Dignity Health
Memorial Hospital

Memorial Hospital
Bakersfield, California

Community Benefit 2017 Report and 2018 Plan

A message from

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

Dignity Health's comprehensive 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 the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital with community partners, and investing in efforts that address social determinants of health.

Memorial Hospital shares a commitment to improve the health of our community, and delivers programs and services to achieve that goal. The Community Benefit 2017 Report and 2018 Plan describe 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 produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. 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 2017 (FY17), Memorial Hospital provided $49,032,368 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $16,268,197 in unreimbursed costs of caring for patients covered by Medicare.

Dignity Health's Memorial Hospital Board of Directors reviewed, approved and adopted the Community Benefit 2017 Report and 2018 Plan at its October 25, 2017 meeting.

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

Jon Van Boening
President/CEO

Robert Noriega
Chairperson, Board of Directors

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Dignity Health Memorial Hospital serves all of Kern County, including Bakersfield and outlying rural communities. The population of Kern County is 896,142. In the county, 29.1% of the population is children, ages 0-17. 60.3% of the population is adults and 10.6% are seniors. Poverty rates in the county (22.9%) are higher than for California (15.9%). Of the population aged 25 and over, 26.08% do not have a high school diploma. On a positive note, rates of health insurance coverage are increasing. Health insurance coverage for children has increased from 90.6% in 2011 to 97.6% in 2016. *(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 https://www.dignityhealth.org/central-california/locations/memorial-hospital/about-us/community-benefit-report-health-needs-assessment. 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

Memorial Hospital took numerous actions to help address identified needs throughout FY17. These included:

- Community Wellness Program
- Chronic Disease Self-Management Programs
- Community Health Initiative
- Homemaker Care Program
- Learning and Outreach Centers
- Art and Spirituality Center

In FY17, Memorial Hospital contributed $319,343 in grant funds to community organizations that worked to increase access to health care, improve chronic disease management, and provide services for the poor.

For FY18, the hospital plans to:

- Establish a youth program for highly motivated low-income students (7^{th} – 12^{th} grade) whose goals are to attend a university or college in the future.
- Establish a rapid response team "Hospital to Home Stat" within the existing Homemaker Care Program to essentially eliminate the current expense to external resources for like-services.

A full listing of the programs and activities to meet the selected health needs is outlined in the following report.

The economic value of community benefit provided by Memorial Hospital in FY17 was $49,032,368, excluding unpaid costs of Medicare in the amount of $16,268,197.

The report is available to the public on the hospital's website at: https://www.dignityhealth.org/central-california/locations/memorial-hospital/about-us/community-benefit-report-health-needs-assessment. A paper copy is available for inspection upon request at the Memorial Hospital's Administrative Office. Written comments on this report can be submitted to the Memorial Hospital's Administration Office at 420 34^{th} Street, Bakersfield, California, 93301 or by e-mail to Felicia.Corona@DignityHealth.org.

MISSION, VISION AND VALUES

Memorial Hospital is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

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.

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. 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. Memorial Hospital is home to the Sarvanand Heart and Brain Institute with Kern County's first Bi-Plane Interventional Suite and Transcatheter Aortic Valve Replacement (TAVR) Program. In addition to its nationally recognized cardiovascular and neurological services, world-class burn care is provided through Memorial's partnership with The Grossman Burn Center. The Lauren Small Children's Center includes a Family Care and Birthing Center, a Level II NICU, the area's only Pediatric Intensive Care Unit, a 35-bed inpatient acute care unit, and the Robert A. Grimm Children's Pavilion for Emergency Services. This emergency room just-for-kids is the first of its kind between Los Angeles and Madera. Other services include the Center for Wound Care and Hyperbarics, Center for Healthy Living, robotic surgery program, oncology, orthopedics, and many more.

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 committee, hospital executive leadership, Board of Directors and Dignity Health review community benefit plans and program updates. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

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. The Department of Special Needs and Community Outreach was founded in 1991 to respond to identified unmet health-related needs in the community. The Committee provides input, advice, and approval for the Community Health Needs Assessment, Implementation Strategy, Community Benefit Plan, and program monitoring. A roster of current Community Benefit Committee members and hospital Board of Directors can be found in Appendix A.

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 based on the top zip codes that constitute 70 percent of the patient discharges from the hospital.

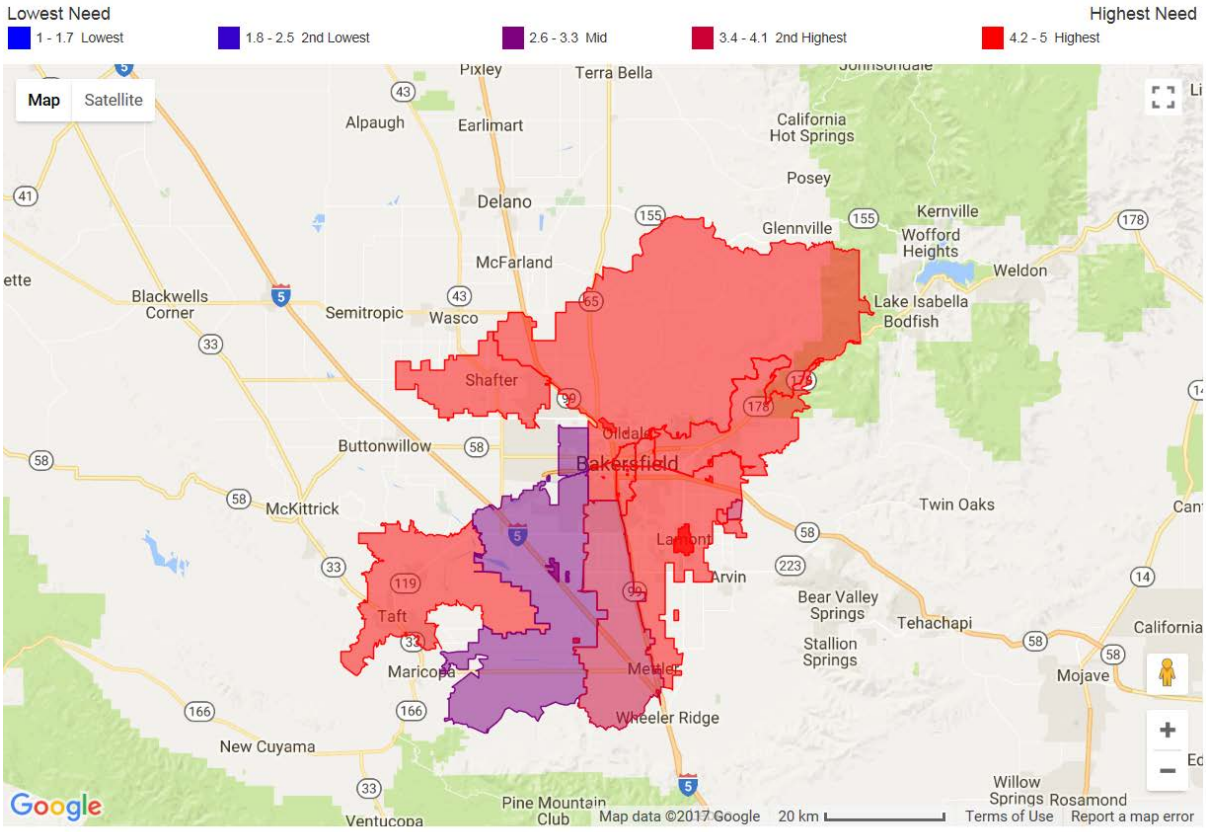
The county covers more than 8,100 square miles, geographically making it the third largest county in the state. The landscape is diverse, ranging from high desert to mountains to vast expanses of rich agricultural flatlands. Kern County consistently ranks among the top five most productive agricultural 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 is below, and additional community facts and details can be found in the CHNA report online.

The following data is from the Claritas Company and Truven Health Analytics:

Total Service Area Population: 592,122
Race: 31.9% White – Non-Hispanic, 5.4% Black/African American, 55.2% Hispanic or Latino, 4.8% Asian/Pacific Islander, 2.7 % All Others
Median Income: $54,262
Unemployment: 7.5%
No HS Diploma: 25.1%
CNI Score: 4.8
Medicaid Population*: 32.6%
Uninsured: 9.4%
Other Area Hospitals: 8
Medically Underserved Areas or Populations: Yes

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

Community Needs Index (CNI) Map



Mean(zipcode): 4.4 / Mean(person): 4.3 CNI Score Median: 4.8 CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
93241	5	18005	Lamont	Kern	California
93263	4.8	21141	Shafter	Kern	California
93268	4.8	19334	Taft	Kern	California
93301	5	12640	Bakersfield	Kern	California
93304	5	49569	Bakersfield	Kern	California
93305	5	37837	Bakersfield	Kern	California
93306	4.6	69290	Bakersfield	Kern	California
93307	5	90399	Bakersfield	Kern	California
93308	4.2	55886	Bakersfield	Kern	California
93309	4.4	58411	Bakersfield	Kern	California
93311	3.2	47715	Bakersfield	Kern	California
93312	2.6	62222	Bakersfield	Kern	California
93313	4	49673	Bakersfield	Kern	California

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 BENEFIT PLANNING 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's 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 Adventist Health. 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, primary data 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. Through the interview and survey process, community stakeholders and residents identified community resources potentially available to address the significant health needs. A list of these resources can be found on page 84 of the CHNA.

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 https://www.dignityhealth.org/central-california/locations/memorial-hospital/about-us/community-benefit-report-health-needs-assessment. 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 affected 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.

All 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, 89.4% of residents are insured; however, there remain many barriers to accessing care. (*Source: California Health Interview Survey, 2017.)*
- Asthma – In Kern County 13.2% of adults and 13.3% of children have 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.
- 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, 2013-2015.)*
- Cardiovascular disease – Conditions may include heart disease, stroke, high blood cholesterol and high blood pressure. For adults in Kern County, 7% have been diagnosed with heart disease and 31.7% of adults have been diagnosed with high blood pressure. (*Source: California Health Interview Survey, 2014.)*
- Dental health – Lack of access to dental health care can contribute to poor health status. 29.8% of children in Kern County have not had a dental visit within the past year. (*Source: California Health Interview Survey, 2014.)*
- Diabetes – Diabetes is a costly chronic condition that can lead to disability, loss of productivity and premature death. In Kern County, 10% of adults have been diagnosed with diabetes. Adults in Kern County have high rates of hospitalization for complications of diabetes. (*Source: California Health Interview Survey, 2017.)*
- 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 – Kern County has high rates of teen births (40.7 per 1,000 live births) and infant deaths (6.4 per 1,000 live births). (*Source: California Department of Public Health, 2015.)*
- Mental health – In Kern County, 14.5% of adults experienced serious psychological distress in the past year. Community stakeholders identified an ongoing stigma associated with having mental health issues. (*Source: California Health Interview Survey, 2014.)*

- Overweight and obesity – Being overweight is a precursor to many chronic diseases. In Kern County, 76.4% of the adult population reported being overweight or obese, higher than the state (62.6%). (*Source: California Health Interview Survey, 2017.)*
- Sexually Transmitted Infections – Rates of chlamydia and gonorrhea are higher in the county than found in the state. (*Source: California Department of Public Health, 2015.)*
- Substance abuse (alcohol, drug, tobacco use) – Binge drinking among adults and teens in Kern County exceed the state rate. 13.7% of adults smoke cigarettes. (*Source: California Health Interview Survey, 2015.)*

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 Community Benefit Plan

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
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

A general approach was taken when planning and developing initiatives to address priority health issues. The 2016 CHNA guided Memorial Hospital's community benefit initiatives for FY17. The 2016 CHNA will be used between now and the 2019 CHNA to actively plan programs. Department of Special Needs and Community Outreach leadership staff engaged the Community Benefit Committee to help shape initiatives and provide internal perspective on issues. Programs will be evaluated throughout the year utilizing input from our Community Benefit Committee, partners, newly published data and our own program outcome data. This approach will allow us to respond to identified needs by revising program strategies and adding enhancements on a regular basis.

The CHNA and relationships with community service organizations help us identify vulnerable populations with disproportionate unmet health needs (DUHN) that have a high prevalence or severity for a particular health concern that we can address with a program or activity.

2017 REPORT AND 2018 PLAN

This section presents strategies, programs and initiatives that Memorial Hospital delivers, funds or collaborates with others to address significant community health needs. It includes both a report on actions taken in FY17 and planned activities for FY18, with statements on anticipated impacts, planned collaboration, and patient financial assistance to address access. Program Digests provide detail on select program goals, measurable objectives, expenses and other information.

The strategy and plan 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 that Memorial Hospital has chosen to address.

Health Need: Access to Health Care			
Strategy or Activity	**Summary Description**	**Active FY17**	**Planned FY18**
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 needed access to care for frail elderly and disabled adults by helping them live independently for as long as possible. • 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.	☒	☒
Financial Assistance	• Provides financial assistance through both free and discounted care for health care services, consistent with the hospital's financial assistance policy.	☒	☒
Anticipated 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 about 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.			

Health Need: Chronic Diseases			
Strategy or Activity	**Summary Description**	**Active FY17**	**Planned FY18**
Community Wellness Program	• Provides community health education and in-home health education on a variety of prevention and treatment topics. • Health screenings for cholesterol, blood pressure, blood sugar, and skin cancer are provided at community sites, health fairs and community events.	☒	☒
Chronic Disease/Diabetes Self-Management Program	• Provides patients who have chronic diseases 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 evaluating new treatments.	☒	☒
Smoking Cessation Program	• Facilitates 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.	☒	☒
Anticipated 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 their life.			

Health Need: Overweight and Obesity			
Strategy or Activity	**Summary Description**	**Active FY17**	**Planned FY18**
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.	☒	☒
Anticipated 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.			

Health Need: Basic Needs Services			
Strategy or Activity	**Summary Description**	**Active FY17**	**Planned FY18**
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, 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.	☒	☒
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 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 begin to live a better quality of life.			

Anticipated Impact

The anticipated impacts of Memorial Hospital's activities on significant health needs are summarized above, and for select program initiatives 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 needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The local Community Benefit Committee, hospital executive leadership, Board of Directors, as well as Dignity Health System Office 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 program in triennial Community Health Needs Assessments.

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, 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. 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.

Financial Assistance for Medically Necessary Care

Memorial Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides 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. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY17 is listed in the Economic Value of Community Benefit section of this report on page 30.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials 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, California Coverage Health Initiatives, 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.

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, intervention actions, health needs that are being addressed, planned collaboration, and program goals with measurable objectives.

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 for cancer, cardiovascular disease, asthma, diabetes, overweight and obesity, and smoking cessation.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops A1-c Community Health Education - Individual health education for uninsured/under insured A2-d Community Based Clinical Services - Immunizations/Screenings
FY 2017 Report	
Program Goal / Anticipated Impact	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2017 were: • 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 Healthy Living-Chronic Disease and Diabetes Self-Management. • 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. • Enroll 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	Intervention actions: • Provide 175 Community Health Education classes that focus on the following community priorities – Obesity, Diabetes, Asthma, and Cardiovascular Disease. • Add 5 new locations for Community Health Education classes. • Further develop collaborative relationships with community based providers to provide health education throughout Kern County. • Identify and implement health education opportunities for specialty populations. • Provide 26 cooking classes through the Kitchen Classroom. • Provide nutrition education to participants in the National Youth Sports Program. • In coordination with community partners, host events at the Community Wellness Center.
Planned 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, and family resource centers.
Program Performance / Outcome	During FY 17, the Community Wellness Program accomplished the following: • Provided 34,052 blood pressure, cholesterol, glucose, and BMI screenings throughout Kern County. Eighty-two percent of clients who attend seven or more screenings saw improved health screening results. • Provided 1,300 flu immunizations for residents of Kern County. • Provided 2,293 clients with health education through in-home visits and classes/seminars including Healthy Living-Chronic Disease and Diabetes Self-Management. • A representative random sample of clients educated was selected to determine effectiveness of in-home and classroom health education. Eighty-seven percent reported increased knowledge on the importance of living a healthy lifestyle. • Seventy-one percent of children who attended six of the eight classes in Healthy Kids in Healthy Homes demonstrated improved physical fitness. • Enrolled 20 clients in the Asthma Program pilot project. Seventy-six percent of the clients demonstrated a reduction in rescue inhaler usages.
Hospital's Contribution / Program Expense	The total FY 2017 expense for the Community Wellness Program was $900,935. Of this amount, $97,259 was grant dollars, $42,787 was fee-for-service and $760,889 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, facility expenses, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program and program's clinic van, bookkeeping, and human resource support for the program.
FY 2018 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)	• Provide 35,000 blood pressure, cholesterol, glucose, and BMI screenings throughout Kern County. Seventy-five percent of clients who attend seven or more screenings will see improved health screening results. • Provide 1,000 flu immunizations for residents of Kern County. • Add two monthly Community Screening Clinics in a new rural county location. • Seventy-five percent of children who attend six of the eight classes in Healthy Kids in Healthy Homes will demonstrate improved physical fitness. • Eighty percent of participants will have a better understanding of how to live a healthy lifestyle after attending a health education class, workshop or program. • Offer 4 Freedom From Smoking® Clinics. • Plan one Cancer Education and Screening event.
Intervention Actions for Achieving Goal	Intervention actions: • Ongoing collection of health screening results in a database. • Provide 150 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 cooking classes through the kitchen classroom. • Further develop collaborative relationships with community-based organizations to provide health education throughout Kern County. • Develop educational opportunities at the Community Wellness Center in the form of classes and events.
Planned 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, and family resource centers.

Chronic Disease/Diabetes Self-Management 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 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. 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
FY 2017 Report	
Program Goal / Anticipated Impact	By offering evidence-based chronic disease self-management (CDSM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).
Measurable Objective(s) with Indicator(s)	The objectives for FY 2017 were: • Provide 25 Healthy Living-Chronic Disease and Healthy Living-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 Healthy Living-Chronic Disease and Healthy Living-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 Healthy Living-Chronic Disease and Healthy Living- Diabetes Seminars in order to expand our services.
Intervention Actions for Achieving Goal	Intervention actions were: • 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	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.
Program Performance / Outcome	During FY 17, the Community Wellness Program accomplished the following: • Provided 28 Healthy Living-Chronic Disease and Healthy Living-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 had access to the seminars. • 98% of all participants with chronic diseases who completed Healthy Living-Chronic Disease and Healthy Living-Diabetes seminars decreased admissions to the hospital or emergency department for the three months following their participation in the program. • Provided 11 new locations in Kern County for Healthy Living-Chronic Disease and Healthy Living- Diabetes Seminars in order to expand our services.
Hospital's Contribution / Program Expense	The total FY 2017 expense for the Healthy Living Self-Management Program (Chronic Disease and Diabetes) was $54,852. Of this amount, $2,500 was fee-for-service and $52,352 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, facility expenses, strategic planning, evaluation, fundraising support, educational materials, liability insurance, bookkeeping, and human resource support for the program.
FY 2018 Plan	
Program Goal / Anticipated Impact	By offering evidence-based chronic disease self-management (CDSM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).
Measurable Objective(s) with Indicator(s)	• Provide 25 Healthy Living-Chronic Disease and Healthy Living-Diabetes 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. • 85% 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 5 new locations in Kern County for Healthy Living-Chronic Disease and Healthy Living-Diabetes 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.

Planned 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.

Community Health Initiative	
Significant Health Needs Addressed	❑ Overweight and Obesity ✓ Access to Care ❑ Diabetes ❑ Cardiovascular Disease ❑ Asthma ❑ Cancer
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
FY 2017 Report	
Program Goal / Anticipated Impact	With a coalition of Kern County organizations, educate and enroll uninsured adults and children into a health insurance plan through innovative approaches.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2017 were: • 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	Intervention actions were: • Partner with school districts and community-based organizations to encourage client referrals for health insurance enrollment assistance and advocacy. • Hold health insurance enrollment 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 meetings. • Survey CACs for training needs and develop appropriate trainings.
Planned Collaboration	Our program works with several local organizations to reach the different populations residing in Kern County. Partners include: community health centers, public health, social services, school districts, community-based organizations and other private and public stakeholders.
Program Performance / Outcome	During FY 17, the Community Health Initiative Program accomplished the following: • 12,966 individuals learned about available health insurance coverage options. • 3,045 individuals received education about health insurance coverage and the importance of preventive care. • 923 individuals were enrolled in Medi-Cal or Covered California. • 100% of clients assisted with health insurance enrollment received information to increase their understanding of their coverage and how to access care. • 69% of individuals served received assistance in choosing a health plan. • 29% of clients enrolled in a health insurance plan scheduled a primary care visit within the first 6 months of enrollment. • Provided 11 trainings to Certified Application Assisters (CACs) to maintain a strong county-wide network of assisters. • Participated in 224 health outreach activities throughout Kern County. • Offered 200 health education events/workshops in partnership with school districts, community-based organizations and Promotoras.
Hospital's Contribution / Program Expense	The total FY 2017 expense for the Community Health Initiative was $327,685.00. Of this amount, $324,646.00 was grant dollars and $3,039.00 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program, bookkeeping, and human resource support for the program.

FY 2018 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)	The objectives for FY 2018 are: • 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 10 trainings to Certified Application Assisters (CACs) to maintain a strong county-wide network of assisters.
Intervention Actions for Achieving Goal	Intervention actions will be: • Partner with school districts and community-based organizations to encourage client referrals for health insurance enrollment assistance and advocacy. • Work with Promotoras to provide outreach and education. • Hold health insurance enrollment 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 meetings. • Survey CACs for training needs and develop appropriate trainings.
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.

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 three-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
FY 2017 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. • Maintain or increase client satisfaction rates to 90% for excellence in dignity and quality of service received. • Conduct four, two-week training sessions with a target of 32 graduates. • Assist 100% of graduates to create a professional, useful and impactful resume. • Improve skill, knowledge and confidence levels for100% of graduates.
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. • Pursue grant funds for a Virtual Dementia Tour training package to enhance both our training program and client experience. • 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.
Program Performance / Outcome	During FY 17, the Homemaker Care Program accomplished the following: SENIOR CARE: • Improved the quality of life for 100% of our clients. • Increased client satisfaction rates for excellence in dignity and quality of service from 89.8% to 92.6% at mid-year and further increased them to 96.6% by Fiscal year-end. TRAINING: • Conducted four 2-week training sessions • Graduated a total of 35 participants • Assisted all students to create a professional, useful and impactful resume. • Improved the skill, knowledge and confidence levels of all graduates.
Hospital's Contribution / Program Expense	During FY 2017, expenses for the Homemaker Care Program were $456,400. Of this amount, $43,313.50 was grant dollars, $224,612.50 was fee for service, and $188,474 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, human resource support, office space, fundraising support, bookkeeping, strategic planning, and evaluation support for the program.
FY 2018 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. • Maintain or increase client satisfaction rates at 90% for excellence in dignity and quality of service received. • Conduct four, three-week training sessions with a target of 32 graduates. • Assist 100% of graduates to create a professional, useful and impactful resume. • Improve skill, knowledge and confidence levels for 100% of graduates.
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 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 E3-a In-kind Donations – Food E3-c In-kind Donations - Clothing/gifts E3-d In-kind Assistance - Basic services for individuals
FY 2017 Report	
Program Goal / Anticipated Impact	Increase access to health and social services to help residents of Kern County stay healthy.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2017 were: • 30,000 individuals will be assisted with basic living necessities at the Learning and Outreach Centers. • 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 environment of the Center is comfortable and allows them to relax.
Intervention Actions for Achieving Goal	Intervention actions were: • 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.

	• The Learning and Outreach Centers will offer after school programs that provide tutoring support to underserved youth. Services are provided in English and Spanish. • 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.
Program Performance / Outcome	During FY 17, the Learning and Outreach Centers and the Art and Spirituality Center accomplished the following: • 44,339 individuals were assisted with basic living necessities at the Learning and Outreach Centers. • 76% of the students who participated in the Homework Club and After School Club achieved a grade point average of 2.5 or above. • 4,689 participants took part in programs at the Art and Spirituality Center. • 99 % of Art and Spirituality Center participants: o Experienced a release of stress and anxiety after completing a workshop. o Felt that the environment of the Center was comfortable and allowed them to relax.
Hospital's Contribution / Program Expense	The total FY 2017 expense for the Learning and Outreach Centers and the Art and Spirituality Center was $455,613. Of this amount, $73,760 was grant dollars, $3,230 was fee for service, and $378,623 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program and program's clinic van, bookkeeping, and human resource support for the program.
FY 2018 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)	• The objectives for FY 2018 are: • 40,000 individuals will be assisted with basic living necessities at the Learning and Outreach Centers. • 76% of the students who participate in the Homework Club and After School Club will achieve a grade point average of 2.0 or above. • 4,500 participants will take part in programs at the Art and Spirituality Center. • 92% of Art and Spirituality Center participants will: o Experience a release of stress and anxiety after completing a workshop. o Feel that the environment was comfortable and allowed them to relax.
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. In collaboration with other community service agencies, the centers will provide: referral services, food, clothing, shelter, and education. • The Learning and Outreach Centers will offer after school programs that provide tutoring support to underserved youth. Services are provided in English and Spanish. • 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, Center for Blind and Visually Impaired.

ECONOMIC VALUE OF COMMUNITY BENEFIT

9/28/2017
324 Bakersfield Memorial Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2016 through 6/30/2017

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses
Benefits for Living in Poverty					
Financial Assistance	1,890	1,365,550	0	1,365,550	0.3
Medicaid	67,794	169,032,740	124,489,318	44,543,422	10.9
Community Services					
A - Community Health Improvement Services	18,334	744,581	203,567	541,014	0.1
E - Cash and In-Kind Contributions	20,480	1,303,368	28,096	1,275,272	0.3
F - Community Building Activities	232	104,697	45,556	59,141	0.0
G - Community Benefit Operations	0	917,426	30,949	886,477	0.2
Totals for Community Services	39,046	3,070,072	308,168	2,761,904	0.7
Totals for Living in Poverty	108,730	173,468,362	124,797,486	48,670,876	11.9
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	6,626	152,595	6,208	146,387	0.0
B - Health Professions Education	23	16,817	0	16,817	0.0
E - Cash and In-Kind Contributions	0	161,597	0	161,597	0.0
F - Community Building Activities	359	36,691	0	36,691	0.0
Totals for Community Services	7,008	367,700	6,208	361,492	0.1
Totals for Broader Community	7,008	367,700	6,208	361,492	0.1
Totals - Community Benefit	115,738	173,836,062	124,803,694	49,032,368	12.0
Medicare	24,874	133,178,345	116,910,148	16,268,197	4.0
Totals with Medicare	140,612	307,014,407	241,713,842	65,300,565	15.9

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

APPENDIX A: BOARD OF DIRECTORS AND COMMITTEE ROSTERS

Dignity Health – Bakersfield Memorial Hospital
Board of Directors
2017

1. Robert Noriega, *Chair*

2. Brad Hannink, *Vice Chair*

3. Stephen T. Clifford, *Secretary/Treasurer*

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

5. Jared Salvo, DO

6. John R. Findley, MD

7. Donald McMurtrey

8. Morgan Clayton

9. Bruce Peters, President - Mercy Hospitals of Bakersfield

10. Javier Miro, MD

11. Sandra Serrano

12. Susie Small

Mercy and Memorial Hospitals
Department of Special Needs and Community Outreach

Community Benefit Committee
Membership

Georgina Bicknell, Nursing Director, Pediatrics & Grossman Burn Center, Bakersfield Memorial Hospital

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

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

Louie Iturriria, Director, Marketing and Public Relations, 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 and Opportunity Foundation

Leonardo Ruiz, Vice President, Univision Communications Inc.

Sandra Serrano, Community Member

Michele Shain, Senior Director, Neuro and Cariac Services, Bakersfield Memorial Hospital

Joan Van Alstyne, Director, Patient Experience, Mercy Hospitals of Bakersfield

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

Jonathan Webster, Community Member

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

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

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 and improve the health and well-being of underserved populations in Kern County (e.g., economically poor, women and children, mentally or physically disabled, at-risk minority, or other disenfranchised populations).

In FY 2017, Mercy and Memorial Hospitals contributed more than $319,343 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.
- Global Family's Daughter Project Girls Home provided crisis and intervention care for female youth who are homeless, runaway or in need of short-term shelter and care. The home served children who had been commercially sexually exploited, providing them with intensive trauma-informed services.

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.

- **Art and Spirituality Center:** Jennifer Nolen tells us that her physical mobility has suffered greatly during the recent years and it has become more and more painful to complete normal, everyday tasks. She has been a long time participant of the Art and Spirituality Center and loves to share her wonderful experience "in this sacred space." She looks forward to workshops at the Art and Spirituality Center, as they help reduce her pain, which means she can reduce her prescribed medicines. Jennifer is thankful for the creative opportunities offered at the Art and Spirituality Center because participating improves her quality of life.

- **Chronic Disease Self-Management Program/Diabetes Self-Management Program:** A group of participants, ranging in ages from 18 to 89 showed great interest in learning the information that was shared during each session of our Chronic Disease Self-Management Seminar. In particular, the 89 year old woman was excited to discover the different exercises that she can complete at home to improve her strength and flexibility. On graduation day she exclaimed, "I learned more about nutrition and exercise during these six weeks than in my 89 years." She was very grateful to Dignity Health for offering this life changing program!

- **Community Wellness Program**: *Freedom From Smoking* uses proven activities and tools to help smokers understand their relationship with tobacco and how to say good-bye to smoking for good. A married couple who had been smokers for over 20 years enrolled in the spring clinic. They decided to quit smoking as a couple and were determined to finish the clinic together. It was important for them to improve their sense of taste and smell as well as have better-smelling breath and clothes. They followed and accepted the advice given and quit smoking on March 28, 2017. To celebrate their life as non-smokers, they decided to take a cross country trip in a Recreational Vehicle. They are scheduled to present at our fall clinic as ex-smoker panelists, where they will share their experience in the program and their journey to a lifestyle free of smoking.

- **Community Health Initiative of Kern County (CHI):** Jesus has not worried about health coverage in the past since it was always a benefit provided by his employer. Unfortunately, he lost his job a few months ago along with health coverage for himself and his family. His wife has a chronic illness and depends on medications to manage her health. Jesus has only been able to purchase some of the needed medications since they are very expensive and he cannot afford all of them. He was listening to the radio one day when he heard about the Community Health Initiative Program. He contacted the program the very next day. He had no idea that his entire family could once again have health coverage through the Medi-Cal program. He can stop worrying about his family's well-being and health knowing that they are now covered.

- **Homemaker Care Program:** Dan was diagnosed with Parkinson's disease a few years back. As the disease progressed, it became more and more difficult for his wife, Linda, to care for him by herself. She contacted the Homemaker Care Program for assistance. Dan and Linda have been clients since January 2016 and they quickly chose their favorite attendant, Mildred Velez. Dan was quite a cook in years past; a favorite thing they both miss. However, "thanks to the Homemaker Care Program", Linda now gets to spend more quality time with Dan, instead of caring for him around-the-clock. Linda frequently praises her attendants and the Homemaker Care Program for helping her family.

- **Learning and Outreach Centers:** Homework Club 2nd grade student Kudrat Powar received four academic awards for her hard work and dedication at school. Kudrat is most proud of her math and English awards. At the beginning of the school year, Kudrat was having difficulties with both subjects. Fortunately, with the assistance of the Homework Club tutors and Kudrat's hard work and dedication, she has been able to overcome these academic obstacles. It is truly inspirational to watch the hard work of our students bring such positive results.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured 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 866-397-9252
www.dignityhealth.org/bakersfieldmemorial/paymenthelp