

Bakersfield Memorial Hospital

2019 Community Health Implementation Strategy





Adopted October 2019



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At-a-Glance Summary

<p>Community Served</p> 	<p>Bakersfield Memorial Hospital is located in Kern County, in California’s Central Valley. The hospital service area encompasses the cities of: Bakersfield, Lamont, Shafter and Taft.</p>
<p>Significant Community Health Needs Being Addressed</p> 	<p>The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital’s most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:</p> <ul style="list-style-type: none"> • Access to health care • Alzheimer’s disease • Chronic diseases • Overweight and obesity • Preventive practices • Social determinants of health/basic needs
<p>Strategies and Programs to Address Needs</p> 	<p>The hospital intends to take several actions and to dedicate resources to these needs, including:</p> <p>Access to care: financial assistance, community grants program, Coordinated Care Network Initiative, Community Health Initiative, Homemaker Care Program and Prescription Purchases.</p> <p>Alzheimer’s disease: community grants program and Homemaker Care Program.</p> <p>Chronic diseases: community grants program and Community Wellness Program seminars and classes.</p> <p>Overweight and obesity: community grants program, Community Wellness Program seminars, classes and health screenings, and Healthy Kids in Healthy Homes.</p> <p>Preventive practices: community grants program, Community Wellness Program, Community Wellness Program seminars and classes, Smoking Cessation Program, and Community Health Initiative.</p> <p>Social determinants of health/basic needs: community grants program, Learning and Outreach Centers, Coordinated Care Network Initiative, Art and Spirituality Center and Homemaker Care Program.</p>
<p>Anticipated Impact</p> 	<p>These strategies and programs will increase early identification and treatment of health issues and diseases, increase public or private health care coverage, increase knowledge on how to access and navigate the health care system, and identify linkages to health care resources and social services that improve the quality of life for vulnerable clients. Additionally the initiatives will decrease hospital admissions for chronic diseases, decrease smoking, and improve nutrition and physical fitness.</p>

**Planned
Collaboration**



Key partners include schools and school districts, colleges and universities, businesses, faith community, cities, parks and recreation agencies, community clinics, community-based organizations, public health, housing and homelessness agencies, disease prevention organizations, food provider agencies, senior agencies.

This document is publicly available online at <https://www.dignityhealth.org/central-california/locations/memorial-hospital/about-us/community-benefit-report-health-needs-assessment>.

Written comments on this report can be submitted to Memorial’s Department of Special Needs and Community Outreach office at 2215 Truxtun Avenue, Bakersfield, California, 93301 by email or by e-mail through the website at <https://www.dignityhealth.org/central-california/locations/memorial-hospital/about-us/community-benefit-report-health-needs-assessment>.

Our Hospital and the Community Served

About Bakersfield Memorial Hospital

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 local and national awards and recognitions for its quality care. When the ground was turned on this community treasure more than 60 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 Hospital has more than 400 licensed beds and includes a full-service Emergency Department with an Accredited Chest Pain Center and Nationally Certified Stroke Center. The facility also features the Robert A. Grimm Children's Pavilion for Emergency Services, Kern County's first and only dedicated children's ER. Memorial Hospital is home to the Sarvanand Heart and Brain Center, offering innovative and minimally-invasive procedures, such as Transcatheter Aortic Valve Replacement (TAVR) and WATCHMAN device implant. The Center also includes Kern County's only bi-plane interventional suite and hybrid catheterization lab, and is the area's only Thrombectomy-Capable Stroke Center, as certified by The Joint Commission.

In addition to its nationally recognized cardiovascular and neurological services, world-class inpatient and outpatient burn care is provided through the S.A. Camp Companies Burn Unit in partnership with The Grossman Burn Center. The hospital also provides expert pediatric acute care and intensive care through the Lauren Small Children's Center, and has a Level II NICU, expanded maternity and family care, Center for Wound Care and Hyperbarics, Center for Healthy Living, robotic surgery program, oncology, and orthopedics among its family of service lines.

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.



Financial Assistance for Medically Necessary Care

Memorial 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. The financial assistance policy and a plain language summary and other materials are on the hospital’s web site.

Description of the Community Served

Memorial serves 13 ZIP Codes representing 4 cities in Kern County.

Bakersfield Memorial Hospital Service Area

Place	ZIP Code
Bakersfield	93301, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313
Lamont	93241
Shafter	93263
Taft	93268

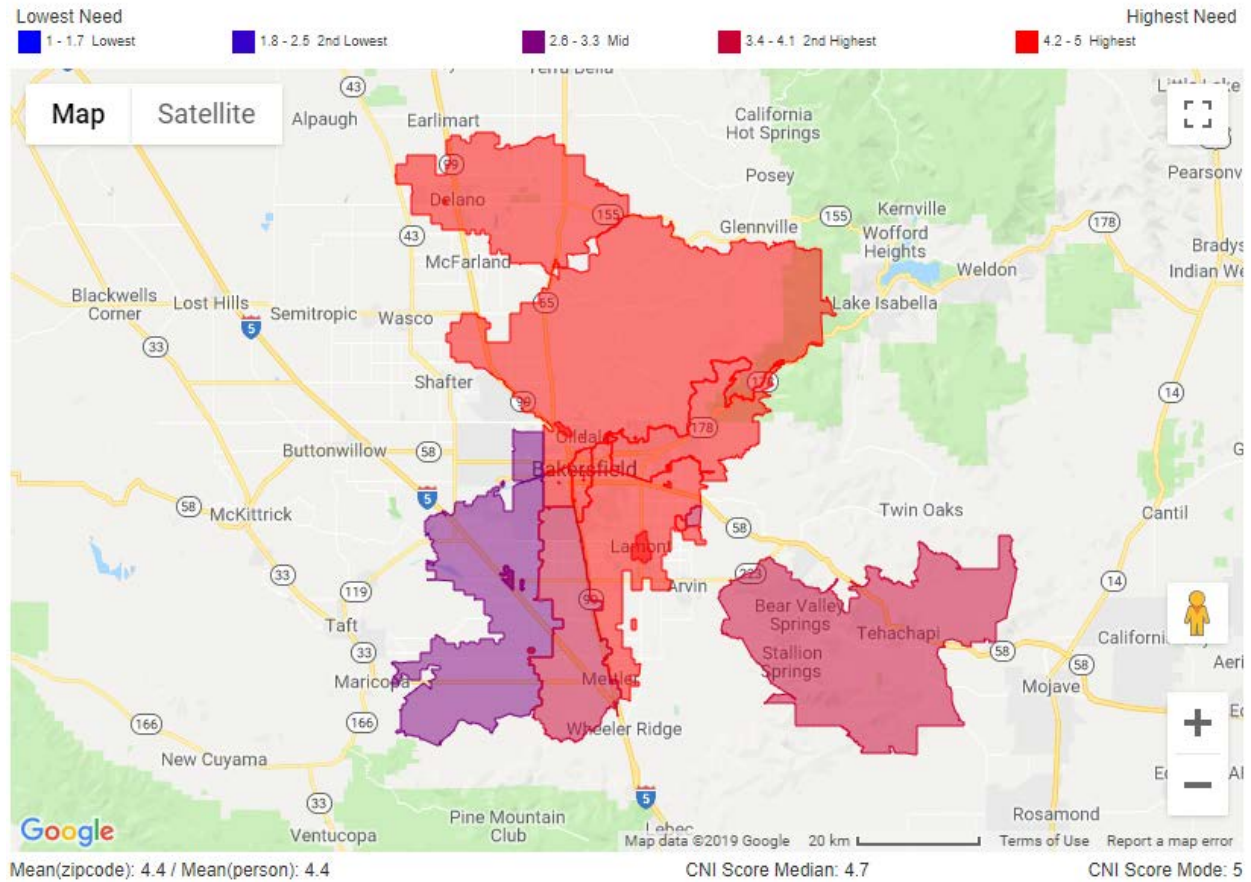
A summary description of the community follows (additional details can be found in the CHNA report online). The population of the hospital service area is 578,397. Compared to the county and the state, the Memorial service area has a high percentage of children. Children, ages 0-17, make up one-third (30.8%) of the population. 38.6% are 18-44 years of age, 21.4% are 45-64, and 9.2% of the population are seniors, 65 years of age and older. Over half the population in the service area is Hispanic or Latino (53.1%) and 34.4% of the population is White. Black or African Americans make up 5.4% of the population in the service area, while Asians are 4.6% of the population. The percentage of Hispanics/Latinos is higher in the hospital service area than found in the county and the state.

The hospital service area has high rates of poverty. Among area residents, 23.7% are at or below 100% of the federal poverty level (FPL) and 47.8% are at 200% of FPL or below (low-income). These rates of poverty are higher than in the county and state. 32.1% of children in the service area live in poverty. For seniors in the service area, 12.6% live in poverty; these rates are also higher than county and state averages. The median household income for the service area is \$52,733. Of the service area population age 25 and over, 25.7% have not attained a high school diploma, a rate higher than the state (17.9%). The health insurance coverage rate in the service area is 86.5%. This is below the rate for the county (86.7%) and state (87.4%). Among children in the service area, 94.4% have insurance coverage, and 80.6% of non-senior adults are insured.

Community Need Index

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

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



Community Assessment and Significant Needs

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

Community Health Needs Assessment

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

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

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

Significant Health Needs

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

- **Access to health care** – In Kern County, 35.8% of the population has employment-based health insurance. 35% are covered by Medi-Cal and 11% of the population has coverage that includes Medicare.
- **Alzheimer's disease** – The mortality rate from Alzheimer's disease in the service area was 61.8 per 100,000 persons. This is higher than the Kern County rate (50.5) and the state rate (35.5 per 100,000 persons).
- **Birth indicators** – Infant mortality reflects deaths of children under one year of age. The infant death rate in Kern County was 6.8 deaths per 1,000 live births. This rate is higher than the California rate of 4.6 and the Healthy People 2020 objective of 6.0 deaths per 1,000 live births.
- **Chronic diseases** – Heart disease, cancer and lung disease are the three leading causes of death in the service area. The cancer death rate in the service area is 177.5 per 100,000 persons, higher than the Healthy People 2020 objective (161.4 per 100,000). The age-adjusted mortality rate for ischemic

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

heart disease in the service area was 146.3 deaths per 100,000 persons. This rate of heart disease death exceeded the Healthy People 2020 objective of 103.4 per 100,000 persons. The age-adjusted rate of death from stroke was 43.1 deaths per 100,000 persons. This rate of stroke death exceeded the Healthy People 2020 objective of 34.8 stroke deaths per 100,000 persons.

- **Dental care** – 2.4% of Kern County residents have never been to a dentist and 11.8% have not visited a dentist for five or more years. 25.3% of adults rated the condition of their teeth as fair to poor. 17.2% of Kern County children, ages 3 to 11, have never been to a dentist.
- **Economic insecurity** – Within Kern County unemployment was 9.2% in 2017. Areas with high unemployment were: Taft Heights (12.7%) and Taft (10.3%). Lamont had the highest rate of seniors (41.6%) living in poverty. Bakersfield (93305) has the highest percentage of children in poverty (58.6%).
- **Environmental pollution** – In 2016, Kern County had 78 days with ground-level ozone concentrations above the U.S. standard of 0.070 parts per million, compared to 22 days of high ozone concentrations in the state for the year.
- **Food insecurity** – Among the population in Kern County, 13.6% experienced food insecurity during the past year. Among children in Kern County, 25% lived in households that experienced food insecurity at some point in the year. The rate of food insecurity was higher in Kern County than in the state.
- **Housing and homelessness** – In Kern County, there was a spike of 9% in homelessness from 2017 to 2018, and a 46% increase in the number of unsheltered homeless. Among children, 3.7% of public school enrollees in Kern County were recorded as being homeless at some point during the 2015-2016 school year.
- **Mental health** – Mortality from suicide was higher in the service area (13.8 per 100,000 persons) than in the state (11.0 per 100,000 persons). The service area rate for suicide does not meet the Healthy People 2020 objective for suicide (10.2 deaths per 100,000 persons). In Kern County, 12% of adults experienced serious psychological distress in the past year. 19.7% of teens needed help for an emotional or mental health problem and 10.9% of these teens received counseling.
- **Overweight and obesity** – In Kern County, 34.8% of adults, 21.6% of teens, and 23.4% of children are overweight. This is a larger percentage of overweight children and teens than in the state. In Kern County, 40.7% of adults, ages 20 and older, are obese. 20.6% of county teens are obese. The Healthy People 2020 objectives for obesity are 30.5% of adults, ages 20 and over, and 16.1% of teens.
- **Preventive practices** – The Healthy People 2020 objective is for 70% of the population to receive a flu shot. 44.1% of Kern County adults received a flu shot. Among Kern County seniors, 69.7% had received a flu shot. Among Kern County children, 6 months to 17 years, 47.7% received the flu shot.
- **Sexually transmitted infections** – Rates of STIs are climbing rapidly in Kern County. The rate for chlamydia in Kern County in 2017 was 763.1 diagnosed cases per 100,000 persons. The Kern County rate of gonorrhea was 251.6 cases per 100,000 persons.
- **Substance use and misuse** – The Healthy People 2020 objective for cigarette smoking among adults is 12%. In Kern County, 14.6% of adults smoke cigarettes. Among county adults, 32.6% of had engaged in binge drinking in the past year. The rate of opioid prescriptions in Kern County was 772.1 per 1,000 persons. This rate is higher than the state rate of opioid prescribing (508.7 per 1,000 persons).

- **Unintentional injuries** – The age-adjusted death rate from unintentional injuries in the service area was 55.1 per 100,000 persons. This rate was higher than for Kern County (51.6 deaths per 100,000 persons). The death rate from unintentional injuries in the service area exceeds the Healthy People 2020 objective of 36.4 deaths for unintentional injuries per 100,000 persons.
- **Violence and injury prevention** – Violent crime rates increased from 2014 to 2017 in Bakersfield. Property crime rates increased from 2014 to 2017 in Bakersfield and Shafter. In Kern County the rate of children, under 18 years, who experienced abuse or neglect, was 11.8 per 1,000 children. This was higher than the state rate of 7.7 per 1,000 children.



Significant Needs the Hospital Does Not Intend to Address

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

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional details on select programs.

This report specifies planned activities consistent with the 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.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. 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 works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.



Creating the Implementation Strategy

Bakersfield Memorial Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

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

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


The Special Needs and Community Outreach team participated in a facilitated meeting to discuss the identified health needs according to these criteria. The CHNA served as the resource document for the

review of health needs as it provided statistical data on the severity of issues and also included community input on the health needs. As well, the community prioritization of the needs was taken into consideration. The Community Benefit Committee also engaged in the process to review the health needs and confirm priority health needs. As a result of the review of needs and application of the above criteria, Memorial chose to focus on: access to care, Alzheimer’s disease, chronic diseases, overweight and obesity, preventive practices and social determinants of health/basic needs.

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

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report. They are organized by health need and include statements of the anticipated impact and any planned collaboration with other organizations in our community.

 Health Need: Access to Care	
Strategy or Program Name	Summary Description
Financial assistance	Memorial 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 will provide financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.
Coordinated Care Network Initiative (CCNI)	Through the CCNI, hospital care coordination and community partner agencies will work together to identify vulnerable patients’ health and health-related social needs, and electronically link health care providers to organizations that provide direct services.
Community Health Initiative	Increases access to health insurance and health care for hard to reach individuals in Kern County. Provides training for application assistance, and educates families on the importance of preventive care.

Homemaker Care Program	Provides in home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients.
Prescription Purchases for Indigents	Purchases necessary medications in emergency situations for people who must have the medicines for their health but have no money to buy them.

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 on how to access and navigate the health care system, and linkages to health care resources and social services that improve the quality of life for vulnerable clients.

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



Health Need: Alzheimer's Disease

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

Anticipated Impact: The initiatives addressing Alzheimer's disease are anticipated to result in: early identification of health issues related to Alzheimer's disease, education and training of caregivers to provide safe and appropriate care for persons with Alzheimer's disease.

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



Health Need: Chronic Diseases

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

Smoking Cessation Program

Facilitates Freedom From Smoking®, an eight session seminar, to help encourage participants to work on the process and problems of quitting.

Anticipated Impact: The initiatives addressing chronic diseases are anticipated to result in: early identification of chronic health issues, avoiding hospital admissions for diabetes and Congestive Heart Failure, and motivating individuals to quit smoking and improve the length and quality of life.

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



Health Need: Overweight and Obesity

Strategy or Program Name	Summary Description
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.
Community Wellness Program	Provides health education on nutrition, diabetes, cholesterol and hypertension. Offers community fitness classes. Health screenings for blood pressure, blood sugar, and BMI are provided at 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, and increased knowledge on how to prevent obesity through nutrition and physical fitness.

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



Health Need: Preventive Practices

Strategy or Program Name	Summary Description
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.
Community Wellness Program	Provides community health screenings, as well as health education on a variety of prevention topics.

Smoking Cessation Program	Facilitates Freedom From Smoking®, an eight session seminar, to help encourage participants to work on the process and problems of quitting.
Community Health Initiative	Increases access to health insurance and health care for hard to reach individuals in Kern County. Provides training for application assistance, and educates families on the importance of preventive care.

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

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



Health Need: Social Determinants of Health/Basic Needs


Strategy or Program Name	Summary Description
Community Grants Program	Grant funds may be awarded to nonprofit organizations to deliver services and strengthen service systems, which improve the health and well-being of vulnerable and underserved populations.
Learning and Outreach Centers	In collaboration with other community service agencies, the centers provide referral services, food, clothing, and education to the most vulnerable and needy residents of the community. After school programs at the centers provide tutoring support 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.
Homemaker Care Program	Provides in home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients.

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 to live a better quality of life.

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

Program Digests

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

 Dignity Health Community Grants Program	
Significant Health Needs Addressed	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Access to care <input checked="" type="checkbox"/> Alzheimer’s disease <input checked="" type="checkbox"/> Chronic diseases <input checked="" type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input checked="" type="checkbox"/> Social determinants of health/basic needs
Program Description	Award grant funds to local non-profit organizations to be used to effect collective impact, addressing the health priorities established by the hospital (based on the most recent Community Health Needs Assessment). Awards will be given to agencies with a formal collaboration and a link to the hospital.
Community Benefit Category	E1 – Cash Donation
Planned Actions for 2019-2020	
Program Goal / Anticipated Impact	Increased access and reduced barriers to health care, preventive care, basic needs and chronic disease prevention and treatment for the medically underserved.
Measurable Objective(s) with Indicator(s)	Funding will be provided to implement programs that support hospital priorities and demonstrate strong collaboration with the hospital. 100% of funded programs will report objectives as a result of grants on a semi-annual basis.
Intervention Actions for Achieving Goal	All awarded agencies will work with Special Needs and Community Outreach staff to ensure programs meet the objectives stated in their grant proposals.
Planned Collaboration	Non-profit community-based organizations, faith organizations, community clinics, senior care providers, food distribution agencies.



Chronic Disease/Chronic Pain/Diabetes Self-Management Programs

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input checked="" type="checkbox"/> Chronic diseases <input checked="" type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input type="checkbox"/> Social determinants of health/basic needs
Program Description	<p>The Healthy Living Self-Management Programs (Chronic Disease, Chronic Pain and Diabetes) are designed for persons who have diabetes and other chronic illnesses, providing them with the knowledge, tools and motivation needed to become proactive in their health. Each program seminar consists of six weekly classes covering a variety of topics including nutrition, exercise, use of medications, communication with doctors, stress management, and evaluating new treatments.</p>
Community Benefit Category	<p>A1- Community Health Education - Lectures/Workshops A1- Community Health Education - Individual health education for uninsured/under insured A2- Community Based Clinical Services - Immunizations/Screenings A3- Health Care Support Services - Case management post-discharge</p>
Planned Actions for 2019-2020	
Program Goal / Anticipated Impact	<p>Decrease hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (diabetes and congestive heart failure).</p>
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • Provide 25 Healthy Living seminars in Kern County areas with a Community Needs Index (CNI) score of 3 or above to ensure that underserved persons throughout the county will have access to the seminars. • At a minimum, 90% of all participants with chronic diseases who complete Healthy Living seminars will remain healthier after their seminars, as measured by those who avoid admissions to the hospital or emergency department for three months following their participation in the program. • Provide three new locations in Kern County for Healthy Living seminars in order to expand our services.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Offer seminars that are six weeks in length that target persons with diabetes and other chronic diseases.

	<ul style="list-style-type: none"> • Focus seminars on the uninsured and populations who qualify for publicly funded health care plans. • Engage clinical health professionals and health plan providers to guide program improvement. • Encourage and support continuing education for leader development to ensure the Healthy Living Self-Management Programs provide quality service
Planned Collaboration	Key partners include community health centers, churches, school districts, health care providers, health plans, senior centers, and family resource centers.

 **Community Wellness Program**

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input checked="" type="checkbox"/> Chronic diseases <input checked="" type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input type="checkbox"/> Social determinants of health/basic needs
Program Description	The 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- Community Health Education - Lectures/Workshops A1- Community Health Education - Individual health education for uninsured/under insured A2- Community Based Clinical Services - Immunizations/Screenings A3- Health Care Support Services - Case management post-discharge

Planned Actions for 2019-2020

Program Goal / Anticipated Impact	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • Annually, provide 25,000 blood pressure, cholesterol, glucose, and hemoglobin in Kern County. At least 75% of participants who attend

	<p>monthly health screenings and at least 2 health education classes, at targeted health screening sites, will show improved blood sugar results at the end of six months.</p> <ul style="list-style-type: none"> • Annually provide 1,000 flu immunizations for residents of Kern County. • 80% of children who attend six of the eight classes in Healthy Kids in Healthy Homes will demonstrate improved physical fitness. • 90% of participants will have a better understanding of how to live a healthy lifestyle after attending a health education class, workshop or program. • Annually offer three Freedom From Smoking® clinics. • Plan and deliver quarterly cancer education or screening events.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Collect health screening results in a database. • Provide 125 Community Health Education classes that focus on the following priorities – Obesity, Diabetes, Asthma, and Cardiovascular Disease. • Provide community health education classes at five new locations. • Provide 15 nutrition education classes. • Further develop collaborative relationships with community-based organizations to provide health education throughout Kern County. • Strengthen educational opportunities at the Community Wellness Center in the form of classes and events.
Planned Collaboration	Our program will collaborate with community health centers, churches, school districts, health care providers, health plans, and family resource centers.



Basic Needs Services

Significant Health Needs Addressed	<input type="checkbox"/> Access to care <input type="checkbox"/> Alzheimer’s disease <input type="checkbox"/> Chronic diseases <input type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input checked="" type="checkbox"/> Social determinants of health/basic needs
Program Description	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

	<p>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.</p> <p>The Art and Spirituality Center provides opportunities for artistic expression, meditation, relaxation, and creativity to improve quality of life and reduce stress.</p>
Community Benefit Category	<p>E3- In-kind Donations – Food</p> <p>E3- In-kind Donations - Clothing/gifts</p> <p>E3- In-kind Assistance - Basic services for individuals</p> <p>F3- Community Support</p>
Planned Actions for 2019-2020	
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)	<p>Annually:</p> <ul style="list-style-type: none"> • 35,000 individuals will be assisted with basic living necessities at the Learning and Outreach Centers. • 85% of the students who participate in the Homework Club, After School Club, and College Dream Program will achieve a grade point average of 2.0 or above. • 4,500 participants will take part in programs at the Art and Spirituality Center. • 94% of Art and Spirituality Center participants will feel reduced stress and report an improved quality of life.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • The Learning and Outreach Centers will provide basic need services to vulnerable residents living in underserved neighborhoods of southeast Bakersfield. • The Learning and Outreach Centers will offer after school programs that provide tutoring support and educational guidance to underserved youth. Services are provided in English and Spanish. • The Art and Spirituality Center will offer programs in a variety of artistic classifications.
Planned Collaboration	Our programs collaborate with local community organizations to achieve its goals, including community health centers and other private and public stakeholders. Some major partners include: community clinics, churches, school districts, food banks, and family resource centers.



Homemaker Care Program

Significant Health Needs Addressed	<input checked="" type="checkbox"/> Access to care <input checked="" type="checkbox"/> Alzheimer’s disease <input type="checkbox"/> Chronic diseases <input type="checkbox"/> Overweight and obesity <input checked="" type="checkbox"/> Preventive practices <input checked="" type="checkbox"/> Social determinants of health/basic needs
Program Description	<p>The Homemaker Care Program provides in-home supportive services to seniors, ages 65 and older, as well as adults with disabilities. Case management for seniors is conducted in the form of wellness checks and home visits to assess client safety, nutrition, and program satisfaction. This education program also provides specialized training for care providers to increase community capacity. The training is a four-week, comprehensive employment readiness skills training focusing on individuals transitioning from unemployment into the workforce as home care providers. Additional and more comprehensive training courses are also offered for persons with dementia and Alzheimer’s disease.</p>
Community Benefit Category	<p>A3- Health Care Support Services - General/Other F5- Leadership Dev/Training for Community Members - Career development</p>
Planned Actions for 2019-2020	
Program Goal / Anticipated Impact	<p>Provide employment readiness training for individuals transitioning from unemployment into the workforce, and provide in-home support services to low-income seniors and disabled adults allowing them to remain in their homes.</p>
Measurable Objective(s) with Indicator(s)	<p>Annually:</p> <ul style="list-style-type: none"> • Improve the quality of life for 100% of clients, as measured by our Client Impact Survey. • Obtain an overall client satisfaction rate of at least 90% for excellence in maintaining dignity and quality of service received, as compiled from the compilation of a semi-annual survey. • Conduct four, four-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.

<p>Intervention Actions for Achieving Goal</p>	<ul style="list-style-type: none"> • Collaborate with senior-related and health care related companies, organizations and public agencies to increase our ability to advocate for our clients and help all seniors advocate for themselves. • Provide services to increase access to care for vulnerable seniors and disabled clients. • Link underserved clients to needed health care and social service resources. • Collaborate with other organizations to identify candidates for the training program.
<p>Planned Collaboration</p>	<p>Our program will collaborate with assisted living facilities, senior services, and local community organizations to achieve its goals.</p>

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