Dignity Health
Memorial Hospital

Memorial Hospital
Bakersfield, California

Community Benefit 2018 Report and 2019 Plan

Dignity Health
Memorial Hospital

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 2018 Report and 2019 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 2018 (FY18), Memorial Hospital provided $5,725,374 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $6,621,762 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 2018 Report and 2019 Plan at its October 24, 2018 meeting.

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

Jon Van Boening
President/CEO

Robert Noriega
Chairperson, Board of Directors

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EXECUTIVE SUMMARY

At-a-Glance Summary

Community Served	Dignity Health Memorial Hospital serves all of Kern County, including Bakersfield and outlying rural communities. The population of Kern County is 895,505. In the county, 28.9% of the population are children, ages 0-17. 60.2% of the population are adults and 10.9% are seniors. Poverty rates in the county (18.63%) are higher than for California (11.73%). Of the population aged 25 and over, 26.3% 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 97.7% in 2017. *(Source: U.S. Census Bureau, American Community Survey accessed from www.healthykern.org.)*
Economic Value of Community Benefit	$5,725,374 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $6,621,762 in unreimbursed costs of caring for patients covered by Medicare

Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are:
	
	• Overweight and Obesity
	• Access to Care
	• Chronic Diseases
	  o Diabetes
	  o Cardiovascular disease
	  o Asthma
	  o Cancer
	• Basic Needs Services

FY18 Actions to Address Needs	• Community Wellness Program - 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. • Chronic Disease Self-Management Programs - The Healthy Living Self-Management Programs (Chronic Disease and Diabetes) are designed for persons who have diabetes and other chronic illnesses, providing them with the knowledge, tools and motivation needed to become proactive in their health. • Community Health Initiative - The Community Health Initiative of Kern County works with more than 50 public, private and non-profit organizations to enroll individuals in health insurance programs. • Homemaker Care Program - The Homemaker Care Program provides in-home supportive services to seniors ages 65 and older, as well as adults with disabilities. • Learning and Outreach Centers - The Learning and Outreach Centers provide referral services, food, clothing, shelter, education, and after school tutoring services to the most vulnerable and needy residents of the community. • Art and Spirituality Center - The Art and Spirituality Center provides opportunities

	for artistic expression, meditation, relaxation, and creativity to improve quality of life and reduce stress.
Planned Actions for FY19	The hospital will continue its major FY18 programs which include the Community Wellness Program, Chronic Disease Self-Management Program, Community Health Initiative, Homemaker Care Program, Learning and Outreach Centers, and Art and Spirituality Centers. New program activities include the addition of the College Dream Program (Learning and Outreach Centers), the Matter of Balance Program (Community Wellness Program) and the Hospital to Home Stat Program (Homemaker Care Program).

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

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. A summary description of the community is below, and additional details can be found in the CHNA report online.

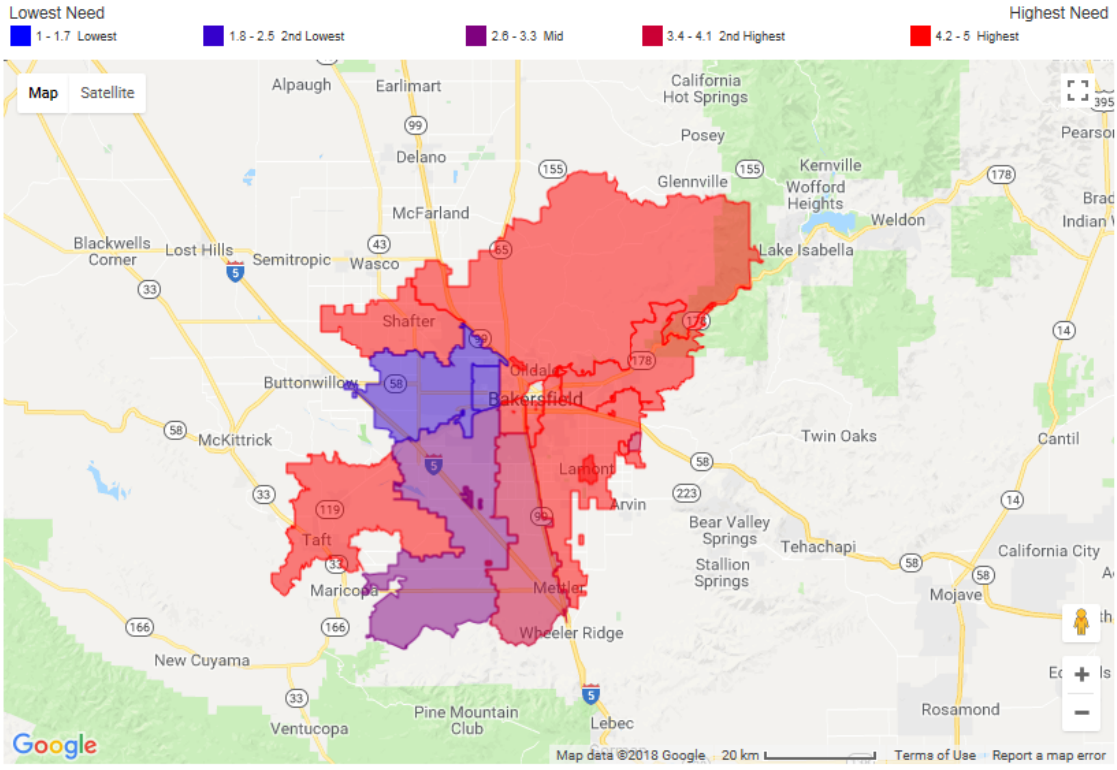
The county covers more than 8,100 square miles, geographically making it the third largest county in the state. The landscape is diverse, ranging from high desert to mountains to vast expanses of rich agricultural flatlands. Kern County consistently ranks among the top five most productive agricultural counties in the United States and is one of the nation's leading petroleum-producing counties. 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: 630,314
Race: 31.5% White – Non-Hispanic, 5.7% Black/African American, 54.4% Hispanic or Latino, 5.7% Asian/Pacific Islander, 2.7 % All Others
Median Income: $59,508
Uninsured: 10.0%

Unemployment: 6.7%
No HS Diploma: 25.3%
Medicaid Population: 37.4%

Community Needs Index (CNI) Map



Mean(zipcode): 4.1 / Mean(person): 4.1 CNI Score Median: 4.5 CNI Score Mode: 4.8,5

Zip Code	CNI Score	Population	City	County	State
93263	4.8	21178	Shafter	Kern	California
93268	4.8	19099	Taft	Kern	California
93304	5	49214	Bakersfield	Kern	California
93305	5	37569	Bakersfield	Kern	California
93306	4.6	68871	Bakersfield	Kern	California
93307	5	89941	Bakersfield	Kern	California
93308	4.2	55484	Bakersfield	Kern	California
93309	4.4	57630	Bakersfield	Kern	California
93311	3.2	47998	Bakersfield	Kern	California
93312	2.4	62182	Bakersfield	Kern	California
93313	3.8	51350	Bakersfield	Kern	California
93314	2.2	29435	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

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in April 2016.

The hospital conducts a CHNA at least every three years to inform its community health strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

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

- **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, 15.6% of adults smoke cigarettes. (*Source: California Health Interview Survey, 2016.)*
- **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. 32.7% of adults binge drink. (*Source: California Health Interview Survey, 2016.)*

Significant Health Needs the Hospital will Not Address

Taking existing hospital and community resources into consideration, Memorial Hospital will not directly address the following health needs identified in the CHNA: 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.

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

Creating the Community Benefit Plan

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, Community Board and Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

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 FY18. 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.

2018 REPORT AND 2019 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 FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance to address access. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report 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 FY18**	**Planned FY19**
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.	☒	☒
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.	☒	☒
Coordinated Care Network Initiative	• Addresses the social determinants of health and ultimately links referred patients to appropriate and needed community-based services.	☒	☒
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 (Diabetes, Cardiovascular Disease, Asthma, Cancer)			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Community Wellness Program	• Provides community health screenings, as well as health education on a variety of prevention and treatment topics.	☒	☒
Chronic Disease/Diabetes Self-Management Program	• Provides residents who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health through 6-week workshops.	☒	☒
Smoking Cessation Program	• Facilitates Freedom From Smoking®, an eight session seminar, to help encourage participants to work on the process and problems of quitting.	☒	☒
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 FY18**	**Planned FY19**
In-Home Health Education	• Provides personalized in-home health education and monitoring on topics including nutrition, diabetes and hypertension.	☒	☐
Health Education and Screenings	• 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	• The 8-session program provides information to children on the topics of nutrition, exercise, and lifestyle.	☒	☒
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 FY18**	**Planned FY18**
Learning and Outreach Centers	• In collaboration with other community service agencies, the centers provide referral services, food, clothing, and education to the most vulnerable and needy residents of the community. • After school programs at the centers provide tutoring support five days a week to underserved youth.	☒	☒
Coordinated Care Network Initiative	• Addresses the social determinants of health and ultimately links referred patients to appropriate and needed community-based services.	☒	☒

Art and Spirituality Center	• Provides opportunities for artistic expression, meditation, relaxation, and creativity to promote health and well-being, aiding in physical, mental, and emotional recovery, including relieving anxiety and decreasing the perception of pain.	☒	☒
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.			

Community Grants Program

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

In FY18, Mercy and Memorial Hospitals awarded 8 grants totaling $328,126. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Alpha House	Alpha House Shelter Program	$ 75,000
Alzheimer's Disease Association of Kern County, Inc. (ADAKC)	ADAKC Adult Day Service Education, and Community Outreach Program	$ 26,401
Bakersfield Senior Center, Inc. (BSC)	Project Access for Better Health and Prevention	$ 30,000
Catholic Charities Diocese of Fresno of Bakersfield	Healthy Food, Healthy You	$ 32,024
Community Action Partnership of Kern (CAPK)	East Kern Health Link	$ 24,701
The Leukemia & Lymphoma Society (LLS)	LLS Access to Pediatric Cancer Care Program	$ 20,000
Links for Life	Comprehensive Breast Health Program (CBHP)	$ 50,000
St. Vincent de Paul Stores and Center (SVDP)	The Homeless Assistance Program	$ 70,000

Anticipated Impact

The anticipated impacts of the 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 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

Mercy and Memorial Hospitals' 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 hospitals provide leadership, advocacy, stewardship of resources, assistance with local capacity building, and participation in community-wide health planning. 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 FY18 is listed in the Economic Value of Community Benefit section of this report on page 29.

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 website;
- 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, Mercy and Memorial Hospitals' 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.

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 2018 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 2018 were: • 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 for FY 18 were: • 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.
Program Performance / Outcome	During FY 18, the Community Wellness Program accomplished the following: • Provided 35,165 blood pressure, cholesterol, glucose, and BMI screenings throughout Kern County. 89% of clients who attended seven or more screenings saw improved health screening results. • Provided 1,200 flu immunizations for residents of Kern County. • 1 monthly Community Screening Clinic was added in new rural county locations. • 90% percent of children who attended six of the eight classes in Healthy Kids in Healthy Homes demonstrated improved physical fitness. • 98% percent of participants had a better understanding of how to live a healthy lifestyle after attending a health education class, workshop or program. • 4 Freedom From Smoking® Clinics were offered. • Provided 1 Cancer Education and Screening event took place.
Hospital's Contribution / Program Expense	The total FY 2018 expense for the Community Wellness Program was $845,607. Of this amount, $68,714 was grant dollars and $776,893 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 2019 Plan	
Program Goal / Anticipated Impact	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
Measurable Objective(s) with Indicator(s)	The objectives for FY 2019 are: • Provide 32,000 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. • Eighty percent of children who attend six of the eight classes in Healthy Kids in Healthy Homes will demonstrate improved physical fitness. • Eighty five 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 3 Freedom From Smoking® Clinics. • Plan and deliver one Cancer Education or Screening Event per quarter.
Intervention Actions for Achieving Goal	Intervention actions for FY 19 are: • 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, communicating with doctors, stress management, and evaluating new treatments.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops
FY 2018 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 2018 were: • 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	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 18, the Community Wellness Program accomplished the following: • Provided 26 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. • 100% 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 15 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 2018 expense for the Healthy Living Self-Management Program (Chronic Disease, Diabetes and Chronic Pain) was $49,748. Of this amount, $48,132 was grant dollars and $1,616 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 2019 Plan	
Program Goal / Anticipated Impact	By offering evidence-based chronic disease self-management (CDSM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).
Measurable Objective(s) with Indicator(s)	The objectives for FY 2019 are: • 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	Intervention actions FY 2019 are: • 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 2018 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 2018 were: • 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 were: • 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 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 18, the Community Health Initiative Program accomplished the following: • 997 individuals were enrolled or renewed in Medi-Cal or Covered California and received information to increase their understanding of their coverage and how to access care. • 77% of individuals served received assistance in choosing a health plan. • 42% of clients enrolled in a health insurance plan scheduled a primary care visit within the first 6 months of enrollment. • Provided 12 trainings to Certified Application Assisters (CACs) to maintain a strong county-wide network of assisters.
Hospital's Contribution / Program Expense	The total FY 2018 expense for the Community Health Initiative was $402,626. Of this amount, $327,094 was grant dollars and $75,532 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 2019 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 2019 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 6 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 outreach events in outlying areas of Kern County. • Meet monthly with agency representatives to coordinate county-wide outreach, enrollment and education efforts. • Review "Path to Good Health" booklet with every client who receives application assistance to help them understand programs and coverage. • Make follow-up utilization calls to those individuals who are assisted with health insurance enrollment.

	• Coordinate the Outreach, Enrollment, Retention and Utilization Committee (OERUC). • Coordinate quarterly Certified Application Counselor (CAC) network 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 2018 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)	The objectives for FY 2018 were: • Improve the quality of life of 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 of 100% of graduates.
Intervention Actions for Achieving Goal	Intervention actions for FY 2018 were: • 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.
Program Performance / Outcome	During FY 18, the Homemaker Care Program accomplished the following: • Improved the quality of life of 100% of clients. • Maintained or increased client satisfaction rates of 91.8% in December 2017 and 96.2% in June 2018, for excellence in dignity and quality of service received. • Conducted 4, three-week training sessions graduating 35 students. • Assisted 100% of graduates to create a professional, useful and impactful resume. • Improved skill, knowledge and confidence levels of 100% of graduates.
Hospital's Contribution / Program Expense	During FY 2018, expenses for the Homemaker Care Program were $447,915. Of this amount, $55,296 was grant dollars, $198,075 was fee for service, and $194,544 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 2019 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)	The objectives for FY 2019 are: • Improve the quality of life for 100% of clients, as measured by our FY2019 Client Impact Survey. • Obtain an overall client satisfaction rate of at least 90% for excellence in maintaining dignity and quality of service received, as compiled from the compilation of a semi-annual survey. • Conduct four, three-week training sessions with a target of 32 graduates. • Improve the knowledge, skill, and confidence level of 100% of the graduates in being prepared to seek employment in the healthcare industry, as disclosed by a post-course survey.
Intervention Actions for Achieving Goal	Intervention actions for FY 2019 are: • Collaborate with senior-related and health care related companies, organizations and public agencies to increase our ability to advocate for our clients and help all seniors advocate for themselves. • Provide services to increase access to care for vulnerable seniors and disabled clients. • Link underserved clients to needed health care and social service resources. • Collaborate with other organizations to identify candidates for the training program.
Planned Collaboration	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 2018 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 2018 were: • 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	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, Hoffmann 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 18, the Learning and Outreach Centers and the Art and Spirituality Center accomplished the following: • 36,025 individuals were assisted with basic living necessities at the Learning and Outreach Centers. • 95% of the students who participated in the Homework Club and After School Club achieved a grade point average of 2.0 or above. • 4,530 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 2018 expense for the Learning and Outreach Centers and the Art and Spirituality Center was $521,823. Of this amount, $86,218 was grant dollars and donations, $6,632 was fee for service, and $428,973 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 2019 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 2019 are: • 32,000 individuals will be assisted with basic living necessities at the Learning and Outreach Centers. • 80% of the students who participate in the Homework Club, After School Club, and College Dream Program will achieve a grade point average of 2.0 or above. • 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. o Feel that they gained something meaningful from the workshop.
Intervention Actions for Achieving Goal	Intervention actions for FY 2019are: • 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 and educational guidance 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, Kern County Health Department, 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, Valley Achievement Center, Bakersfield Association for Retarded Citizens, Recovery Innovations Freise Hope House, Action Family Counseling, Housing Authority of Kern County, Kern Linkage/Kern Mental Health, Hoffmann Hospice, Global Family Daughter Project, and Jamison Center.

ECONOMIC VALUE OF COMMUNITY BENEFIT

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.

Bakersfield Memorial Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2017 through 6/30/2018

	Persons Served	Net Benefit	% of Org. Expenses
Benefits for Living in Poverty			
Financial Assistance	**1,916**	**1,727,638**	**0.4**
Medicaid *	**77,914**	**73,452**	**0.0**
Community Services			
A - Community Health Improvement Services	26,883	791,092	0.2
C - Subsidized Health Services	5	9,576	0.0
E - Cash and In-Kind Contributions	16,024	2,187,595	0.5
F - Community Building Activities	312	101,466	0.0
G - Community Benefit Operations	0	673,810	0.2
Totals for Community Services	**43,224**	**3,763,539**	**0.9**
Totals for Living in Poverty	**123,054**	**5,564,629**	**1.3**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	4,105	37,061	0.0
B - Health Professions Education	10	6,010	0.0
E - Cash and In-Kind Contributions	830	20,229	0.0
G - Community Benefit Operations	2,525	97,445	0.0
Totals for Community Services	**7,470**	**160,745**	**0.0**
Totals for Broader Community	**7,470**	**160,745**	**0.0**
Totals - Community Benefit	**130,524**	**5,725,374**	**1.3**
Medicare	**19,616**	**6,621,762**	**1.6**
Totals with Medicare	**150,140**	**12,347,136**	**2.9**

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $16,874,375.

APPENDIX A: BOARD OF DIRECTORS AND COMMITTEE ROSTERS

Dignity Health – Bakersfield Memorial Hospital
Board of Directors
2018

1. Robert Noriega, *Chair*
2. Brad Hannink, *Vice Chair*
3. Susie Small, *Secretary/Treasurer*
4. Jon Van Boening, *BMH President and CEO*
5. John R. Findley, MD
6. Donald McMurtrey
7. Morgan Clayton
8. Bruce Peters, President - Mercy Hospitals of Bakersfield
9. Javier Miro, MD
10. Stephen Helvie, MD
11. Sandra Serrano
12. Stephen T. Clifford

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

Morgan Clayton, President, Tel-Tec Security

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

Tom Corson, Executive Director, Kern County Network for Children

Danny Edwards, Community Member

Steve Flores, The Naina and Ravi Patel Foundation

Rita Flory, Community Benefit Coordinator, Mercy & Memorial Hospitals

Julie Franks, State Farm Agent

Mikie Hay, Director of Community Affairs, Jim Burke Ford

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

Denise Hunter, Director, Service Excellence, Bakersfield Memorial Hospital

Louie Iturriria, Director, Marketing and Public Relations, Kern Health Systems

Gloria Morales, Services Coordinator, Mercy Housing

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

Genie Navarro, Property Manager, Mercy Housing

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

Norma Rojas-Mora, Director, Communication and Community Relations, Bakersfield College

Leonardo Ruiz, Vice President, Univision Communications Inc.

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

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

Amanda Valenzuela, Development Manager, Alzheimer's Association

Jonathan Webster, Community Member

Michelle Willow, Director of External Communications, Dignity Health Central California Service Area

Donna Winkley, Regional Director, Mercy & Memorial Hospitals

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.

Dignity Health's Community Grants Program - 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).

Health Profession Education – Memorial Hospital regularly sponsors training for medical students, nurses, and other students in the health care field. Hundreds of hours each year are committed to providing a clinical setting for undergraduate training and internships for dietary professionals, technicians, social workers, pharmacists, and other health professionals from universities and colleges. For over three years the hospitals have partnered with California State University Bakersfield by donating money so the college could disperse funding as needed for purposed of addressing community wide workforce issues such as school-based programs on health care careers.

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

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

Community Committees and Boards - Hospital staff serves on many community committees and boards in the service area such including the CBCC Infusion Center Family Centered Care Advisory Committee, Kegley Institute of Ethics Planning Committee, Links for Life Committee, Kern County Cancer Fund Patient Eligibility Committee Meeting, Kern Coalition Against Human Trafficking, Binational Health Week Taskforce and the Dignity Health Community Grants Committee.

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