2025 Community Health Implementation Strategy and Plan

Adopted October 2025

Mercy Hospital Downtown

Mercy Hospital Southwest

Dignity Health®
A member of CommonSpirit

Table of Contents

At-a-Glance Summary

Community Served	Mercy has two hospital facilities in Bakersfield: Mercy Hospital Downtown and Mercy Hospital Southwest (Mercy Hospitals). These hospital facilities operate under one license. The service area includes 13 ZIP Codes in the cities of Arvin, Bakersfield and Taft, within Kern County in California's Central Valley..
Significant Community Health Needs Being Addressed	The significant community health needs the hospitals are helping to address and that form the basis of this document were identified in the hospitals' most recent Community Health Needs Assessment (CHNA). Needs the hospitals intend to address with strategies and programs are: • Access to health care • Chronic diseases • Food insecurity • Mental health • Overweight and obesity • Preventive practices • Substance use
Strategies and Programs to Address Needs	The hospitals intend to take several actions and dedicate resources to address these needs, including: ***Access to Health Care and Preventive Care*** Community Health Improvement Grants Program Community Health Initiative Community Wellness Program Patient Financial Assistance Homemaker Care Program Kern Connected Community Network Outpatient Nurse Navigation Program Prescription Purchasing Transportation for Patients in Financial Need ***Chronic Diseases*** Asthma Management Program Chronic Disease/Diabetes Self-Management Program Community Health Improvement Grants Community Wellness Program Healthy Kids in Healthy Homes ***Food Insecurity*** Community Health Improvement Grants Replate edible food recovery and donation program Kern Connected Community Network Learning and Outreach Centers

Mental Health and Substance Use

Anti-Vaping Program
Art and Spirituality Center
Behavioral Health Navigator Program
Community Health Improvement Grants
Mental Health Support Groups

Overweight and Obesity

Community Health Improvement Grants
Community Wellness Program
Health Equity Plan Activities
Healthy Kids in Healthy Homes

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online on the hospitals' website. Written comments on this strategy and plan can be submitted to the Mercy Downtown Administration Office at 2215 Truxtun Avenue, Bakersfield, California, 93301 or by e-mail to Donna.Sharp@commonspirit.org.

Our Hospitals and the Community Served

About the Hospitals

Mercy Hospitals are part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Mercy Hospital Downtown

- Located at 2215 Truxtun Avenue, Bakersfield, California, 93301.
- Licensed for 144 acute care beds.
- This hospital includes a full range of medical and surgical services: a 14-station, Level II Base-Station Emergency Department, six surgical suites, post anesthesia care unit, ambulatory and prep units, outpatient surgery and outpatient GI laboratory. Mercy Hospital Downtown is also home to the area's only inpatient oncology unit.

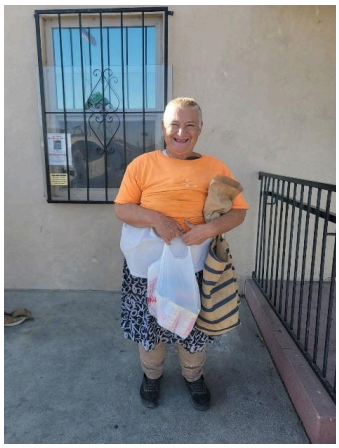
Mercy Hospital Southwest

- Located at 400 Old River Road, Bakersfield, California, 93311.
- Licensed for 78 acute care beds.
- This hospital includes a Family Birth Center, which features a labor delivery recovery postpartum unit, a postpartum unit, and a NICU. Mercy Hospital Southwest is the only acute care hospital west of Hwy 99 in Bakersfield. It has a 14-bed Level II Emergency Department, an 8-bed ICU along with 10 tele beds, and 6 operating rooms.

Our Mission

The hospitals' dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care



It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

These hospitals have a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language

summary and related materials are available in multiple languages on the hospitals' website.

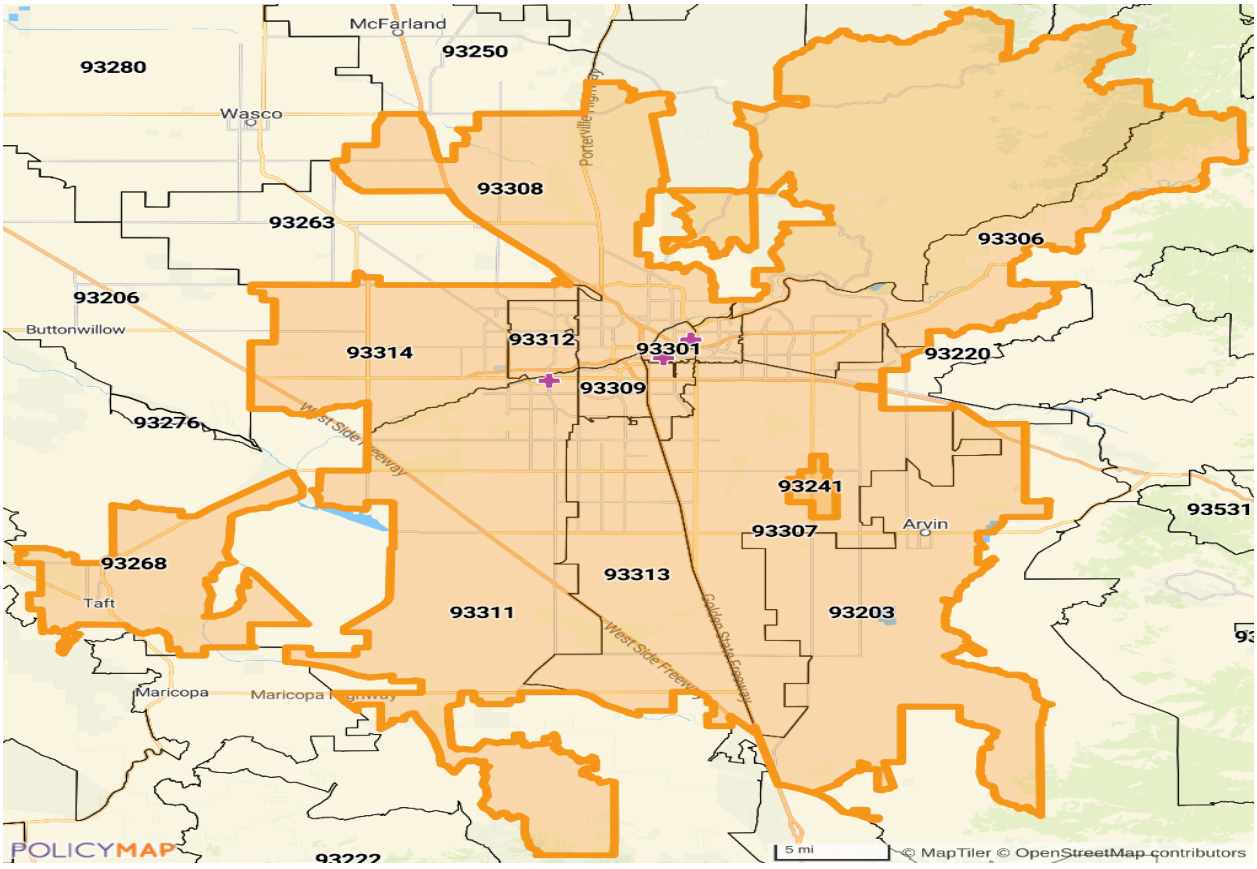
Description of the Community Served

The hospitals' service area includes the following cities and ZIP Codes.

Mercy Hospitals Service Area

Place	ZIP Code
Arvin	93203
Bakersfield	93301, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93314
Taft	93268

Service Area Map



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

The population of the service area is 625,147. Children and youth, ages 0-17, make up 29.8% of the population, 59.6% are adults, ages 18-64, and 10.6% of the population are seniors, ages 65 and older. The largest portion of the population in the service area are Hispanic or Latino residents (55.4%), 30.7% are White or Caucasian residents, 5.2% are Asian residents, and 5% are

Black or African American residents. 2.7% of the population are non-Latino multiracial (two-or-more races) residents, 0.4% are American Indian or Alaskan Native residents, and 0.1% are Native Hawaiian or Pacific Islander residents.

Among the residents in the service area, 19.1% are at or below 100% of the federal poverty level (FPL) and 42.1% are at 200% of FPL or below. In the service area, 25.7% of children live in poverty, 13.9% of senior adults live in poverty, and 44.6% of families with a female head of household with minor children live in poverty. The unemployment rate in the service area among the civilian labor force, averaged over 5 years, is 8%. The median household income in the service area is $71,566.

In the service area, 92% of the civilian, non-institutionalized population have health insurance, and 96.3% of children, ages 18 and younger, have health insurance coverage. Among county residents, 40.6% have Medi-Cal coverage.

Educational attainment is a key driver of health. In the hospitals' service area, 22.4% of adults, ages 25 and older, lack a high school diploma, which is higher than the state rate (15.6%).

The U.S. Health Services Administration (HRSA) designates medically underserved areas/populations (MUA) as areas or populations having too few primary care providers, high infant mortality, high poverty, or a high elderly population. Much of the service area, including the East Bakersfield area, and rural areas surrounding and between Taft and Arvin, as well as north of Bakersfield, are designated as Medically Underserved Areas (MUAs) for primary care.

Community Assessment and Significant Needs

The health issues that form the basis of the hospitals' community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in April 2025. The CHNA report includes:

- description of the community assessed consistent with the hospitals' service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospitals since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospitals' website or upon request, using the contact information in the At-A-Glance Summary.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospitals intend to address. Identified needs may include specific health conditions, behaviors or health care services, and health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Care	Access to health care refers to the availability of primary care, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	●
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition.	
Chronic Diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	●
Crime and Safety	Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary,	

Significant Health Need	Description	Intend to Address?
	larceny and motor vehicle theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes.	
Economic Insecurity	Economic insecurity is correlated with poor health outcomes. People with low incomes are more likely to have difficulty accessing health care, have poor-quality health care, and seek health care less often.	
Education	Education significantly impacts health. People who possess higher levels of education generally experience better health outcomes and longer lifespans.	
Environmental Conditions	Polluted air, contaminated water, and extreme heat are environmental conditions that can negatively impact community health.	
Food Insecurity	The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially acceptable ways.	●
Housing and Homelessness	Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing.	
Mental Health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	●
Overweight and Obesity	Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for chronic diseases. Overweight and obesity are linked to a lack of physical activity and unhealthy eating habits.	●
Preventive Care	Preventive practices refer to health maintenance activities that help to prevent disease. For example, preventive care includes vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention strategies.	●
Sexually Transmitted Infections	Sexually transmitted infections (STIs) usually pass from one person to another through sexual contact. Common STIs include syphilis, gonorrhea, and chlamydia.	
Substance Use	Substance use is the use of tobacco products, illegal drugs, prescription drugs,	●

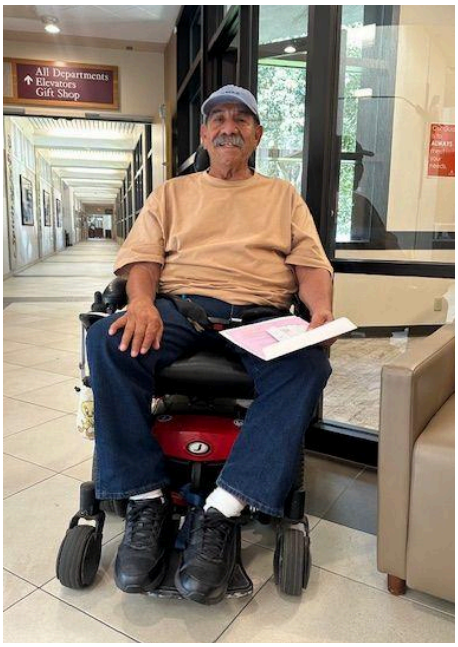
Significant Health Need	Description	Intend to Address?
	over-the-counter drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	

Significant Needs the Hospitals Do Not Intend to Address

Taking existing hospital and community resources into consideration, Mercy Hospitals will not directly address the remaining significant health needs identified in the CHNA, which include birth indicators, crime and safety, economic insecurity, education, environmental conditions, housing and homelessness, and sexually transmitted infections.

Knowing there are not sufficient resources to address all the community health needs, Mercy Hospitals chose to concentrate on those health needs that can most effectively be addressed given the organizations' areas of focus and expertise. The hospitals have insufficient resources to effectively address all the identified needs and, in some cases, the needs are being addressed by others in the community.

2025 Implementation Strategy and Plan



This section presents strategies and program activities the hospitals intend to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospitals' mission and capabilities. The hospitals may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

The hospitals are dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

Mercy Hospitals engaged the Community Benefit Committee and the Special Needs and Community Outreach Leadership Team to examine the significant health needs. The CHNA served as the resource document for the review of the significant health needs as it provided statistical data on the severity of issues and included community input. Also, the community prioritization of the significant health needs was taken into consideration.

The programs and initiatives described here were selected based on:

- 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: The hospitals have acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

Community Health Core Strategies

The hospitals believe that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally identified needs.

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

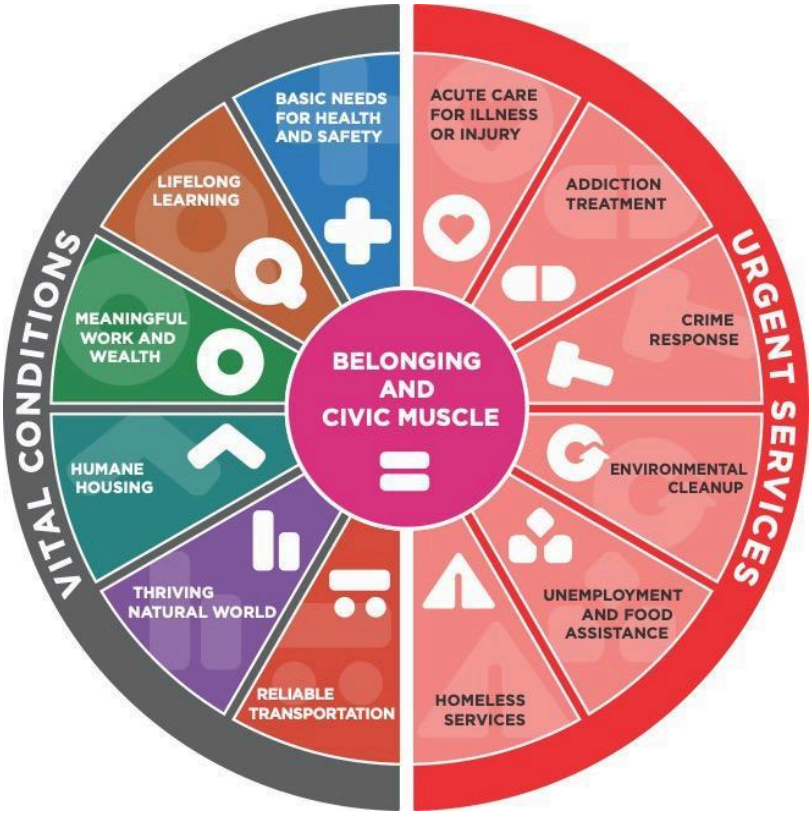
Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.



Well-Being Portfolio in this Strategy and Plan
The hospitals' planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs and also acknowledges that the hospitals are one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need	**Access to Health Care and Preventive Care**				
Population(s) of Focus	Individuals who experience barriers to accessing health care and preventive care services. Uninsured and underinsured people.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide health care access and preventive care programs and services.			●	Basic needs for health and safety (VC)
Community Health Initiative	Increases access to health insurance and health care for hard-to-reach individuals in Kern County. Provides application assistance and educates families on the importance of preventive care.	●		●	Basic needs for health and safety (VC)
Community Wellness Program	Provides community health screenings and health education on a variety of prevention topics.	●	●		Basic needs for health and safety (VC)
Financial assistance for the uninsured or underinsured	Provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	●			Basic needs for health and safety (VC)
Homemaker Care Program	Provides in-home services, linkages to health care resources and social services that improve the quality of life for vulnerable clients.	●		●	Basic needs for health and safety (VC)

Health Need	**Access to Health Care and Preventive Care**				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Kern Connected Community Network (CCN)	Hospital care coordination and community partner agencies work together to identify the health and health-related social needs of vulnerable patients and electronically link health care providers to organizations that provide direct services.	●		●	Basic needs for health and safety (VC)
Outpatient Nurse Navigation Program	Provides comprehensive case management to patients identified as being at high risk for hospital readmission. Services are initiated by referrals from the Care Coordination team.	●			Basic needs for health and safety (VC)
Prescription Purchases for Indigents	Purchase necessary medications in emergency situations for people who cannot afford to purchase the needed medicines.	●			Basic needs for health and safety (VC)
Transportation	Provides transportation support to vulnerable people to access health care services.	●			Basic needs for health and safety (VC)
Planned Resources	The hospital will provide health care providers, care coordinators, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support.				
Planned Collaborators	Community clinics, faith groups, health care providers, community-based organizations, public health and city agencies				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase access to health care for the medically underserved and reduce barriers to care.	Reduce to 5.9% the proportion of people who can't get medical care when needed.	Healthy People 2030
Increase the number of adults who get recommended preventive health care.	11.5% of adults receive recommended preventive care services.	Healthy People 2030

Health Need	**Chronic Diseases**				
Population(s) of Focus:	Individuals with chronic diseases and their families, people at risk of developing chronic diseases.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Asthma Management Program	Asthma educators provide education to individuals and monitor client usage of rescue and controller medications.	●	●		Basic needs for health and safety (VC)
Chronic Disease/Diabetes Self-Management Program	Provides residents who have chronic diseases, including diabetes, with the knowledge, tools and motivation needed to become proactive in their health through six-week workshops.	●	●		Basic needs for health and safety (VC)
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide programs and services that address chronic disease prevention and treatment and healthy eating and active living.	●	●	●	Basic needs for health and safety (VC)
Community Wellness Program	Provides health education on nutrition, diabetes, cholesterol and hypertension.	●	●		Basic needs for health and safety (VC)
Health Equity Plan Activities	Increases awareness and confidence among participants in the Diabetes Self-Management Program by providing them with knowledge and tools to actively manage their health.	●	●	●	Basic needs for health and safety (VC)
Healthy Kids in Healthy Homes	Provides information to children on the topics of nutrition, exercise, and lifestyle in an eight-session program.		●		Basic needs for health and safety (VC)

Health Need	Chronic Diseases
Planned Resources	The hospitals will provide care coordinators, health care providers, community health educators, philanthropic cash grants and outreach communications.
Planned Collaborators	Community-based organizations, public health, faith community, senior service agencies, youth organizations, community clinics, schools and school districts

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased compliance with chronic disease management recommendations.	55.2% of people with diabetes get formal diabetes education. Reduce asthma attacks to 35.1% of people who have asthma.	Healthy People 2030

Health Need	Food Insecurity				
Population(s) of Focus	Individuals and families who experience food insecurity (limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire foods in socially acceptable ways).				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants	Grant funds are awarded to nonprofit organizations to deliver services and strengthen service systems, which improve access to food for vulnerable and underserved populations.		●	●	Basic needs for health and safety (VC)
Kern Connected Community Network	Addresses the social determinants of health and links referred patients to appropriate and needed community-based services.	●		●	Basic needs for health and safety (VC)
Learning and Outreach Centers	In collaboration with other community service agencies, provide referral services, food, clothing, and education to the most vulnerable and needy residents of the community.		●	●	Unemployment and food assistance (US)
Replate Program	Facilitates food donation by collecting the hospitals' surplus food to distribute to communities facing food insecurity		●	●	Unemployment and food assistance (US)
Planned Resources	The hospitals will provide care managers, outreach workers, health educators, philanthropic cash grants, outreach communications, and program management support.				
Planned Collaborators	Community clinics, faith groups, food pantries, community-based organizations, homelessness agencies, public health and city agencies, senior services, and youth organizations				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Reduce household food insecurity and reduce hunger.	6.0% of households are food insecure.	Healthy People 2030

Health Need	**Mental Health and Substance Use**				
Population(s) of Focus	Individuals and families at-risk for and/or experiencing mental health distress and/or substance disorders.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Anti-Vaping program	Offers anti-vaping education programs at local schools.		●	●	Basic needs for health and safety (VC)
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.		●	●	Basic needs for health and safety (VC)
Behavioral Health Navigator Program	Supports the emergency department as a primary access point for treating substance use disorders and mental health conditions. It employs trained navigators to identify patients who can benefit from starting medication for addiction or mental health services.	●	●	●	Addiction treatment (US)
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide mental health and substance use programs and services.		●	●	Addiction treatment (US)
Mental health support groups	The Community Health Initiative provides free mental health support groups to individuals who live with mental health challenges.		●		Basic needs for health and safety (VC)
Planned Resources	The hospitals will provide mental health and substance use care providers, care managers, social workers, philanthropic cash grants, outreach communications, and program management support.				

Health Need	**Mental Health and Substance Use**
Planned Collaborators	Schools and school districts, community-based organizations, youth programs, law enforcement, and collaboratives that seek to support mental health and substance use needs

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Reduce drug and alcohol addiction.	14% of people, ages 12 and older, receive substance use treatment when needed.	Healthy People 2030
Increase prevention, screening, assessment, and treatment of mental health disorders.	65.6% of adults, ages 18 and older with depression, receive treatment.	Healthy People 2030

Health Need	**Overweight and Obesity**				
Population(s) of Focus	People who are overweight or obese or at risk of becoming overweight. Individuals and families who want to improve healthy eating and increase physical activity.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide programs and services that address healthy eating and active living to reduce obesity.			●	Basic needs for health and safety (VC)
Community Wellness Program	Provides health education on nutrition, diabetes, cholesterol and hypertension.		●	●	Basic needs for health and safety (VC)
Healthy Kids in Healthy Homes	Provides information to children on nutrition, exercise, and lifestyle in an eight-session program.		●	●	Basic needs for health and safety (VC)
Planned Resources	The hospitals will provide care coordinators, health care providers, community health educators, philanthropic cash grants and outreach communications.				
Planned Collaborators	Community-based organizations, public health, faith community, senior service agencies, youth organizations, community clinics, schools and school districts				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved healthy eating and physical activity behaviors.	Reduce the proportion of adults with obesity to 36%. Reduce the proportion of children and teens with obesity to 15.5%.	Healthy People 2030