for the three months following their participation in the program. • Provide 5 new locations in Kern County for Empowerment-Chronic Disease and Empowerment- Diabetes Seminars in order to expand our services.
Intervention Actions for Achieving Goal	1. Offer seminars that are six weeks in length that target persons with diabetes and other chronic diseases. 2. Focus seminars on the uninsured and populations who qualify for publicly funded health care plans. 3. Engage clinical health professionals and health plan providers to guide program improvement. 4. Encourage and support continuing education for leader development to ensure the Empowerment Self-Management Programs provide quality service.

Planned Collaboration	Our program will continue to collaborate with over a dozen 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, and family resource centers.

Community Health Initiative	
Significant Health Needs Addressed	❑ Overweight and Obesity ✓ Access to Care ❑ Diabetes ❑ Cardiovascular Disease ❑ Asthma ❑ Cancer ❑ Basic Needs Services
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
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 (CECs) 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
Planned Actions for 2016 - 2018	
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)	• 6,500 individuals will learn about available health insurance coverage options. • 1,500 individuals will receive education about health insurance coverage and the importance of preventive care. • 600 individuals will be enrolled in Medi-Cal or Covered California. • 100% of clients assisted with health insurance enrollment will 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 10 trainings to Certified Application Assisters (CACs) to maintain a strong county-wide network of assisters. • Participate in 120 health outreach activities throughout Kern County. • Offer 30 health education events/workshops in partnership with school districts, community-based organizations and Promotoras.

Intervention Actions for Achieving Goal	1. Partner with school districts and community-based organizations to encourage client referrals for health insurance enrollment assistance and advocacy. 2. Hold health insurance enrollment events in outlying areas of Kern County. 3. Meet monthly with agency representatives to coordinate county-wide outreach, enrollment and education efforts. 4. Review "Path to Good Health" booklet with every client who receives application assistance to help them understand programs and coverage. 5. Make follow-up utilization calls to those individuals who are assisted with health insurance enrollment. 6. Coordinate the Outreach, Enrollment, Retention and Utilization Committee (OERUC). 7. Coordinate quarterly Certified Application Counselor (CAC) network meetings. 8. Survey CACs for training needs and develop appropriate trainings.
Planned Collaboration	Our program will continue to collaborate with dozens 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.

Homemaker Care Program	
Significant Health Needs Addressed	❑ Overweight and Obesity ✓ Access to Care ❑ Diabetes ❑ Cardiovascular Disease ❑ Asthma ❑ Cancer ✓ Basic Needs Services
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The Homemaker Care Program provides a two-week comprehensive employment readiness skills training focusing on individuals transitioning from unemployment into the workforce. Participants are trained to offer competent and reliable services to the ever growing senior population. The Homemaker Care Program provides in-home supportive services to seniors ages 65 and older, as well as adults with disabilities. Case management of the seniors is conducted in the form of wellness checks and home visits to assess client safety, nutrition, and program satisfaction.
Community Benefit Category	E3-d In-kind Assistance - Basic services for individuals F5-c Leadership Dev/Training for Community Members - Career development
Planned Actions for 2016 - 2018	
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 of 100% of clients. • Maintain or increase client satisfaction rates to 90% for excellence in quality and dignity of service received. • Conduct twelve, two-week training sessions with a target of 96 graduates. • Assist 100% of graduates to create a professional, useful and impactful resume. • Improve skill, knowledge and confidence levels of 100% of graduates.
Intervention Actions for Achieving Goal	1. 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. 2. Provide services to increase access to care for vulnerable seniors and disabled clients. 3. Link underserved clients to needed health care and social service resources. 4. Pursue grant funds for a Virtual Dementia Tour training package to enhance both our training program and client experience. 5. Collaborate with other organizations to identify candidates for the program.
Planned Collaboration	Collaboration with many community-based organizations is essential to our ultimate success. Our programs will continue to work with: Alzheimer's Disease Association of Kern County, Garden Pathways, Kern Senior Network, UC Cal Fresh, and Centre for Neuro Skills.

Basic Needs Services	
Significant Health Needs Addressed	❑ Overweight and Obesity ❑ Access to Care ❑ Diabetes ❑ Cardiovascular Disease ❑ Asthma ❑ Cancer ✓ Basic Needs Services
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
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	A1-a Community Health Education - Lectures/Workshops A3-g Health Care Support Services - Case management post-discharge E3-a In-kind Donations – Food E3-c In-kind Donations - Clothing/gifts E3-d In-kind Assistance - Basic services for individuals
Planned Actions for 2016 - 2018	
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)	• 30,000 individuals will be assisted with basic living necessities. • 75% of the students who participate in the Homework Club and After School Club will achieve a grade point average of 2.5 or above. • 4,000 participants will take part in programs at the Art and Spirituality Center. • 90% of Art and Spirituality Center participants will: o Experience a release of stress and anxiety after completing a workshop. o Feel that the Center environment allowed them to relax.

Intervention Actions for Achieving Goal	1. The Learning and Outreach Centers will provide basic need services to vulnerable residents living in underserved neighborhoods of southeast Bakersfield. In collaboration with other community service agencies, the centers will provide: referral services, food, clothing, shelter, and education. 2. The Learning and Outreach Centers will offer after school programs that provide tutoring support to underserved youth. Services are provided in English and Spanish. 3. The Art and Spirituality Center will offer programs in the following classifications: o Contemplative and reflective o Drawing and painting o Handmade creations o Music and movement o Writing and poetry
Planned Collaboration	Collaboration with many community-based organizations is essential to our ultimate success. Among the major collaborators, are: Clinica Sierra Vista, Tevis Jr. High School, Bakersfield City School District, Golden Empire Gleaners, St. Philip Apostle Church, Greenfield Family Resource Center, Community Action Partnership of Kern, Flood Ministries, Love Inc., The Hope Center, Bethany Homeless Shelter, Bakersfield Rescue Mission, Hoffman Hospice, Valley Achievement Center, Bakersfield Association for Retarded Citizens, Recovery Innovations Freise Hope House, Action Family Counseling, Housing Authority of Kern County.

APPENDIX A: BOARD OF DIRECTORS AND COMMITTEE ROSTERS

Dignity Health – Bakersfield Memorial Hospital
Board of Directors
2016

1. Robert Noriega, *Chair*

2. Stephen T. Clifford, *Vice Chair*

3. Brad Hannink, *Secretary/Treasurer*

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

5. Kurt Finberg, MD

6. John R. Findley, MD

7. Donald McMurtrey

8. Morgan Clayton

9. Bruce Peters, President - Mercy Hospitals of Bakersfield

10. Javier Miro, MD

11. Stephen Helvie, MD

12. Sandra Serrano

13. Susie Small

Mercy and Memorial Hospitals
Department of Special Needs and Community Outreach

Community Benefit Committee
Membership

Justin Cave, Executive Director, Advanced Center for Eyecare

Morgan Clayton, President, Tel-Tec Security

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

Tom Corson, Executive Director, Kern County Network for Children

Rita Flory, Community Benefit Coordinator, Mercy & Memorial Hospitals

Mikie Hay, Director of Community Affairs, Jim Burke Ford

Tyler Hedden, COO, Mercy Hospitals of Bakersfield

Della Hodson, President, United Way Kern County

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

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

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

Gloria Morales, Services Coordinator, Mercy Services Corp.

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

Genie Navarro, Property Manager, Mercy Services Corp.

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

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

Leonardo Ruiz, Vice President, General Manager/Director of Sales, Univision Communications Inc.

Sandra Serrano, Chancellor, Kern Community College District

Bhavna Sharma, Lead Coordinator, Global Family Care Network

Joan Van Alstyne, Director, Quality Improvement, Mercy Hospitals of Bakersfield

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

Jonathan Webster, Executive Director, Brotherhood Alliance

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

Partnering with others who share our vision and values is necessary to bring about real and lasting improvements in the health care system and the health of those we serve. Dignity Health's Community Grants Program is one way we are working collaboratively to increase access to quality care and improve the social determinants of health. Dignity Health grant funds are to be used to deliver services to and improve the health and well-being of underserved populations (e.g., economically poor, women and children, mentally or physically disabled, at-risk minority, or other disenfranchised populations).

From 2013-2015, Mercy and Memorial Hospitals contributed more than $810,000 in grant funds to community organizations that worked to increase access to health care, improve chronic disease management, and provide services for the poor.

Examples of programs receiving grant funds include:

- Westside Resource Center increased access to health care and family sustainability by providing prescription medications, transportation to medical services, lice treatment kits, car seats and safety supplies for infants, basic needs, and health and safety information for underserved children, and disenfranchised adults living in rural communities on the West Side of Kern County.
- Advanced Center for Eyecare provided eye exams and glasses for children in Kern County. Eye exams were provided in partnership with the Bakersfield City School District and the OneSight Vision Van. Children identified as needing follow up or more comprehensive exams were referred to the ACE facilities and provided specialized screening by the Ophthalmologists. Family members who were at risk of losing their vision or need preventive care were referred for counseling and services.
- Garden Pathways is a neighborhood transformation program that provided opportunities for the poor and transients residing in zip codes 93301, 93305, and 93308 to build productive lives and lead their families to educational advancement, employment, family stability, self-sufficiency, healthy living, and improved quality of life. The following priorities were addressed: neighborhood cleanup, street outreach to the homeless, literacy and GED education, job training, mentoring, referral to support services, building caring and trusting relationships and life skills education. Kern Adult Literacy Council assessed all residents who entered the program to determine their educational levels. They also offered tutors to teach adult basic education and help individuals obtain their GEDs. Westec provided participants with general industry recognized training and certification that leads to employment in agriculture, oil, or general labor.

Making a Difference

The community programs offered by Mercy and Memorial Hospitals have a very real impact on vulnerable community residents of Kern County. These examples illustrate our support for the community and the positive impact of our community benefit initiatives.

Chronic Disease Self-Management Program/Diabetes Self-Management Program: During a follow-up call to a participant of the Diabetes Self-Management Seminar, Program Specialist Luz was able to hear about the positive impact the class had on a woman who was caring for her diabetic husband. The wife now uses the textbook she received during the class to determine the amount of carbohydrates and fiber in the food that she is preparing and can make healthy food choices. Prior to the seminar her husband's blood sugar levels were typically near 400. Now, his levels are routinely between 150 and 200.

Community Health Initiative of Kern County (CHI): During an enrollment event, one of our Certified Enrollment Counselors was able to enroll a 50-year old woman who wasn't qualified for health benefits through her work since she worked part-time. She had immediate health needs that required medical testing, but she was uninsured and used a large portion of her income to pay for her daughter's college education. With the help of our counselor, she was able to qualify for premium assistance through Covered California and made an appointment with a primary care physician.

Community Wellness Program: Recently, Health Educator Coordinator Angelica saw a former participant from a nutrition class at the grocery store. The participant spoke of how the class changed her eating habits and she lost 15 lbs. She was so grateful that the class taught her how to make changes to live a healthier lifestyle.

Homemaker Care Program: The Homemaker Care program has enabled two elderly sisters, Wanda and Linda, who have lived with each other their entire lives, to remain together in their home. Prior to the Homemaker Care Program, they were desperately in need of care, but were too afraid of being separated to ask for help. Now, they have a caregiver they trust. She prepares their favorite meals and provides them soothing manicures for their severely arthritic hands.

APPENDIX C: 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 200% 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 200-350% 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.