



## Mercy Hospital Downtown

Community Benefit Report 2012  
Community Benefit Implementation Plan 2013

A message from the Chief Executive Officer, and Board Chair of Mercy Hospitals of Bakersfield

At Mercy Hospital Downtown we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$34.9 million in charity care, community benefits, and unreimbursed patient care.

At Mercy Hospital Downtown we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges, we see this as a time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our Kern County community through health and wellness programs and services.

In accordance with policy the Advisory Board of Mercy Hospitals of Bakersfield has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 24, 2012 meeting.



**Russell Judd**  
President  
Mercy Hospitals of Bakersfield



**Kevin Andrew**  
Board Chair  
Mercy Hospitals of Bakersfield

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## EXECUTIVE SUMMARY

Founded in 1910, Mercy Hospital Downtown, reflects the values of the Sisters of Mercy. That compassionate and comprehensive care still continues to this day, with "the Spirit of Mercy" nurtured by our family of employees. Situated in downtown Bakersfield, Mercy Hospital is licensed for 144 acute care beds, including a 31-bed medical unit, a 31-bed surgical unit, a 31-bed telemetry unit, a 29-bed guarded care unit and a 20-bed adult ICU. The full range of medical and surgical services also includes; 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. The Florence R. Wheeler Cancer Center provides quality care related to cancer detection, education, treatment and follow-up care as well as access to the essential supportive services related to the treatment of cancer. Mercy Hospital Downtown is a member of Dignity Health, formerly Catholic Healthcare West (CHW)<sup>1</sup>, the largest not-for-profit health care provider in California. This facility employs 1,000 people.

Caring for the community beyond the hospital walls led to the founding of the Department of Special Needs and Community Outreach in 1991. In response to identified unmet health-related needs in the community, today the department operates more than 59 programs in Bakersfield, Arvin, Shafter, McFarland, Delano, Lake Isabella, Ridgecrest, Taft, Tehachapi, and other outlying communities in Kern County where there is limited access to health care and related services.

With 25 employees and an annual budget of \$2,352,000, the department's programs target low-income, uninsured, or underinsured individuals, as well as Kern County citizens with unmet health needs, including migrant farm workers and other disenfranchised populations. The department frequently collaborates with more than 80 public, private, and nonprofit organizations. 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. Combining resources, Mercy and Memorial Hospitals respond to identified unmet health-related needs throughout Kern County in a unified way through three Outreach Centers:

### **Outreach Centers -**

#### **Learning Center**

631 E. California Avenue, Bakersfield, CA 93307, (661) 325-2995

#### **Outreach Center**

1627 Virginia Avenue "C", Bakersfield, CA 93307, (661) 323-7964

#### **Community Wellness Center**

2634 G Street, Bakersfield, CA 93301, (661) 861-0852

The Learning Center and the Outreach Center are located in economically depressed neighborhoods of southeast Bakersfield. The Community Wellness Center is located in the center of downtown 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. Our three outreach centers employ a total of 18 people and utilize an average of 140 volunteers each month.

Mercy Hospital Downtown's FY 2012 Community Benefit Report and FY 2013 Community Benefit Plan document our commitment to the health and improved quality of life in our community. The total value of community benefit for FY 2012 is \$18,255,844 which excludes the unpaid costs of Medicare which totaled \$16,617,661.

Following are the highlights of major community benefit activities during FY 2012:

**Community Wellness Program** - provides personalized in-home health education and monitoring, community health screening clinics, health education classes, and referrals to other local health care and

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<sup>1</sup> For more information on the name change, please visit [www.dignityhealth.org](http://www.dignityhealth.org)

social service resources. In FY 2012, the program served 8,839 patients through educational classes on high blood pressure, cancer, diabetes, and nutrition. A total of 35,752 blood pressure, cholesterol, and glucose screenings were provided at monthly clinics throughout Kern County. 27 of 31 (87%) case managed clients saw a decrease in at least one of their screening levels.

**Chronic Disease Self-Management Program/Diabetes Self-Management Program** – provides patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. Each program seminar consists of six (6) weekly classes covering a variety of topics including nutrition, exercise, use of medications, communication with doctors, stress management, and evaluating new treatments. In FY 2012, seven English and seven Spanish seminars were held in Kern County areas with a Community Need Index (CNI) score of 3 or above. Of the 108 participants who completed the seminars, 94.8% of participants completing the EMPOWERMENT Program avoided admissions to the hospital or emergency department for the six months following their participation in the program.

**Homemaker Care Program** - provides homemaker services to frail elderly by helping them live independently for as long as possible. This program also provides job training to unemployed individuals by helping them learn marketable skills and transition into the work force. In FY 2012, the program provided 8,847 hours of services to an average of 63 client households per month. Of the 83 individuals who completed the training program, 75% found employment.

**Homework Club** – provides after-school academic tutoring for low-income children in kindergarten through seventh grade and engages them in structured, academic and cultural/social enrichment activities. In FY 2012, 35 students participated in the program. To monitor the academic progress of first through seventh grade students, the Homework Club staff uses the Kauffman Test of Educational Achievement (KTEA). The KTEA test is also used in the Bakersfield City School District, the largest elementary school district in the state. Results of the KTEA test indicated that 87% of the first through seventh grade students were reading at or above grade level. 92% of 1st through 7th grade students achieved at or above grade level in Mathematics.

**Children's Health Initiative of Kern County (CHI)** – increases access to health insurance and health care for children, and promotes the use of medical/dental homes for all Kern County children. Studies show that insured children are less likely to miss school due to illness, more likely to make "well-child" doctor visits, and more likely to receive early treatment that may prevent an illness from becoming more serious. To assist in this effort, CHI collaborates with over 50 social service and health care organizations, community groups and agencies throughout Kern County. CHI provides training for application assistance, and educates families on the importance of preventive care. In FY 2012, the CHI enrolled 10,119 children into Medi-Cal and Healthy Families health insurance programs.

Mercy Hospital Downtown is a key player when it comes to building a healthier Kern County. This is demonstrated by several on-going programs including:

**Breast Health Program** - provides qualifying individuals who are poor and uninsured with a mammogram free of charge for preventative health care and when necessary, a breast ultrasound or a breast needle biopsy. Various community clinics and agencies refer qualifying patients to the Department of Special Needs and Community Outreach. All three procedures are performed at the Women's Health Center at Mercy Hospital Southwest. During FY 2012, the Breast Health Program provided 38 ultrasounds and 32 biopsies.

**Prescription Program** - purchases necessary medications in emergency situations for people who must have the medicines for their health but have no money to buy them. The hospital's care managers identify patients in need of medication and request it from Komoto Pharmacy. The Department of Special Needs and Community Outreach processes the paperwork from the care managers and Komoto Pharmacy. During FY 2012, the Prescription Program provided 393 patients with their needed prescriptions/DME and IV Therapy (\$110,299.10).

# MISSION STATEMENT

## OUR MISSION

Dignity Health is 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.

# ORGANIZATIONAL COMMITMENT

## Hospital's Organizational Commitment

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

A Community Benefit Committee assists the Department of Special Needs and Community Outreach in prioritizing programs that are in line with the hospital's strategic plan. Committee members include representatives of the hospital Executive Management Team, the business community, social service agencies, community volunteers, board members, and employees. This group meets four times annually to help ensure that our outreach services respond to identified community needs and are effectively working to improve the overall health status of the community. The Committee provides input, advice, and approval for the Community Benefit Plan. The approved plan is then submitted to the board of Mercy Hospitals for final approval. Members of the Community Benefit Committee have remained the same from FY 2011 to FY 2012 with the exception of Jeremy Zoch, COO, Mercy Hospitals, who resigned his position at the hospital. Two new members were added: Robin Mangarin-Scott, Director of Strategic Marketing, Mercy and Memorial Hospitals and Jerry Starr, VP of Operations, Mercy Hospitals. A roster of current Committee members is attached as APPENDIX 1.

The Board's involvement is further reflected in their on-going endorsement of the Dignity Health Community Grants Program which supports the continuum of care in the community offered by other not-for-profit organizations. Every year Mercy Hospitals contributes to a fund for the Dignity Health Community Grants Program. This program awards grants to nonprofit organizations in Kern County whose proposals respond to the priorities identified in the health assessment and community benefit plan for Mercy Hospital Downtown. Dignity Health grant funds are used to provide services to underserved populations. During FY 2012, the following grants were awarded:

Alzheimer's Disease Association of Kern County - \$44,888	CASA of Kern County - \$40,000
Kern Assistive Technology Center - \$29,276	Links for Life - \$25,000
Special Olympics Southern California Kern County - \$7,000	Mercy Housing California - \$19,990
West Side Community Resource Center - \$24,888	St. Vincent de Paul Center - \$36,000

The hospital board is responsible for the following areas regarding the community benefit activities:

- Budgeting Review
  - Review community benefit budget for the Department of Special Needs and Community Outreach with explicit understanding and assumption of their role to ensure that the hospitals fulfill their obligation to benefit the community.
  - Ensure long-term planning and budgeting to set multiyear goals and objectives.
  - Budget adequate financial resources to hire competent employees to plan, develop, implement, and effectively manage community benefit initiatives.
- Program Content
  - The selection of priority program content areas by community benefit employees and diverse local stakeholders is based upon the following objective criteria:
    - ✓ Size of the problem (i.e., number of people per 1,000, 10,000, or 100,000)
    - ✓ Seriousness of the problem (i.e., impact at individual, family, and community levels)
    - ✓ Economic feasibility (i.e., cost of the program, internal resources, and potential external resources)

- ✓ Available expertise (i.e., can we make an important contribution?)
  - ✓ Necessary time commitment (i.e., overall planning, implementation, evaluation)
  - ✓ External prominence (i.e., evidence that it is important to diverse community stakeholders)
- Program Design
    - The selection and design of community benefit activities are based on the following criteria:
      - Estimated effectiveness/efficiency (i.e., What is the track record to date on this approach? Are there adequate resources to implement this intervention strategy?)
      - Existing efforts (i.e., Who else is working on this? What is our role? Is it meaningful? How can we best complement/enhance an existing effort?)
      - Collaborative opportunities with local stakeholders in a community health assessment that establishes priorities, develops a plan to address identified needs, and integrates community health priorities into the strategic planning and annual budgeting process.
  - Program Targeting
    - The targeting of specific project activities is based on the following criteria:
      - Target Population(s) (i.e., Will the intervention fit the needs and characteristics of the people we are trying to serve?)
      - Number of people (i.e., How many people will be helped by this intervention?)
      - Degree of controversy (i.e., Is this intervention acceptable to the community? Will this intervention offend important constituents?)
  - Program Continuation or Termination
    - Schedule annual, detailed verbal and written reports of progress towards identified performance targets by hospital community benefit leadership.
    - Approve continuation or termination of community benefit programs after receiving evaluation findings and other program information from community benefit employees and the Community Benefit Committee.
  - Program Monitoring
    - Use the Community Benefit Inventory for Social Accountability (Lyon Software) to identify, track, quantify, and report community benefit initiatives.
    - Continue on-going efforts to align all programs with these five core principles:
      - Focus on populations with disproportionate unmet health-related needs
      - Emphasize primary prevention
      - Build a seamless continuum of care
      - Increase community capacity
      - Strengthen collaborative governance

## **Non-Quantifiable Benefits**

Working collaboratively with community partners, the hospital provides leadership and advocacy, stewardship of resources, assistance with local capacity building, and participation in community-wide health planning. Employees of the Department of Special Needs and Community Outreach participate and chair a variety of collaborative committees throughout Kern County including the Kern Promotoras Network, Kern County Needs Assessment Committee, and “Ray of Hope” Luncheons. These employees serve on 16 different boards or committees that respond to a wide variety of community concerns. Each quarter all hospital exempt employees report the names of the community organizations, neighborhood groups, and related community health activities in which they participate. 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. Hospital funds are important to leveraging improvements throughout our entire county. Money and efforts invested in our programs grow through the acquisition of grants to supplement our funding, and the development of partnerships to extend the reach of our visions.

# COMMUNITY

Mercy Hospital Downtown serves all of Kern County, including Bakersfield (the county seat) and outlying rural communities such as Taft, Tehachapi, and Lake Isabella. We further define the community served by the hospital considered its primary service area. This is based on the Community Need Index (CNI) map for the hospital (APPENDIX 2). The county covers more than 8,100 square miles, geographically making it the third largest county in the state. The landscape is diverse, ranging from high desert to mountains to vast expanses of rich agricultural flatlands.

Kern County consistently ranks among the top five most productive agricultural counties in the United States and is one of the nation's leading petroleum-producing counties. Agriculture is the third largest industry in the county and accounts for 14.1 percent of total employment. Seasonal and cyclical fluctuations in employment in the agriculture and petroleum industries drive Kern County's unemployment rate consistently well above the state average. Below is a summary of Mercy Hospital Downtown's service area demographic data.

- Population: 542,440
- Diversity: Caucasian 41.0%| Hispanic 45.9%| Asian 4.7%| African American 5.6%| Other 2.8%
- Average Household Income: \$64,156
- Uninsured: 24.65%
- Unemployed in Labor Force: 6.0%
- No HS Diploma: 24.3%
- Renters: 34.3%
- CNI Score: 4.4
- Medicaid Patients: 22.09%
- Other Area Hospital: 9

Nearly two-thirds of Kern County's residents—and most of its major health care providers—are clustered in and around Bakersfield. In addition to Mercy Hospital Downtown, other health providers in Kern County include: two other Dignity Health hospitals – Mercy Hospital Southwest and Memorial Hospital, Kern Medical Center, Kaiser Permanente, San Joaquin Community Hospital, The Heart Hospital, Good Samaritan Hospital, Clinica Sierra Vista and National Health Services. The service area for these providers is Kern County. Whenever possible, an effort is made for community-based collaboration to solve problems and ensure sustainable health programs over the long term to populations that need it the most.

Many of Bakersfield's poorest residents are concentrated in the city's southeast quadrant, the site of two of our community outreach centers. The population is largely African American and Hispanic/Latino, with a high concentration of limited-English speaking individuals (many undocumented), elevated youth gang activity, and a high unemployment rate. These neighborhoods include seedy motels that house a transient homeless population, including many families with children.

Most of these residents have not received health services or assistance because of poverty, chronic substance abuse, language barriers, lack of transportation, a strong mistrust of established institutions, and lack of knowledge and understanding about accessing and using available services. For many low-income individuals and families living in the outlying rural communities of Kern County, geographic isolation heightens these barriers to health care and other services.

# COMMUNITY BENEFIT PLANNING PROCESS

## Community Needs and Assets Assessment Process

Mercy Hospital Downtown's designated service area is Kern County. The hospital primarily utilizes the following methods to assess community needs and the effectiveness of our response to these challenges: The Kern County Community Needs Assessment, Community Need Index (CNI), direct input from community leaders, residents, and staff of our Department of Special Needs and Community Outreach. The annual Kern County Network for Children Report Card is also used to corroborate the focus of our services.

The selection of priority needs involves collaboration with a variety of internal and external stakeholders. As an adjunct to the organization's Strategic Planning Process, community benefit planning derives input and guidance from administrative leadership and the Community Advisory Board. The regional Community Benefit Committee is directly involved in the selection of priorities and development of specific program goals and objectives. It is also their responsibility to ensure quality services are provided within each program and those we serve are satisfied with our services.

## Kern County Community Assessment

The 2010 Kern County Community Need Assessment (APPENDIX 3) combines quantitative and qualitative information based on review of health and quality of life data and interviews with community leaders and representatives of local agencies. To assist with identifying priorities, comparisons are made to other California counties, as well as to national benchmarks such as Healthy People 2020, which is a set of key national health objectives.

The needs assessment is a collaborative effort by Memorial Hospital, Delano Regional Medical Center, Kaiser Permanente, Kern County Department of Public Health Services, Mercy Hospital Downtown, Mercy Hospital Southwest, San Joaquin Community Hospital and other local partners. Debbie Hull, Regional Director of Community Benefit for Mercy and Memorial Hospitals convened this collaborative group. The 2010 assessment is a Web-based, living community needs assessment, which uses the Healthy Communities Network (HCN) Web tool to display health status and track progress in the community. The 2010 assessment highlights important issues in the community.

The Kern County HCN Website, [www.HealthyKern.org](http://www.HealthyKern.org), provides over 120 health and quality of life indicators for Kern County. Rather than focus on one isolated area of need, the needs assessment sought to create a comprehensive needs assessment for the county using multiple health and quality of life indicators. The needs assessment process involved assessment and understanding of demographics, health access, health care usage, health behaviors, health status, as well as social and environmental factors that ultimately affect health outcomes. The review and evaluation of this quantitative data, combined with community consultation and feedback, have enabled us to identify key priority areas in the community that require attention. The findings of this needs assessment are being used to inform strategic planning, decision-making, and resource investments and allocations.

The Center for Healthy Aging (CHA), an independent consulting group, analyzed each of the indicators on the [www.HealthyKern.org](http://www.HealthyKern.org) website. CHA presented their findings to the collaborative for their input. The top ten priority areas were agreed upon by the collaborative. Once the priorities were determined, the collaborative created a set of interview questions and obtained input from key stakeholders in the community to validate the top issues, identify gaps, and suggest evidenced-based and/or promising practices to address the issues.

## Key Findings

The top five priority areas of the 2010 needs assessment are:

- *Obesity*
- *Basic Needs/Unemployment Rate*
- *Education Attainment*
- *Access to Health Care*
- *Mortality Rates*

## Community Need Index (CNI)

The Dignity Health Reporting Sheet for the Community Need Index (CNI) for Kern County, prepared by Thomson/Dignity Health (APPENDIX 2), is used to further validate the identification of communities (based on ZIP codes) that are the most socio-economically disadvantaged and thus most in need. Residents of these communities tend to have Disproportionate Unmet Health-Related Needs (DUHN): lack of education, lack of health care insurance, homelessness or transient lifestyles, no or limited access to quality health care, high prevalence of conditions such as diabetes, heart disease, obesity, and substance abuse.

Those communities identified on the CNI for Kern County (2009) with the highest CNI score (rated 1 to 5 with 5 being the most economically disadvantaged and most in need) are the primary focus of programs and services coordinated by Mercy Hospital Downtown.

This summary provides a focus for our hospitals to increase the health and quality of life of residents in Kern County.

Bakersfield (93304 Zip Code)	5	Bakersfield (93309 Zip Code)	4.2
Bakersfield (93307 Zip Code)	5	Bear Valley Springs (93561 Zip Code)	4.2
Dustin Acres (93268 Zip Code)	4.8	Bakersfield (93313 Zip Code)	3.4
Bakersfield (93306 Zip Code)	4.8	Bakersfield (93311 Zip Code)	3
Oildale (93308 Zip Code)	4.6	Rosedale (93312 Zip Code)	1.8

The community needs assessment is available for all residents. Those who have computer access can go to [www.HealthyKern.org](http://www.HealthyKern.org) and find the assessment posted on the site. Those who do not have computer access can visit one of the many libraries throughout Kern County.

## Assets Assessment

In addition to identifying community need, the collaborative also identified community assets and promising practices available in Kern County that respond to the needs. Also, by virtue of their frequent contact with residents of Kern County's most disadvantaged communities, employees of the Department of Special Needs and Community Outreach are familiar with the community assets available to address health and human service issues that affect the residents. Listed below are some of the promising practices in Kern County.

### Obesity

- Mercy and Memorial Hospitals – Healthy Kids in Healthy Homes
- Community Action Partnership of Kern - Shafter Youth Center

### Basic Needs

- 23 Collaboratives and Family Resource Centers throughout Kern County
- St. Vincent De Paul – Services for the Homeless
- Garden Pathways – Family to Family Mentoring

#### Educational Attainment

- Mercy and Memorial Hospitals – Homemaker Care Program Training
- Kern County Network for Children – The Dream Center
- United Way – Financial Literacy Program
- Clinica Sierra Vista – Cal-Learn Program

#### Access to Health Care

- Free clinics accessible to farm workers
- Community Action Partnership of Kern County – Family Health Clinic
- Partners in Care and Visiting Nurse Community Services – Care-A-Van Mobile Medical Clinic

#### Mortality Rates

- Mercy and Memorial Hospitals – Chronic Disease Self-Management Program
- Low cost/no cost health insurance

### **Developing the Hospital's Implementation Plan (Community Benefit Report and Plan)**

Each year Department employees present progress reports to the Community Benefit Committee. During 2012, the Committee concentrated on program expansions and service quality. The Committee, as well as management and executive employees of each hospital, provide input and, as a result, make adjustments to programs, services, and the Community Benefit Plan. The Plan is then submitted to the boards for final approval.

Other stakeholders involved in the selection of priorities are those organizations with which our hospitals cosponsor community benefit programs and outreach activities. Some include the Kern County Public Health Services Department, Greater Bakersfield Legal Assistance, Clinica Sierra Vista, United Way of Kern County, Community Action Partnership of Kern, Kern Family Health Care, Kern Partnership of Wellness, Kern County Department of Human Services, National Health Services, Kern County Network for Children, First 5 Kern, Jesus Shack and Stop the Violence.

Each initiative in the Community Benefit Plan for Mercy Hospital Downtown relates directly to one or more needs identified in the Community Assessment. Other factors considered in selecting priorities for programs include:

- Size of the problem
- Severity of the problem
- Resources required and available
- Sustainability
- Availability of appropriate collaborators
- Efforts by other organizations

Intervention to address identified health issues is achieved through the following five main programs:

- Community Wellness Program (community health screening clinics; in-home health consultations, education, and monitoring; health education classes/seminars; and referrals to other local health care and social service agencies)
- Homework Club (after-school tutoring and social/cultural enrichment activities)
- Homemaker Care Program (homemaker services for the frail elderly and job training for unemployed adults)
- Children's Health Initiative (access to health care insurance for low-income children age 0 – 18 years and the establishment of a medical and dental health care home for all children in Kern County)
- Chronic Disease Self-Management Programs (EMPOWERMENT provides patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health)

Whenever possible, priority is given to the southeast Bakersfield neighborhoods where we have an established presence by virtue of our two outreach Centers: Learning Center and Outreach Center. These neighborhoods contain a high concentration of vulnerable population groups, including children, seniors, limited-English-speaking individuals, and low-income families.

Programs offered through these centers respond to the identified needs in the county-wide assessment. They provide youth activities to deter delinquency, develop leadership skills, enhance literacy and academic achievement, cultivate community responsibility, and provide educational and cultural enrichment opportunities. In addition, the centers are the hubs for many programs that provide basic support services to families in Bakersfield's most economically depressed areas. Programs include health screenings, meal and nutrition services, clothing, counseling, transportation, family support, and enrollment in low or no-cost health insurance programs. Our newest Outreach Center – The Community Wellness Center in downtown Bakersfield – gives us the opportunity to expand our preventative health care services in another underserved area of Bakersfield.

Because of our health education component and the depth of the collaboration with other local organizations, our community benefit programs help to contain the growth of community health care costs. For example, our Community Wellness Program raises awareness of risk factors such as high cholesterol, high blood pressure, and obesity. It helps people develop and maintain a healthy lifestyle. As a result, individuals will be better qualified to self-manage their health and thus avoid costly visits to Emergency Rooms. Additionally, our programs are structured to share resources and expertise with partner organizations. In short, our community benefit programs do not just apply a band-aid to unmet health-related needs, but are designed to improve health outcomes through changes in each individual situation and through the capacity of our community to respond to unmet health-related needs.

### **Planning for the Uninsured/Underinsured Patient Population**

Mercy Hospital Downtown is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or are otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Mercy Hospital Downtown strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with the hospital's procedures for obtaining financial assistance and contribute to the cost of their care based on individual ability to pay. (APPENDIX 4) Brochures announcing financial assistance are located in each Emergency Department, patient registration area and various locations throughout each facility for patient and family review. Every patient is given a financial assistance brochure upon admission. If admitted in an emergent manner, the patient information binder contains the financial assistance information. Each facility also has financial counselors on site to assist patients and their families upon discharge with bill resolution and applications for government sponsored insurance services.

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

# PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major initiatives and key community based programs of Mercy Hospital Downtown. These programs were developed in response to the 2010 Kern County Community Needs Assessment and are guided by the following five core principles:

- Focus on Populations with Disproportionate Unmet Health-Related Needs  
Seeking to accommodate the needs of communities with disproportionate unmet health-related needs.
- Emphasize Primary Prevention  
Addressing the underlying causes of persistent health problems.
- Build a Seamless Continuum of Care  
Emphasizing evidence-based approaches by establishing a link between clinical services and community health improvement services.
- Increase Community Capacity  
Targeting charitable resources to mobilize and build the capacity of existing community assets.
- Strengthen Collaborative Governance  
Engaging diverse community stakeholders in the selection, design, implementation, and evaluation of program activities

## Initiative I: Obesity

- Boy Scouts/Girl Scouts
- Healthy Kids in Healthy Homes
- Health Education Seminars and Classes
- In-Home Health Education

## Initiative II: Basic Needs - Poverty and Unemployment

- Breakfast Club
- Dinner Bell Program
- Emergency Pantry Baskets
- Food Certificate Program
- Guidance and Referrals to Community Services
- Holiday Food Baskets
- Hygiene/Diaper Distribution
- Pack-A-Sack Lunch Program
- Senior Grocery Bingo
- Shared Christmas

## Initiative III: Educational Attainment

- Homemaker Care Program - Training
- Homework Club
- Operation Back to School
- Subsidized Child Care

## Initiative IV: Access to Health Care

- Breast Health Program
- Charity Care for uninsured/underinsured and low income residents
- Children's Health Initiative
- Emergency Department Physician Services for Indigent Patients
- Enrollment Assistance/Government Programs
- Flu Clinics

- Guidance and Referrals to Community Services
- Health Fairs
- Health Screenings
- Healthy Promotions Dental Program
- Homemaker Care Program - In-Home Care
- Prescription Purchases for Indigents

Initiative V: Mortality

- Cancer Detection Program
- Car Seat Program
- Chronic Disease Self-Management Program
- Diabetes Self-Management Program
- Mercy Hospitals' Disease Management Program

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Executive Leadership, the Community Board and Dignity Health receive quarterly updates on program performance and news.

The following pages include Program Digests for five key programs that address one or more of the Identified Needs listed above.

# PROGRAM DIGESTS

<b>COMMUNITY WELLNESS PROGRAM</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>• Access to Health Care</li> <li>• Diabetes</li> <li>• Obesity</li> <li>• Basic Needs: Poverty and Unemployment</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> <li><input checked="" type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<p>According to the 2010 Kern County Community Health Needs Assessment:</p> <ul style="list-style-type: none"> <li>• 30.8% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2009). Latinos are leading in rates of obesity at 39.9% with Whites next at 27%.</li> <li>• The age-adjusted diabetes death rate in Kern County averaged for 2008 to 2010 is 31.2 per 100,000 compared to the State value of 18.4 per 100,000. These rates each <i>declined</i> by three points from the previous reporting period.</li> <li>• During the 2008-2010 measurement period the hospitalization rate due to diabetes was 29.9 hospitalizations per 10,000 population.</li> <li>• Overall, Kern County residents have shown slight improvement in rates of insurance since the previous reporting period. 77.1% of adults and 94.2% of children have health insurance. However, Latinos continue to be the least likely among Kern residents to have health coverage, with 61.7% insured (CHIS 2009).</li> </ul>
<b>Program Description Community Wellness Program</b>	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.
<b>REPORT FOR FY 2012</b>	
<b>Goal FY 2012</b>	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
<b>Results FY 2012</b>	<p>During FY 12, the Community Wellness Program accomplished the following:</p> <ul style="list-style-type: none"> <li>• Provided 35,752 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. (Goal: 26,000)</li> <li>• Provided 8,839 clients with health education through in-home visits and classes/seminars including EMPOWERMENT, Healthy Kids in Healthy Homes, and Diabetes Self Management. (Goal: 6,500 clients)</li> <li>• 27 of 31 (87%) case managed clients saw a decrease in at least one of their screening levels. (Goal 50%) <ul style="list-style-type: none"> <li>○ 17/31 (55%) improved blood pressure levels</li> <li>○ 15/31 (48%) improved cholesterol levels</li> <li>○ 13/31 (41%) improved blood glucose levels</li> <li>○ 20/31 (65%) saw improvement in two or more areas</li> <li>○ 15/31 (48%) saw improvement in three or more areas</li> </ul> </li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>• Added three new monthly community screening clinics – two in Shafter and a second clinic in Arvin.</li> <li>• Improved the availability of the latest health education materials for staff and clients by adding Krames On-Demand literature and StreaMed videos.</li> <li>• Added capabilities for HbA1c testing in-home and in conjunction with diabetes education. HbA1c is the test commonly used by physicians to determine whether a patient's diabetes is under control.</li> <li>• Published a new cookbook targeting children and families, and began providing it free of charge to program clients. Cookbook was created by a Jim Burke Ford Dream Builders team, and is written in English and Spanish.</li> <li>• Remodeled one of three classrooms at the Community Wellness Center and upgraded the lobby area.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	The total FY 2012 expense for the Community Wellness Program was \$797,908. Of this amount, \$277,459.70 was grant dollars, and \$520,448.30 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.

<b>UPDATE FOR FY 2013</b>	
<b>Goal FY 2013</b>	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
<b>2013 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2013 are to:</p> <ul style="list-style-type: none"> <li>• Provide 39,500 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. (Increase of 10%)</li> <li>• Provide 10,000 clients with health education through in-home visits and classes/seminars including EMPOWERMENT-Chronic Disease and Diabetes, and Healthy Kids in Healthy Homes. (Increase of 13%)</li> <li>• Decrease at least one screening level for 60 of 75 case-managed clients. (80%;15 individuals from each of five Community Clinics)</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Research an evidence-based case-management model to ensure positive outcomes in health screening levels and healthy behavior patterns.</li> <li>• Develop and expand health and wellness services offered at the Community Wellness Center.</li> <li>• Add no less than six new classes of health education topics to assist in the primary prevention of prevalent diseases and health issues in Kern County.</li> </ul>
<b>Baseline</b>	<p>During FY 2012:</p> <ul style="list-style-type: none"> <li>• Provided 35,752 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County.</li> <li>• Provided 8,839 clients with health education through in home visits/on-site classes.</li> <li>• 87% of 31 case managed clients saw a decrease in their screening levels.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>• Increase participation and on-site education at our regularly scheduled Community Clinics in order to provide more residents with access to a model continuum of care.</li> <li>• Enhance our work with Mercy &amp; Memorial Hospital's Case Management Department and other health care entities to implement a model continuum of care.</li> <li>• Increase utilization of our wellness software program to create improved tracking mechanisms that will enhance monitoring, follow-up, and retention of Community Clinic participants.</li> <li>• Demonstrate the impact on hospital utilization patterns by expanding the environment of seamless continuum of care between the hospital, the provider and the Community Wellness Program.</li> </ul>
<b>Community Benefit Category</b>	<p>A1-a Community Health Education - Lectures/Workshops  A1-c Community Health Education - Individual health ed. for uninsured/under insured  A2-d Community Based Clinical Services - Immunizations/Screenings</p>

<b>CHRONIC DISEASE SELF MANAGEMENT PROGRAMS</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Obesity</li> <li>• Access to Health Care</li> </ul>
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	<p>According to the 2010 Kern County Community Health Needs Assessment:</p> <ul style="list-style-type: none"> <li>• 30.8% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2009). Latinos are leading in rates of obesity at 39.9% with Whites next at 27%.</li> <li>• The age-adjusted diabetes death rate in Kern County averaged for 2008 to 2010 is 31.2 per 100,000 compared to the State value of 18.4 per 100,000. These rates each <i>declined</i> by three points from the previous reporting period.</li> <li>• During the 2008-2010 measurement period the hospitalization rate due to diabetes was 29.9 hospitalizations per 10,000 population.</li> </ul>
<b>Program Description Chronic Disease Self Management Programs</b>	<p>Our comprehensive Chronic Disease Self Management Programs (EMPOWERMENT - Chronic Disease and EMPOWERMENT-Diabetes) are designed to provide patients who have Diabetes and other chronic illnesses with the knowledge, tools and motivation needed to become proactive in their health. Each program seminar consists of six (6) weekly classes covering a variety of topics including nutrition, exercise, use of medications, communication with doctors, stress management, and evaluating new treatments.</p>
<b>REPORT FOR FY 2012</b>	
<b>Goal FY 2012</b>	<p>By offering evidence-based chronic disease management (CDM) programs, Mercy &amp; 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).</p>
<b>Results FY 2012</b>	<p>During FY 2012, EMPOWERMENT accomplished the following:</p> <ul style="list-style-type: none"> <li>• Completed three English and two Spanish EMPOWERMENT- Chronic Disease seminars in Kern County areas with a Community Index (CNI) score of 3 or above. (Goal: 4 in each language)</li> <li>• Completed four English and five Spanish EMPOWERMENT-Diabetes seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above. (Goal: 4 in each language)</li> <li>• 94.8% of participants completing the EMPOWERMENT Program avoided admissions to the hospital or emergency department for the six months following their participation in the program:             <ul style="list-style-type: none"> <li>○ 93.7% of those completing EMPOWERMENT-Chronic Disease seminars. (Goal 85%)</li> <li>○ 96.2% of those completing EMPOWERMENT-Diabetes seminars. (Goal 70%)</li> </ul> </li> <li>• 108 participants completed EMPOWERMENT Seminars:             <ul style="list-style-type: none"> <li>○ 47 began EMPOWERMENT-Chronic Disease seminars, and 40 completed (85%)</li> <li>○ 82 began EMPOWERMENT-Diabetes seminars, and 68 completed (83%)</li> </ul> </li> <li>• The process for referring CHF patients to the Community Wellness Center is still in the planning stage. Therefore, no referral increase was accomplished.</li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>• Improved system for referring Community Health Screening clients into EMPOWERMENT Seminars.</li> <li>• Trained 25 new Leaders to facilitate EMPOWERMENT Seminars:             <ul style="list-style-type: none"> <li>○ Five hospital employees outside of the Community Wellness Program: four in English Diabetes, one in Spanish Diabetes.</li> <li>○ Twenty community (lay) leaders trained: seven in Spanish Diabetes, two in both English and Spanish Diabetes, eight in Spanish Chronic Disease, and one in both Spanish Diabetes and Chronic Disease.</li> <li>○ Seventeen of the new Leaders trained were as a result of a partnership with the Kern County Promotoras Network to improve our reach into Spanish-speaking communities.</li> </ul> </li> </ul>
<b>Hospital's Contribution/Program Expense</b>	<p>Mercy and Memorial Hospitals have contributed \$24,378.23 to the Chronic Disease Self Management Programs' annual budget. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance, bookkeeping, and human resource support for the program.</p>
<b>UPDATE FOR FY 2013</b>	
<b>Goal FY 2013</b>	<p>By offering evidence-based chronic disease management (CDM) programs, Mercy &amp; 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).</p>

<b>2013 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2013 are:</p> <ul style="list-style-type: none"> <li>• Provide 16 EMPOWERMENT seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above.</li> <li>• Provide an appropriate mix of seminars by type (Chronic Disease, Diabetes) and by language (English, Spanish).</li> <li>• 85% of all participants completing EMPOWERMENT seminars will avoid admissions to the hospital or emergency department for the six months following their participation in the program.</li> <li>• Increase CHF patient referrals from Mercy &amp; Memorial Hospitals to the Community Wellness Center and improve follow-up and tracking process.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Expand access to EMPOWERMENT Chronic Disease and Diabetes self management education to residents of Kern County by continuing to establish key community partnerships that will allow for sharing of resources, expertise, and increase opportunities for community awareness.</li> <li>• Continue to work toward increasing provider referral processes for program participants.</li> </ul>
<b>Baseline</b>	<p>During FY 2012:</p> <ul style="list-style-type: none"> <li>• Completed three English and two Spanish EMPOWERMENT-Chronic Disease seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above.</li> <li>• Completed four English and five Spanish EMPOWERMENT-Diabetes seminars in Kern County areas with a Community Index (CNI) score of 3 or above.</li> <li>• 94.8% of participants completing the EMPOWERMENT Program avoided admissions to the hospital or emergency department for the six months following their participation in the program.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>• Engage clinical health professionals in the expansion of the program.</li> <li>• Focus on the uninsured and populations covered by Medicaid, Medicare/Medicaid.</li> <li>• Expand awareness and access of EMPOWERMENT Self Management Programs by increasing partnership with community organizations serving residents with chronic conditions, i.e., Arthritis Foundation, MS Society, etc.</li> <li>• Encourage and support continuing education for staff development to ensure quality service is offered by the EMPOWERMENT Self Management Programs.</li> </ul>
<b>Community Benefit Category</b>	A1-a Community Health Education - Lectures/Workshops

<b>CHILDREN'S HEALTH INITIATIVE</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>• Access to Health Care</li> <li>• Mortality Rates</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> <li><input checked="" type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<p>Although Kern County is above the state average in the number of children with health insurance, local health care experts feel that this issue still requires focus. The indicators for Kern County, based on 2009 data, show that 94% of children have health insurance. However, this same study shows that 48% of Kern's children rely on a public health insurance program compared to 36% for the state. Kern families continue to struggle in the slow economy, and more families are turning to public insurance programs for their children. Getting children enrolled into a public program is a good first step, but keeping children enrolled through annual renewal processes requires an ongoing focus to achieve. Studies show that children with a usual source of care are more likely receive routine checkups and screenings, and their parents are more likely to know where to go when their child needs treatment in acute situations. Not having a usual source of care or a usual place to go to when sick or in need of health advice can cause a delay of necessary care, leading to increased risk of complications.</p>
<b>Program Description: Children's Health Initiative</b>	<p>The Children's Health Initiative of Kern County is a grant-funded project which works with more than 50 public, private and non-profit organizations to enroll children into health insurance programs. The Children's Health Initiative works to provide access to health care for children for whom no insurance program is available. The Children's Health Initiative provides training for Certified Application Assistants (CAAs) 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.</p>
<b>REPORT FOR FY 2012</b>	
<b>Goal FY 2012</b>	<p>The Children's Health Initiative will ensure that 95% of all Kern children have access to health care through a health insurance plan or another type of Medical Home environment.</p>
<b>Results FY 2012</b>	<p>During FY 2012, the Children's Health Initiative accomplished the following:</p> <ul style="list-style-type: none"> <li>• Verified 10,119 children enrolled or renewed. (Goal: 8,300 enrolled or renewed)</li> <li>• Retained 29% of children enrolled through the SAS program. (Goal: 50%)</li> <li>• Trained 374 CAAs (Goal: 250 CAAs) and coordinated an annual CAA Conference.</li> <li>• Provided support and guidance to 24 agencies. (Goal: 20 agencies)</li> <li>• Launched a new effort to revive Healthy Kids Kern County insurance plan. (Goal: Develop a coordinated-care plan with clinic partners)</li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>• Provided CAA training and began application assistance for adults in April 2012. (Goal: Explore ways to expand CHI services to include adults)</li> <li>• Began providing direct application assistance in Bakersfield Memorial Hospital's NICU in May 2012.</li> <li>• Continued to support Kern County Promotoras Network to develop additional skills among Promotoras to provide application assistance, education and utilization support.</li> </ul>
<b>Hospital's Contribution/Program Expense</b>	<p>The total FY 2012 expense for the Children's Health Initiative was \$423,384. Of this amount, \$365,823 was grant dollars and \$57,561 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, office space, fundraising support, bookkeeping, and human resource support.</p>
<b>UPDATE FOR FY 2013</b>	
<b>Goal FY 2013</b>	<p>The Children's Health Initiative will ensure that 95% of all Kern children have access to health care through a health insurance plan or another type of Medical Home environment.</p>

<b>2013 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2013 are:</p> <ul style="list-style-type: none"> <li>• Assist applications that result in the enrollment or renewal of 10,625 children into health insurance programs.</li> <li>• Assist applications that result in the enrollment or renewal of 100 adults into Affordable Care Act (ACA) bridge to Medi-Cal programs.</li> <li>• Establish on-site application assistance in two hospital departments (i.e., Maternity units, ERs).</li> <li>• Retain 35% of children enrolled through the SAS program at annual renewal in Medi-Cal and Healthy Families.</li> <li>• Conduct trainings for 350 participants through certification and refresher trainings, CAA Network meetings and conferences.</li> <li>• Provide support and guidance to 24 agencies to improve their rate of success when assisting applications.</li> <li>• Develop a plan that will result in access to preventive and acute care for children who don't qualify for Medi-Cal or Healthy Families insurance programs.</li> </ul> <p>Enhancement strategies based on ASACB principles are:</p> <ul style="list-style-type: none"> <li>• Develop the capabilities and/or certification needed to assist families in making health plan decisions through the Health Care Benefits Exchange by October, 2013.</li> </ul>
<b>Baseline</b>	<p>During FY 2012:</p> <ul style="list-style-type: none"> <li>• Verified the enrollment or renewal of 10,119 children into a health insurance program</li> <li>• 374 Certified Application Assisters received training</li> <li>• 27% of children enrolled through SAS program were retained in a health plan</li> <li>• 24 Enrollment Entity partner agencies received technical assistance and support</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>• Continue development of continuous flow of funding for program sustainability.</li> <li>• Provide training and education sessions that support the objectives of the program, targeting populations that have been hard-to-reach through our traditional channels.</li> <li>• Eliminate barriers and streamline application processes.</li> </ul>
<b>Community Benefit Category</b>	A3-d Health Care Support Services - Enrollment Assistance

<b>HOMEMAKER CARE PROGRAM</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>• Basic Needs: Poverty and Unemployment</li> <li>• Education Attainment</li> <li>• Access to Health Care</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>• In 2011, Kern County's Annual unemployment rate was 14.9% compared to 11.7% in the state. One effect of high unemployment is that the labor force is not able to supply appropriate skills to employers.</li> <li>• In 2010, 10.5% of Kern County seniors 65 years or older were living in poverty compared to 10% in the state. A senior who lives in poverty faces a higher risk of losing his or her ability to live independently due to physical limitations, medical needs, and reliance on low fixed income.</li> <li>• During school year 2009-2010, Kern County's high school dropout rate was 4.8% compared to 4.9% in the state. Students who do not finish high school are more likely to lack the basic skills required to function in an increasingly complicated job market and society.</li> </ul>
<b>Program Description Homemaker Care Program</b>	The Homemaker Care Program provides in-home supportive services to homebound seniors ages 65 and older and adults with disabilities living in poverty. Case management of the seniors is conducted in the form of wellness checks and home visits to track client safety, nutrition, and program satisfaction. The Homemaker Care Program provides a two-week comprehensive employment readiness skills training focusing on individuals transitioning from unemployment into the workforce. Participants are trained to offer competent and reliable services to the ever growing senior population.
<b>REPORT FOR FY 2012</b>	
<b>Goal FY 2012</b>	<p>The Homemaker Care Program will provide in-home support services to homebound low-income seniors and disabled adults allowing them to remain in their homes.</p> <p>The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce.</p>
<b>Results FY 2012</b>	<p>During FY 2012, the Homemaker Care Program accomplished the following:</p> <ul style="list-style-type: none"> <li>• Trained 83 individuals during five two-week trainings. (Goal: Train 80 individuals during five two-week training sessions)</li> <li>• Ensured that 76 of 83, or 92%, of trainees completed the program. (Goal: 72 of 80, or 90% completion rate)</li> <li>• Ensured that 57 of 76, or 75%, of trainees gained employment. (Goal: 56 of 80, or 70% gain employment)</li> <li>• Enhanced 13 of 26, or 50%, of training components. (Goal: 13 of 26, or 50%)</li> <li>• Provided 100% of new households with health screenings. (Goal: 100%)</li> <li>• Provided 8,847 hours of services to an average of 63 client households per month. (Goal: Serve 90 senior and/or disabled adult clients with 12,000 hours of service)</li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>• Enhanced employment opportunities for the trainees by assisting with transportation, coordinating graduate interviews with Home Instead Senior Care, and collaborating with Homeless Court to assist trainees with misdemeanor expunging. Job club meetings did not begin this year.</li> <li>• Sustainability of the program improved with 27 new households, a 42% increase over the total new clients from last fiscal year. Of the new clients, 14 were full pay.</li> <li>• Client awareness of the program improved by issuing program newsletters highlighting staff and key health and safety topics.</li> <li>• Enhanced recruitment of the program through advertising in an area newsletter, material distribution to local religious groups and participating in health and resource fairs.</li> <li>• Developed a business plan that included growth projection with monthly updates and a marketing strategy.</li> </ul>
<b>Hospital's Contribution/Program Expense</b>	During FY 2012, expenses for the Homemaker Care Program were \$231,631. Of this amount, \$60,588 was grant dollars, \$70,344 was fee for service, and \$100,699 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.
<b>UPDATE FOR FY 2013</b>	
<b>Goal FY 2013</b>	<p>The Homemaker Care Program will provide in-home support services to homebound low-income seniors and disabled adults allowing them to remain in their homes.</p> <p>The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce.</p>

<b>2013 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2013 are:</p> <ul style="list-style-type: none"> <li>• Enroll 90 individuals during six two-week training sessions, which includes employment development services.</li> <li>• Ensure 90% of program participants complete the course.</li> <li>• Ensure 70% of program graduates gain employment within six months following completion of training.</li> <li>• Enhance 17 of the training components, focusing on curriculum content and classroom delivery.</li> <li>• Provide 9,840 hours of in-home supportive services to senior and disabled clients.</li> </ul> <p>Enhancement strategies based on ASACB review are:</p> <ul style="list-style-type: none"> <li>• Develop hands-on training opportunities that will enhance employment outcomes.</li> <li>• Ensure sustainability of the program by increasing the number of hours of service provided, focusing on full pay households.</li> <li>• Ensure client awareness of program updates.</li> <li>• Enhance recruitment efforts of the program by following our marketing plan.</li> </ul>
<b>Baseline</b>	<p>During FY 2012:</p> <ul style="list-style-type: none"> <li>• 83 individuals participated in four Homemaker Care Training sessions</li> <li>• 76 of 83, or 92%, completed the training</li> <li>• Provided a total of 8,847 hours of service to a monthly average of 63 households</li> <li>• 27 new clients, or 100%, received health screenings</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>• Establish agreements with three senior focus agencies or facilities to allow hands-on training by the training participants.</li> <li>• Provide opportunities for trainees to conduct on-line applications and job search at the Wellness Center.</li> <li>• Conduct monthly visits to businesses and agencies that serve the senior population.</li> <li>• Conduct monthly meetings with In-Home Care Attendants to discuss providing safety and quality service to each client.</li> <li>• Conduct monthly wellness checks and home visits to ensure meeting the needs of each client.</li> </ul>
<b>Community Benefit Category</b>	<p>E3-d In-kind Assistance - Basic services for individuals F5-c Leadership Dev/Training for Community Members - Career development</p>

<b>HOMEWORK CLUB</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>• Educational Attainment</li> <li>• Obesity</li> <li>• Access to Health Care</li> <li>• Basic Needs</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>• In Kern County, only 59% of 4<sup>th</sup> grade students are proficient in math and just 53% of 4<sup>th</sup> grade students are proficient in reading.</li> <li>• The high school graduation rate for Kern County is 72.6%.</li> <li>• Only 64% of Kern County's 7<sup>th</sup> grade students are physically fit and only 66.8% of teens report engaging in vigorous physical exercise 3 out of every 7 days.</li> <li>• Just 53% of children in Kern County eat at least 5 servings of fruits and vegetables each day.</li> <li>• 28.2% of children under 18 are living below the Federal poverty level. (<a href="http://www.healthykern.org">www.healthykern.org</a>)</li> </ul>
<b>Program Description: Homework Club</b>	<p>The Homework Club provides an academically structured after school program for underserved students attending kindergarten through seventh grades. The Program focuses on providing a safe environment for pre-teens to work on homework and other academic skills. The Homework Club promotes a commitment to community through participation in community service activities and offers cultural enrichment and socialization opportunities for grade school aged children after school. The Program encourages and rewards positive behaviors and teamwork. The importance of physical exercise is stressed through daily exercise routines and games. Quarterly nutritional education classes are offered to the Homework Club students. The program also provides students' families the opportunity to access other services that will improve the quality of life for the family unit. The Homework Club offers a six week summer program when school is not in session.</p>
<b>REPORT FOR FY 2012</b>	
<b>Goal FY 2012</b>	Low income/at-risk students, ages 5 to 13, will receive after school tutoring and mentoring.
<b>Results FY 2012</b>	<p>During FY 2012, the Homework Club accomplished the following:</p> <ul style="list-style-type: none"> <li>• 79% of 35 students had perfect attendance. (Goal: 95%)</li> <li>• 92% of 35 students achieved at least grade level outcomes on the KTEA Math Assessment. (Goal: 90%)</li> <li>• 87% of 35 students achieved at least grade level outcomes on the KTEA Reading Assessment. (Goal: 80%)</li> <li>• 100% of students were screened for enrollment in a health care plan and were encouraged to establish a medical and dental home.</li> <li>• 91% of 35 students demonstrated improved knowledge through pre and post questions regarding healthy food choices and the importance of daily exercise. 89% of students participated in a minimum of two nutrition education programs. (Goal: 90%)</li> <li>• 60% of 35 students demonstrated overall improvement in three fitness areas (push-ups, curl-ups, and sit 'n reach) (Goal: 75%), and 59% of students participated in three community "walks". (Goal: 60%)</li> <li>• 91% of 35 students participated in 15 community service projects offered through the program. (Goal: 90%)</li> <li>• 83% of parents attended 3 of the 4 parent group meetings. (Goal: 84%)</li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>• Held monthly volunteer meetings, recognized exceptional volunteer each month, and scheduled an end-of-year appreciation dinner for program volunteers.</li> <li>• Provided parenting skills classes. Offered monthly health screening opportunities to parents, and 2 nutrition education programs.</li> </ul>
<b>Hospital's Contribution/Program Expense</b>	The total FY 2012 expense for the Homework Club was \$20,106.88. This money was contributed by Mercy and Memorial Hospitals. Other hospital contributions include fundraising, human resource support, project supervision, training of staff, bookkeeping, strategic planning, and evaluation support.

<b>UPDATE FOR FY 2013</b>	
<b>Goal FY 2013</b>	Low income/at-risk students, ages 5 to 13, will receive after school tutoring and mentoring.
<b>2013 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2013 are:</p> <ul style="list-style-type: none"> <li>• Ensure 85% of 35 students have perfect attendance.</li> <li>• Ensure 92% of 35 students achieve at least grade level outcomes on the KTEA Math Assessment in a nine-month period.</li> <li>• Ensure 88% of 35 students achieve at least grade level outcomes on the KTEA Reading Assessment in a nine-month period.</li> <li>• Ensure 100% of students are screened for enrollment in a health care plan and are encouraged to establish a medical and dental home.</li> <li>• Ensure 92% of 35 students demonstrate improved knowledge through pre and post questions regarding healthy food choices and the importance of daily exercise.</li> <li>• Ensure 75% of 35 students meet the qualifying standards for the National Physical Fitness Award Program in three areas (push-ups, curl-ups, and sit 'n reach).</li> <li>• Ensure 85% of parents attend a minimum of 3 of the 4 parent group meetings.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Hold monthly volunteer meetings and recognize exceptional volunteer each month.</li> <li>• Provide workshops to Homework Club volunteers that focus on personal development.</li> <li>• Schedule ESL classes, parenting skills and money management workshops for parents.</li> </ul>
<b>Baseline</b>	<p>During FY 2012:</p> <ul style="list-style-type: none"> <li>• 79% of 35 students had perfect attendance.</li> <li>• 92% of 35 students achieved at least grade level results in math and 87% of students achieved at least grade level results in reading.</li> <li>• 100% of students were screened for health insurance coverage.</li> <li>• 91% of 35 students demonstrated improved knowledge of making healthy food choices and the importance of daily exercise.</li> <li>• 60% of students achieved overall improvement in three fitness areas (push-ups, curl-ups, and sit 'n reach).</li> <li>• 83% of parents attended 3 of 4 scheduled parent group meetings.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>• Offer after-school tutoring, nutrition education, mentoring, exercise activities, and educational field trips from 2:30 pm to 4:30 pm, Monday through Friday.</li> <li>• Case manage health insurance enrollment and utilization of health care services.</li> <li>• Maintain data collection and evaluation records for students on a weekly, monthly and annual basis.</li> <li>• Provide to Homework Club parents: <ul style="list-style-type: none"> <li>Health screenings and health education opportunities.</li> <li>Educational and personal development classes.</li> <li>Quarterly parent group meetings.</li> </ul> </li> </ul>
<b>Community Benefit Category</b>	F3-Community Support

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

# COMMUNITY BENEFIT AND ECONOMIC VALUE

## Classified Summary of Un-sponsored Community Benefit

Mercy Hospital Downtown utilizes the Community Benefit Inventory for Social Accountability (CBISA) computer program created by Lyon Software to track Community Benefit activities. This software enhances our ability to capture data uniformly over a multiyear period and allows data to be updated as needed to develop trending information.

Patient costs are determined by utilizing the HBOC Cost Accounting System.

8/28/2012  
 322 Mercy - Mercy Hospital Baker  
 Complete Summary - Classified Including Non Community Benefit (Medicare)  
 For period from 7/1/2011 through 6/30/2012

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<b><u>Benefits for Living in Poverty</u></b>						
Financial Assistance	5,903	6,425,821	0	6,425,821	2.6	2.3
Medicaid	25,466	43,505,258	34,712,384	8,792,874	3.6	3.1
<b>Community Services</b>						
Community Benefit Operations	721	601,025	0	601,025	0.2	0.2
Community Building Activities	4,231	52,260	0	52,260	0.0	0.0
Community Health Improvement Servic	22,747	693,548	14,854	678,694	0.3	0.2
Financial and In-Kind Contributions	22,318	436,452	39,234	397,218	0.2	0.1
Subsidized Health Services	30,087	381,125	0	381,125	0.2	0.1
<b>Totals for Community Services</b>	<b>80,104</b>	<b>2,164,410</b>	<b>54,088</b>	<b>2,110,322</b>	<b>0.9</b>	<b>0.7</b>
<b>Totals for Living in Poverty</b>	<b>111,473</b>	<b>52,095,489</b>	<b>34,766,472</b>	<b>17,329,017</b>	<b>7.1</b>	<b>6.1</b>
<b><u>Benefits for Broader Community</u></b>						
<b>Community Services</b>						
Community Building Activities	1,625	25,148	0	25,148	0.0	0.0
Community Health Improvement Servic	9,147	1,481,982	1,079,655	402,327	0.2	0.1
Financial and In-Kind Contributions	371	158,849	0	158,849	0.1	0.1
Health Professions Education	107	203,865	0	203,865	0.1	0.1
Research	0	136,638	0	136,638	0.1	0.0
<b>Totals for Community Services</b>	<b>11,250</b>	<b>2,006,482</b>	<b>1,079,655</b>	<b>926,827</b>	<b>0.4</b>	<b>0.3</b>
<b>Totals for Broader Community</b>	<b>11,250</b>	<b>2,006,482</b>	<b>1,079,655</b>	<b>926,827</b>	<b>0.4</b>	<b>0.3</b>
<b>Totals - Community Benefit</b>	<b>122,723</b>	<b>54,101,971</b>	<b>35,846,127</b>	<b>18,255,844</b>	<b>7.4</b>	<b>6.5</b>
<b>Unpaid Cost of Medicare</b>	<b>15,222</b>	<b>59,365,926</b>	<b>42,748,265</b>	<b>16,617,661</b>	<b>6.8</b>	<b>5.9</b>
<b>Totals with Medicare</b>	<b>137,945</b>	<b>113,467,897</b>	<b>78,594,392</b>	<b>34,873,505</b>	<b>14.2</b>	<b>12.4</b>
<b>Totals Including Medicare</b>	<b>137,945</b>	<b>113,467,897</b>	<b>78,594,392</b>	<b>34,873,505</b>	<b>14.2</b>	<b>12.4</b>

## Telling the Story

As in prior years, the final community benefit report will be publicized and distributed to our partner agencies, elected officials, schools, and faith-based organizations throughout the county. The annual report and most recent needs assessment will also be posted on the facility website at

[www.mercybakersfield.org](http://www.mercybakersfield.org)

[www.choosemercymemorial.org](http://www.choosemercymemorial.org)

Note: The needs assessment report can be found on [www.healthykern.org](http://www.healthykern.org).

## Success Stories

### Community Wellness Program

#### Diabetes Self-Management Program:

Jacob is a 51-year-old man who attended our EMPOWERMENT – Diabetes Seminar in McFarland. Jacob was diagnosed with diabetes two years ago, but believes he was an undiagnosed diabetic for many years prior. During the third session of the seminar, Jacob could not wait to share his good news. He lost a total of 31 pounds by using techniques he learned in the seminar, such as controlling his meal portions, eating healthier food, and walking 30 minutes a day 3-4 times a week. Jacob said he has more energy and is sleeping better at night since becoming a self-manager of his diabetes. He is excited and looks forward to how he will continue with his success.

#### In-Home Health Education:

Bilingual Health Educator Sylvia first saw 17-year-old Isabel last summer for nutrition education. Isabel was unhappy with her image because she was overweight and even tried to commit suicide at the age of twelve. She was seeing a psychologist regularly, but had been unable to make changes to her daily routine or emotions. Sylvia explained how to make nutrition changes and increase her physical activity, along with talking about the way she felt. Sylvia saw Isabel's mother recently, and the mother told Sylvia about the tremendous change in her daughter. Isabel immediately changed her eating habits and increased her physical activity after Sylvia's visit. Her communication with her parents has improved along with her grades. Isabel's mother is grateful for our services that gave her daughter the help she needed.

### Homemaker Care Program

Emma is 72-years-old, low-income, bed-bound, and lives alone. During our initial assessment, we found Emma had little food, no cleaning supplies, and minimal finances remaining for the month. We arranged for our In-Home Care Attendant to begin assisting. We contacted the Mercy and Memorial Learning Center for an emergency food basket, and purchased the needed supplies to begin creating a healthy and safe living environment. We arranged for the Food Bank to provide additional food items and for two of our In-Home Care Attendants to begin providing daily visits to prepare meals, clean and most importantly offer companion care. We are proud of our Homemaker Care Program team for taking quick action to ensure the safety and dignity of this vulnerable senior.

*\*The clients' names in these stories have been changed.*

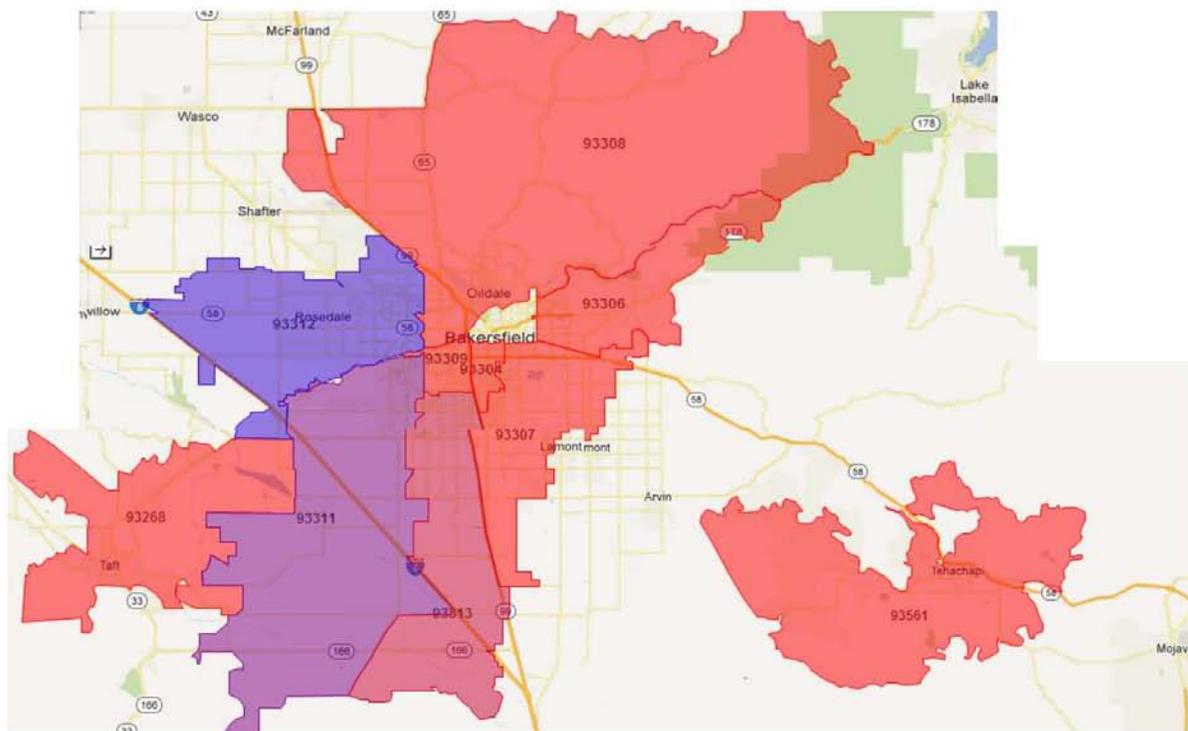


## **Department of Special Needs & Community Outreach**

### **Community Benefit Committee Membership**

**Felicia Barraza**, Community Benefit CBISA Coordinator, Mercy & Memorial Hospitals  
**Morgan Clayton**, President, Tel-Tec Security  
**Tom Corson**, Executive Director, Kern County Network for Children  
**Rita Flory**, Community Benefit Coordinator, Mercy & Memorial Hospitals  
**Gary Frazier**, Vice President, Business Development, Bakersfield Memorial Hospital  
**Judith Harniman**, Assistant Director, First 5 Kern  
**Mikie Hay**, Director of Community Affairs, Jim Burke Ford  
**Della Hodson**, President & CPO, United Way Kern County  
**Pam Holiwell**, Assistant Director, Kern County Department of Human Services  
**Debbie Hull**, Regional Director, Special Needs and Community Outreach, Mercy & Memorial Hospitals  
**Louis Iturriria**, Manager of Marketing and Public Affairs, Kern Health Systems  
**Robin Mangarin-Scott**, Director of Strategic Marketing, Mercy & Memorial Hospitals  
**Gloria Morales**, Services Coordinator, Mercy Services Corp.  
**Sr. Judy Morasci**, Vice President, Mission Integration, Mercy Hospitals of Bakersfield  
**Genie Navarro**, Property Manager, Mercy Services Corp.  
**Eddie Paine**, President, Edward Paine & Associates  
**Sandra Serrano**, Chancellor, Kern Community College District  
**Jerry Starr**, Vice President, Operations, Mercy Hospitals of Bakersfield  
**Joan Van Alstyne**, Director, Quality Management, Bakersfield Memorial Hospital  
**Cindy Wasson**, Director of Public Health Nursing, Kern County Public Health Services Department  
**Stephanie Weber**, Executive Director, Friends of Mercy Foundation  
**Jonathan Webster**, Executive Director, Brotherhood Alliance

## Mercy Hospitals of Bakersfield – Kern County



**Lowest Need**      **Highest Need**  
■ 1 - 1.7 Lowest    ■ 1.8 - 2.5 2nd Lowest    ■ 2.6 - 3.3 Mid    ■ 3.4 - 4.1 2nd Highest    ■ 4.2 - 5 Highest

<span style="color: red;">■</span>	<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
<span style="color: red;">■</span>	93268	4.8	13620	Dustin Acres	Kern	California
<span style="color: red;">■</span>	93304	5	50472	Bakersfield	Kern	California
<span style="color: red;">■</span>	93306	4.8	60756	Bakersfield	Kern	California
<span style="color: red;">■</span>	93307	5	73563	Bakersfield	Kern	California
<span style="color: red;">■</span>	93308	4.6	49283	Oildale	Kern	California
<span style="color: red;">■</span>	93309	4.2	63712	Bakersfield	Kern	California
<span style="color: purple;">■</span>	93311	3	42067	Bakersfield	Kern	California
<span style="color: blue;">■</span>	93312	1.8	61080	Rosedale	Kern	California
<span style="color: red;">■</span>	93313	3.4	42771	Bakersfield	Kern	California
<span style="color: red;">■</span>	93561	4.2	31537	Bear Valley Springs	Kern	California

**CNI Median Score: 4.4**

# KERN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

[www.HealthyKern.org](http://www.HealthyKern.org)

## Executive Summary

The 2010 Kern County Community Needs Assessment combines quantitative and qualitative information based on review of health and quality of life data and interviews with community leaders and representatives of local agencies. To assist with identifying priorities, comparisons are made to other California counties, as well as to national benchmarks such as Healthy People 2020, which is a set of key national health objectives. This report summarizes the results of the 2010 Kern County Community Needs Assessment.

The needs assessment is a collaborative effort by Memorial Hospital, Delano Regional Medical Center, Kaiser Permanente, Kern County Department of Public Health, Mercy Hospital Downtown, Mercy Hospital Southwest, San Joaquin Community Hospital and other local partners. The 2010 assessment is a web-based, living community needs assessment, which uses the Healthy Communities Network (HCN) web tool to display health status and track progress in the community. The 2010 assessment highlights important issues in the community. The next steps will be to propose an implementation strategy for the priority areas.

The Kern County HCN website, [www.HealthyKern.org](http://www.HealthyKern.org), provides over 120 health and quality of life indicators for Kern County. Rather than focus on one isolated area of need, the needs assessment sought to create a comprehensive needs assessment for the county using multiple health and quality of life indicators. The needs assessment process involves assessment and understanding of demographics, health access, health care usage, health behaviors, health status, as well as social and environmental factors that ultimately affect health outcomes. The review and evaluation of this quantitative data combined with community consultation and feedback have enabled us to identify key priority areas in the community that require attention. The findings of this need assessment can be used to inform strategic planning, decision-making, and resource investments and allocations.

The Center for Healthy Aging (CHA), independent consultants, analyzed each of the indicators on the [www.HealthyKern.org](http://www.HealthyKern.org) website. CHA presented their findings to the collaborative for their input. The top ten priority areas were agreed upon by the collaborative. Once the priorities were determined, the collaborative created a set of interview questions and obtained input from key stakeholders in the community to validate the top issues, identify gaps, and suggest evidenced-based and/or promising practices to address the issues. Next steps will be to create the strategic plan to target the top priority areas.

This summary highlights the identified county needs to focus on in order to increase the health and quality of life of residents in Kern County.

### Key Findings and Themes

- *Top health problems and community issues (not ranked)*
  - Obesity
  - Basic Needs: Poverty and Unemployment
  - Educational Attainment
  - Sexually Transmitted Infections
  - Access to Health Care
  - Teen Birth Rate and Infant Health
  - Diabetes
  - Mortality rates
  - Air Quality
  - Public Safety and Social Environment

## Obesity

Obesity increases the risk of many diseases and health conditions including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being overweight or obese also carries significant economic costs due to increased health care spending and lost earnings. 29.3% of Kern County [adults are obese](#) and the percentage has consistently increased over the 2003 – 2007 timeframe. Latinos are leading at 34% with Whites next at 26%. Males between the ages of 45 and 65 have the highest obesity rates. Healthy People 2020 national health target is to reduce the proportion of adults who are obese to 15%. If accomplished, this would be about a 50% reduction in the rate of obesity in Kern County.

Kern County would benefit in reducing the number of diabetes deaths and related diabetes attributes by focusing their efforts on reducing obesity and increasing physical activity in the low ranking categories noted above.

## Basic Needs: Poverty and Unemployment

All but one of the Kern County 'below poverty level' indicators are high: Based on the 2000 Census, [Children Living Below Poverty Level](#) is 28.2%, [Families Living Below Poverty Level](#) is 16.8%, and [People Living Below Poverty Level](#) is 20.8%. Only [People 65+ Living Below Poverty Level](#) is low at 10.5%. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the community (which coincides with the high unemployment rate). Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival. Children in poverty are more likely to have physical health problems like low birth weight or lead poisoning, and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education. Seniors who live in poverty are an especially vulnerable group due to increased physical limitations, medical needs, and social isolation. Seniors often live on a fixed income from pensions or other retirement plans and social security. If this income is insufficient in the face of increasing prescription costs and other costs of living, most seniors have no way to supplement their income. Retirement plans may be vulnerable to fluctuations in the stock market as well; the increasing reliance of retirees on stock market based retirement plans may explain why more seniors nationwide are now slipping into poverty.

Kern County is experiencing [high unemployment](#) rates. The June 2010 unemployment rate rose to 15.7% compared to the State of California unemployment rate of 12.2%. During the past year, the unemployment rate ranged from 14% to 18.3% of the adult civilian population in Kern County. The unemployment rate is a key indicator of the local economy: a high unemployment rate has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs. Families with unemployed adults face significant challenges in caring for and meeting their health needs and the health needs of their children.

## Educational Attainment

Kern County schools are struggling with low assessment rates and high dropout rates. From 2005 – 2008 the number of students who [completed high school](#) decreased from 81.6% to 73.5%. The dropout rate during this period was 5.5%, placing Kern County 42<sup>nd</sup> out of 56 reporting counties. Students who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime. Completion of high school and achieving

standard literacy levels align with future employment opportunities, and encourage the transition from adolescence to responsible adulthood.

In 2009, the educational indicators of 4<sup>th</sup> grade students proficient in [math](#) and [reading](#) were low at 56% and 51%, respectively. Competence in mathematics and reading are essential for functioning in everyday life. The ability to read proficiently is a fundamental skill that affects the learning experiences and school performance of children and adolescents. Students who take higher level mathematics and science courses, which require strong fundamental skills in mathematics and who are competent readers are more likely to attend and to complete college. The high [Student-to-Teacher Ratio](#) may be contributing to the low achievement levels of students in Kern County. In 2007-2008, the student-to-teacher ratio was high in Kern County at 18.3 students/teacher, with 50% of the U.S. counties having 14.4 students/teacher or less. This indicator does not take class size into consideration; however, the student-teacher ratio is often a reasonable proxy for estimates of class size. The student-teacher ratio is an indicator of how well a school or district is preparing their students to function in society.

### **Sexually Transmitted Infections**

Kern County has exceedingly high rates of sexually transmitted infections. The major areas identified are [HIV](#), [chlamydia](#), and [gonorrhea](#) rates. The HIV prevalence rate 62.5 cases per 100,000 population, ranking 49<sup>th</sup> out of 58 California counties. The chlamydia incidence rate ranks 58th of 58 counties in California; the gonorrhea incidence rate ranks 55<sup>th</sup>. In 2009, Kern County had 622.8 cases per 100,000 female population of chlamydia. The cases of chlamydia have primarily increased from 2004 to 2008 with a small decline in 2006 and again in 2009. Under reporting of chlamydia is substantial, as most people with chlamydia are not aware of their infections and do not seek testing. This can lead to more serious health outcomes such as Pelvic Inflammatory Disease and infertility.

The gonorrhea incidence rate in Kern County does not meet national targets. In 2009, the gonorrhea incidence rate in Kern County was 98.8 per 100,000 population; whereas, the Healthy People 2020 target is 19 per 100,000 population. However, unlike chlamydia, gonorrhea rates have been in steady decline since 2006.

Compared to older adults, adolescents are at higher risk for acquiring sexually transmitted diseases (STDs) for a number of reasons, including limited access to preventive and regular health care and physiologically increased susceptibility to infection. Responsible sexual behavior can eliminate or reduce the chances of contracting a sexually transmitted disease and unintended pregnancies, thus reducing the number of cases of STDs and births. The Healthy People 2020 national health target is to increase the proportion of adolescents aged 17 years and younger who have never had sexual intercourse to 75%.

### **Access to Health Care**

Although the access to health care indicators are not showing in the 'red' for Kern County, there is still concern by Kern County health care experts that this is an issue that needs to be addressed. The indicators for Kern County, based on 2007 data, show that [adults with private health insurance](#) and [people with a usual source of health insurance](#) are 57% and 87.5%, respectively, and [children with Health Insurance](#) is at 91%. African American and Latinos who have health insurance are lowest at 47.9% and 36.3%. A high rate of private insurance coverage may indicate greater financial security, since it means that more businesses are able to provide insurance, and more individuals can afford to purchase it when necessary. Areas with high rates of private insurance coverage also place less strain on the public programs that are available. People with a usual source of care are more likely to go in for routine checkups and screenings, and are more likely to know where to go for treatment in acute situations. Not having a usual source of care or a usual place to go to when sick or in need of health advice can cause a delay of necessary care, leading to increased risk of complications.

## Teen Birth Rate and Infant Health

The teen birth rate in Kern County has been consistently high for many years. This has led to more low birth weight babies, and also leads to a lack of education attainment for female youth. In 2006-2008, Kern County had the highest [teen birth rate](#) of all California counties at 63.7 births per 1,000 female ages 15 – 19, compared to 36.6 per 1,000 females ages 15 – 19 in the State of California.

High teen birth rates result in a high percent of babies with a low (<2500 grams) or very low (<1500 grams) birth weight. The Healthy People 2020 national health target is to reduce the proportion of [infants born with low birth weight](#) to 5.0%. In California, 6.9% of infants have a low birth weight. Kern County ranks 50<sup>th</sup> among the 58 counties in California at 7.4%. The percentage of babies with a low birth weight has continued to increase over the past five years. While it is not trending up in high percentages, infants born with [very low birth weight](#) is also rising. The 2010 national health target is to reduce the proportion of infants born with very low birth weight to .09%. In 2009, 1.4% of babies in Kern County were born with a very low birth weight.

Babies born with a low or very low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with premature birth and babies born with very low birth weight are at the highest risk of dying in their first year. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability.

The [Infant Mortality Rate](#) in Kern County is also exceedingly high. Kern County ranks 45<sup>th</sup> out of all 58 counties in California with an infant mortality rate of 7.2/1,000 and the trend is rising. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. The Healthy People 2020 national health target is to reduce the infant mortality rate to 4.5 deaths per 1,000 live births.

[Preterm births](#) from 2005 to 2008 in Kern County have been rising steadily. The 2008 preterm birth rate was 13.9%. The Healthy People 2020 national health target is to reduce the proportion of infants who are born preterm to 7.6%. In all of the above cases, the most important things an expectant mother can do to prevent and/or reduce prematurity, low and very low birth weight and also preterm births are to take prenatal vitamins, stop smoking, stop drinking alcohol and using drugs, and most importantly, get prenatal care. The good news is that the trend of mothers who received early prenatal care is going up. Kern County is at 72.2%, close to meeting the State of California at 78.7%, and is rising to meet the 2010 Healthy People 2020 goal of 90%.

Disparities can be seen among indicators of teen sexual health, maternal health, and infant health such as teen birth rate, prenatal care, low birth weight, and infant mortality rates. Birth and infant health outcomes tend to be the worst for African Americans. Additionally, in Kern County, African American and Hispanic teens have a birth rate nearly 3.5 times as high as White females.

## Diabetes

Kern County places in the bottom quartile of California counties for *all* diabetes-related indicators. The age-adjusted diabetes death rate averaged over 3 years (2006-2008) is nearly 34 per 100,000 compared to the State value of 21 per 100,000. Diabetes risk factors such as obesity and physical inactivity contribute to the prevalence of diabetes and diabetes-related health outcomes in the community. Age, race, and ethnicity are also important risk factors. In Kern County, Asians have the lowest diabetes death rate of 17.5 per 100,000 population; whereas African Americans, Hispanics, and American Indians have death rates 3 – 4 times this rate.

Kern County ranks in the bottom ten percent for all hospital utilization rates due to diabetes-related admissions and emergency room visits. During the 2006-2008 measurement period, the hospitalization rate

due to diabetes was 28.4 hospitalizations per 10,000 population and ranked 55 out of 58 California counties. The hospitalization rate due to long-term and short-term complications of diabetes was 17.2 and 8.9 hospitalizations per 10,000 population, respectively – ranking 52<sup>nd</sup> and 54<sup>th</sup> out of 58 California counties.

Persons with diabetes are at risk for ischemic heart disease, neuropathy, and stroke. Healthy People has identified 17 goals that aim to “reduce the disease and economic burden of diabetes, and improve the quality of life for all persons who have or are at risk for diabetes.” Goals include improved diabetes education, improved compliance with recommended care and screening procedures, and reduced rates of serious complications such as foot ulcers, amputation, and death.

## **Mortality Rates**

The high mortality rates in Kern County point to multiple systemic problems in the health care system. Mortality rates in Kern County rank in the bottom third of all California counties. In addition, the rates for nearly all causes of death are increasing over time. The age-adjusted death rates due to coronary heart disease, diabetes, stroke, suicide, and influenza and pneumonia all place in the bottom quartile of all California counties. The suicide death rate is more than double the Healthy People 2020 national target, and the heart disease death rate is 25% higher than the national target. Significant racial and ethnic disparities exist for many death rates, especially for African Americans.

## **Air Quality**

Ozone is the primary ingredient of smog air pollution. Inhaling ozone can result in a number of health effects, including induction of respiratory symptoms, inflammation of airways, and decreased lung functioning. During 2006 -2008, the [annual ozone air quality](#) was rated an “F” (a 5 in the numeric scale) in Kern County, whereas the US standard is a B or better (a 1 or a 2 in the numeric scale). [Annual particle pollution](#) is also very high, rating an “F”, or 5, during the 2006 – 2008 measurement period. Particle pollution refers to the amount of particulate matter in the atmosphere. In addition to poor air quality due to high ozone and particulate matter, the quantity (in pounds) of [carcinogens released](#) into the air is increasing over time in Kern County. All of these factors result in poor air quality in Kern County and can adversely affect health through illnesses such as asthma, cardiovascular problems, or premature death.

## **Public Safety and the Social Environment**

Kern County is disproportionately affected by violence. In 2008, Kern County ranked 27<sup>th</sup> of 35 reporting counties in California, with a [Violent Crime Rate](#) of 562.3 crimes per 1,000 population. The violent crime rate includes homicide, assault, rape and robbery. Violence surrounds and threatens many people in their homes, schools and neighborhoods. In addition, race, ethnic and gender disparities are an issue.

In addition to a high violent crime rate, the [Child Abuse Rate](#) in Kern County ranks 52<sup>nd</sup> of the 58 California counties. From 2004-2008 child abuse in Kern County steadily increased. In 2009, the rate decreased from 22.3 cases/1,000 population to 18.5 cases/1,000 population - a step in the right direction; however, the Healthy People 2020 national health target is to reduce the child maltreatment rate to 10.3 cases per 1,000 children under 18 years of age. The current rate in Kern County is nearly two times the target value. Child abuse and neglect can have enduring physical, intellectual, and psychological repercussions into adolescence and adulthood. Abuse can affect a person’s ability to lead a healthy life at home, at work, and at school.

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It is clear that Kern County has many health and quality of life areas that need attention and concerted effort to improve. This 2010 Kern County Community Needs Assessment is the beginning effort to address the most pressing needs. These needs will be addressed by the individual hospitals, health and human service

organizations within the community, as well as the collaborative efforts by the organizations gathered to create the most significant needs summarized in this needs assessment.

The 2010 needs assessment provided a listing of the top ten health priority areas that the county of Kern would need to address in order to create a healthier community for its residents. Of those ten identified areas, five rose to the top of the list as critical to the immediate health crisis in our community. Our community in collaboration through public agencies, private organizations and non-profit groups will work diligently to implement evidence based strategies to close the gaps for service and quality thus creating a healthier community.

The top five priority areas of the 2010 needs assessment are:

1. *Obesity*
2. *Basic Needs/Unemployment Rate*
3. *Education Attainment*
4. *Access to Health Care*
5. *Mortality Rates*

**DIGNITY HEALTH**  
**SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY**  
 (June 2012)

**Policy Overview:**

**Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.**

**Eligibility for Patient Payment Assistance:**

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

**Determination of Financial Need:**

- Financial need will be determined through an individual assessment that may include:
  - a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
  - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
  - c. a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

### Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

### Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

### Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

### Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for

payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.

- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, dignity health management and dignity health facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.