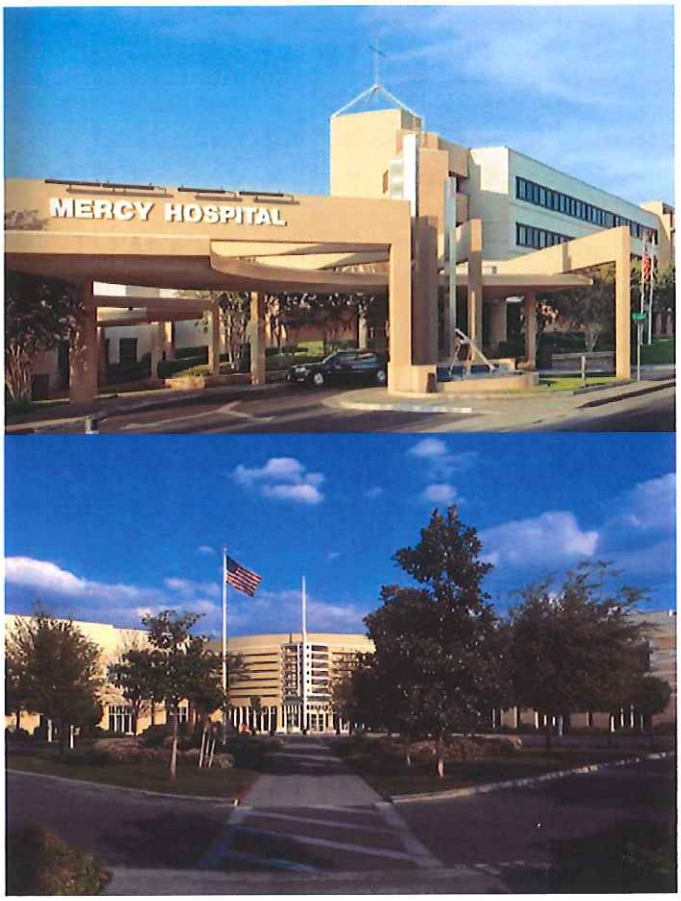
Dignity Health
Mercy Hospitals



Mercy Hospital Downtown
Mercy Hospital Southwest

Community Benefit Report 2013
Community Benefit Implementation Plan 2014

Dignity Health.
Mercy Hospitals

A message from Russell Judd, President of Mercy Hospitals and Kevin Andrew, Board Chair of Mercy Hospitals

When we talk about health care today, the words *budget, cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care.* At Mercy Hospitals we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Mercy Hospitals we share a commitment to optimize the health of our community. In fiscal year 2013 Mercy Hospitals provided $26,368,904 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Mercy Hospitals Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 23, 2013 meeting.

Russell Judd
President
Mercy Hospitals

Kevin Andrew
Board Chair
Mercy Hospitals

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EXECUTIVE SUMMARY

Founded in 1910, Mercy Hospitals 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. Mercy Hospitals is a member of Dignity Health, formerly Catholic Healthcare West (CHW)[1], the largest not-for-profit health care provider in California. Mercy Hospitals employs 1,346 people.

Situated in downtown Bakersfield, Mercy Hospital Downtown 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 Southwest has quickly established a reputation for superior health care, since opening in 1992. This 78-bed facility adjacent to California State University includes our respected Family Birth Center, which features an 18-bed Labor Delivery Recovery Postpartum Unit (LDRP), an 11-bed Postpartum Unit, and a 9-bed NICU. Family Birth Center offers expectant mothers a warm, home-like setting with bedroom suites for labor, delivery and recovery. For several years, Mercy Southwest Family Birth Center has been honored by the Bakersfield Californian as the "Best place in Bakersfield to have a baby." Mercy Hospital Southwest also includes a 43-bed Medical and Surgical Unit. It is the only full Acute Care hospital in Kern County west of Freeway 99 with a 14-bed Level II Emergency Department, an 8-bed ICU along with 10 Tele beds, and 6 operating rooms, one of which is a state-of-the-art Minimally Invasive Surgical video suite. The technology offers patients the opportunity for surgery with less scarring and quicker recovery. Complete with all digital video monitors and a plasma screen for wide viewing, this suite is the only one available between Los Angeles and San Francisco.

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 28 employees and an annual budget of $2,131,160, 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

[1] For more information on the name change, please visit www.dignityhealth.org

health screenings to the most vulnerable and needy residents of the community. Our three outreach centers employ a total of 20 people and utilize an average of 132 volunteers each month.

Mercy Hospitals' FY 2013 Community Benefit Report and FY 2014 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 2013 is $26,368,904 which excludes the unpaid costs of Medicare which totaled $9,336,780.

Following are the highlights of major community benefit activities during FY 2013:

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 weekly classes covering a variety of topics including nutrition, exercise, use of medications, and evaluating new treatments. In FY 2013, 16 seminars were held in Kern County areas with a Community Need Index (CNI) score of 3 or above. Of the 136 participants who completed the seminars, 93.2% of participants completing the program avoided admissions to the hospital or emergency department for the six months following their participation in the program.

Community Health Initiative of Kern County (CHI) – increases access to health insurance and health care for hard to reach individuals in Kern County. 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 2013, the CHI enrolled 9,519 children into Medi-Cal and Healthy Families health insurance programs.

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 social service resources. In FY 2013, the program served 12,393 patients through educational classes on high blood pressure, cancer, diabetes, and nutrition. A total of 36,675 blood pressure, cholesterol, and glucose screenings were provided at monthly clinics throughout Kern County.

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 2013, the program provided 13,037.5 hours of services. Of the 113 individuals who completed the training program, 66% found employment.

Mercy Hospitals 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 2013, the Breast Health Program provided 37 ultrasounds, 54 biopsies and 2 mammograms.

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 2013, the Prescription Program provided 373 patients with their needed prescriptions/DME and IV Therapy ($102,300.33).

MISSION STATEMENT

OUR MISSION

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

ORGANIZATIONAL COMMITMENT

Hospital's Organizational Commitment
Mercy Hospitals 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 Hospitals' 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 2012 to FY 2013 with the exception of Jerry Starr, VP of Operations, Mercy Hospitals, who resigned his position at the hospital and Cindy Wasson, Director of Public Health Nursing, Kern County Public Health Services Department, who retired. One new member was added: Michelle Pearl-Krizo, Coordinator, Child Health and Disability Prevention, Kern County Public Health Services Department. 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 Hospitals. Dignity Health grant funds are used to provide services to underserved populations. During FY 2013, the following grants were awarded:

Advanced Center for Eyecare - $30,000
Alzheimer's Disease Association of Kern County - $29,000
California Veterans Assistance Foundation, Inc. - $25,000
Golden Empire Gleaners, Inc. - $25,000
The Hope Center - $10,884
MARE Therapeutic Riding Center - $25,000
MOVE International - $10,000
St. Vincent de Paul Center - $39,600
Valley Achievement Center - $20,000
West Side Community Resource - $20,000

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 Hospitals 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 Hospitals' service area demographic data.

- Population: 545,364
- Diversity: Caucasian 36.6%| Hispanic 50.4%| Asian 4.7%| African American 5.6%| Other 3.0%
- Average Household Income: $64,850
- Uninsured: 22.3%
- No HS Diploma: 25.9%
- Renters: 36.7%
- Medicaid Patients: 20.0%
- CNI Score: 4.8

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 Hospitals, other health providers in Kern County include: 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.

The Health Resources and Services Administration Shortage Designation Branch develops shortage designation criteria and uses them to decide whether or not a geographic area, population group or facility is a Health Professional Shortage Area or a Medically Underserved Area or Population. At least part of Kern County, California, is designated as a Medically Underserved Area (MUA). The service areas designated as MUAs include Bakersfield East, Lakeview, and La Loma. This designation was approved in July 1994 by the California Healthcare Workforce Policy Commission.

COMMUNITY BENEFIT PLANNING PROCESS

Community Needs and Assets Assessment Process
Kern County has been designated the service area for Mercy Hospitals. 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 Needs Index (CNI), community leaders, residents, and direct input from 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.

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

Kern County Community Assessment
The 2012/2013 Kern County Community Health Needs Assessment (CHNA) was conducted to identify primary health issues, status and needs, as well as to provide critical information to those in a position to make a positive impact on the health of the region's residents. The results enable community members to more strategically establish priorities, develop interventions and direct resources to improve the health of people living in the community. The geography selected for the study was Kern County, CA. This geography was selected for the study because 70% of the hospitals' discharges originate throughout the county.

The 2012/2013 Kern County Community Needs Assessment Process was initiated by the Kern County Community Benefit Collaborative in July 2012. The Collaborative is comprised of Delano Regional Medical Center, Dignity Health (Mercy and Memorial Hospitals), Kaiser Permanente, and San Joaquin Community Hospital. To complete the needs assessment, the Collaborative utilized information from www.healthykern.org and retained the services of the Healthy Communities Institute and Strategy Solutions, Inc. to assist.

The Kern County Community Benefit Collaborative along with its Steering Committee guided the study. The Steering Committee met numerous times over the course of the process to provide guidance on the components of the Kern County Community Health Needs Assessment. The full collaborative met with community and hospital/health system leaders in November 2012 to review and prioritize the community needs.

In an effort to examine the health related needs of the residents of Kern County and to meet all of the known guidelines and requirements of the IRS 990 standards that had been published to date, the Steering Committee and consulting team employed both qualitative and quantitative data collection and analysis methods. The research and data analysis of this effort began in earnest in March 2012 and concluded in November 2012. The report development was completed in early 2013.

The Assessment identified 10 top needs though a prioritization process with community leaders.

1) Heart Disease and Stroke
2) Cancer
3) Diabetes
4) Preventative Screenings
5) Cancer Screenings
6) Access to Health Care
7) Low Birth Weight/Infant Mortality
8) Asthma
9) Women's Health Screenings
10) Sexually Transmitted Diseases (STDs)

Key Findings
Mercy and Memorial Hospitals (through our Community Benefit Committee and Department employees) further prioritized these 10 needs to 5 focus areas.

1) Access to Health Care
2) Preventative Screenings
3) Heart Disease and Stroke
4) Diabetes
5) Asthma

Community Need Index (CNI)
The Dignity Health Reporting Sheet for the Community Need Index (CNI) for Kern County, prepared by Truven/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 (2012) 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 Hospitals.

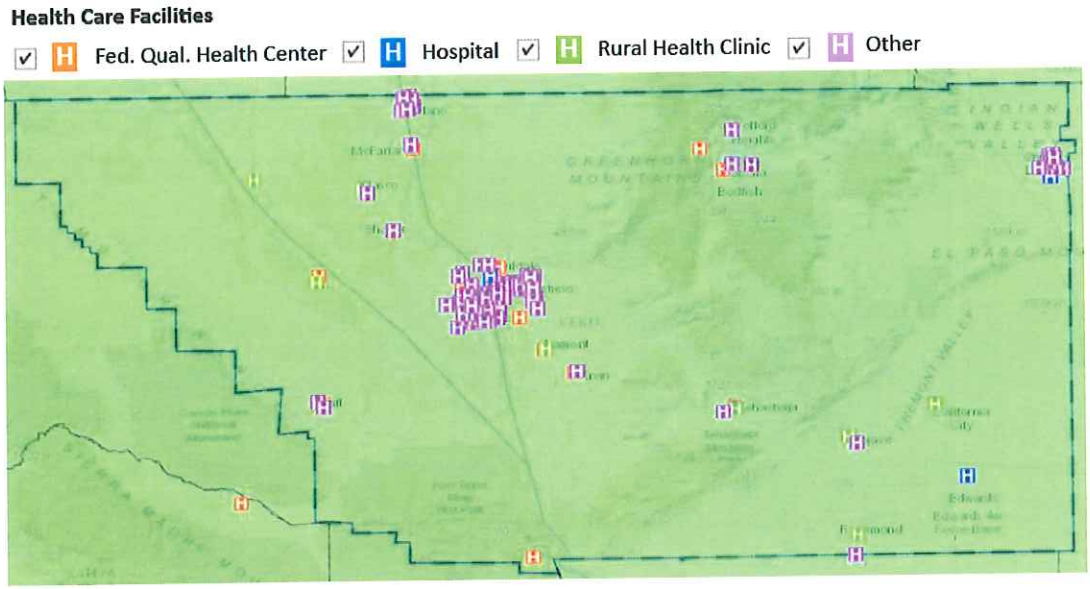
This summary provides a focus for our hospitals to increase the health and quality of life of residents in Kern County.

Taft (93268 Zip Code)	4.8	Bakersfield (93307 Zip Code)	5
Lamont (93241 Zip Code)	5	Bakersfield (93309 Zip Code)	4.2
Bakersfield (93311 Zip Code)	3	Bakersfield (93301 Zip Code)	5
Bakersfield (93312 Zip Code)	1.8	Bakersfield (93263 Zip Code)	5
Bakersfield (93313 Zip Code)	3.4	Bakersfield (93305 Zip Code)	5
Bakersfield (93304 Zip Code)	5	Rosedale (93306 Zip Code)	4.8
Bakersfield (93308 Zip Code)	4.6		

The community needs assessment is available for all residents. Those who have computer access can go to www.HealthyKern.org and find the assessment posted on the site. It is also posted on the Dignity Health website at http://www.dignityhealth.org/Who_We_Are/Community_Health/235026. Those who do not have computer access can visit one of the many libraries throughout Kern County. Printed copies of the assessment are also available upon request.

Assets Assessment
The Steering Committee identified the existing health care facilities and resources within the community that are available to respond to the health needs of the community. The list is a subset of the information compiled in the 2012 Kern County Community Resource Directory.

The following are some of the existing health care facilities and resources within the community that are available to respond to the health needs of the community. The assets are listed in 4 categories: Federally Qualified Health Centers, Hospitals, Rural Health Clinics, and Other.



Developing the Hospital's Implementation Plan (Community Benefit Report and Plan)
Each year Department employees present progress reports to the Community Benefit Committee. During 2013, 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 Hospitals 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 four 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)
- Homemaker Care Program (homemaker services for the frail elderly and job training for unemployed adults)
- Community Health Initiative (access to health care insurance for Kern County residents)

- 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 Hospitals 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 Hospitals 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 3) 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, Kern County Public Health Services Department and The California Endowment, Mercy and Memorial Hospitals coordinate the County's Community Health Initiative. It uses monthly meetings, websites, a strong network of partner agencies, and other methods to enroll and renew adults and children in health insurance through the Affordable Care Act. They minimize or eliminate barriers to enrollment. The Community Health Initiative of Kern County conducts outreach to inform and enroll hard to reach individuals into health insurance, and to build awareness and support in the community at large. The Community Health Initiative also works to develop new ways that residents might access health care outside of an insurance program so that all Kern County residents might have a medical home.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major initiatives and key community based programs of Mercy Hospitals. These programs were developed in response to the 2012/2013 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: Access to Health Care
- Breast Health Program
- Charity Care for uninsured/underinsured and low income residents
- Community Health Initiative
- Emergency Department Physician Services for Indigent Patients
- Enrollment Assistance/Government Programs
- Flu Clinics
- Guidance and Referrals to Community Services
- Health Fairs
- Homemaker Care Program - In-Home Care
- Prescription Purchases for Indigents

Initiative II: Preventative Screenings
- Health Screenings

Initiative III: Heart Disease and Stroke
- Health Education Seminars and Classes
- Chronic Disease Self-Management Program

Initiative IV: Diabetes
- Healthy Kids in Healthy Homes
- In-Home Health Education
- Diabetes Self-Management Program

Initiative V: Asthma
- Asthma Program

Other programs promoting health and well being for the poor and underserved

- 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
- Homemaker Care Program - Training
- Homework Club
- Operation Back to School
- Cancer Detection Program
- Car Seat 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

COMMUNITY WELLNESS PROGRAM	
Hospital CB Priority Areas	☒ Preventative Screenings ☒ Diabetes ☒ Asthma ☒ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	According to the 2013 Kern County Community Health Needs Assessment: • 30.8% of adults in the County are obese and the percentage has continued to increase over the past five years (CHIS 2009). • 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 *declined* by three points from the previous reporting period. • During the 2008-2010 measurement period the hospitalization rate due to diabetes was 29.9 hospitalizations per 10,000 population. • 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 65.7% insured (CHIS 2009).
Program Description Community Wellness Program	The Community Wellness Program is focused on preventive health care by providing on-site screenings and health and wellness education classes on relevant topics for residents throughout Kern County.
FY 2013	
Goal FY 2013	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
2013 Objectives Measure/Indicator of Success	The objectives for FY 2013 are to: • Provide 39,500 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. (Increase of 10%) • 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%) • Decrease at least one screening level for 60 of 75 case-managed clients. (80%;15 individuals from each of five Community Clinics) Enhancement strategies are: • Research an evidence-based case-management model to ensure positive outcomes in health screening levels and healthy behavior patterns. • Develop and expand health and wellness services offered at the Community Wellness Center. • 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.
Baseline	During FY 2012: • Provided 35,752 blood pressure, cholesterol, glucose, and BMI screenings throughout Kern County. • Provided 8,839 clients with health education through in home visits/on-site classes. • 87% of 31 case managed clients saw a decrease in their screening levels.
Intervention Strategy for Achieving Goal	Intervention strategies are: • 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. • Enhance our work with Mercy & Memorial Hospital's Case Management Department and other health care entities to implement a model continuum of care. • Increase utilization of our wellness software program to create improved tracking mechanisms that will enhance monitoring, follow-up, and retention of Community Clinic participants. • 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.

Results FY 2013	During FY 13, the Community Wellness Program accomplished the following: • Provided 36,675 health screenings. (Goal: provide 39,500 screenings) • Provided 12,393 clients with health education. (Goal: Educate 10,000 clients) • Our pilot program in FY 2012 indicated that client results would improve by assigning an educator in each Community Clinic. That practice was implemented in November 2012. Enhancement strategies completed: • Added one-on-one health education for all clients at screening clinics. • Began extensive remodel of Community Wellness Center enable expansion of services. • Added three new monthly Community Screening Clinics in Shafter (2) and Delano. • Developed a standardized presentation and curriculum (Fall Prevention) to be presented by various Community Wellness Program employees.
Hospital's Contribution/Program Expense	The total FY 2013 expense for the Community Wellness Program was $733,173. Of this amount, $234,080 was grant dollars, and $499,093 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program and program's clinic van, bookkeeping, and human resource support for the program.
FY 2014	
Goal FY 2014	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
2014 Objectives Measure/Indicator of Success	The objectives for FY 2014 are: • Provide 32,000 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. • Provide 12,640 clients with health education through in-home visits and classes/seminars including EMPOWERMENT-Chronic Disease and Diabetes. • Achieve an average evaluation score of 4 or higher from attendees at Community Health Education Classes. • 70 percent of clients of the Community Health Screening Clinics will have 2 or more normal or improved screening levels throughout the year. Enhancement strategies are: • Create profiles of four monthly screening clinics. Use profile to develop a customized approach to serving clients to increase participation and client satisfaction. • Create a protocol binder for Health Screenings, including equipment maintenance and calibration, staff training and event procedures.
Baseline	During FY 2013: • Provided 36,675 health screenings. • Provided 12,393 clients with health education. • Our pilot program in FY 2012 indicated that client results would improve by assigning an educator in each Community Clinic. That practice was implemented in November 2012.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Enhance our work with Mercy & Memorial Hospital's Case Management Department and other health care entities to implement a model continuum of care. • Improve tracking mechanisms that will enhance monitoring, follow-up, and retention of Community Clinic participants. • 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.
Community Benefit Category	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

CHRONIC DISEASE SELF MANAGEMENT PROGRAMS	
Hospital CB Priority Areas	☒ Preventative Screenings ☒ Diabetes ☒ Asthma ☒ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	According to the 2013 Kern County Community Health Needs Assessment: • The age-adjusted diabetes death rate in Kern County averaged for 2009 to 2011 is 32.4 per 100,000 compared to the State value of 20.2 per 100,000. Kern has the second highest diabetes death rate in the State. • During the 2009-2011 measurement period the hospitalization rate due to diabetes was 24.5 hospitalizations per 10,000 population. • 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 38.9% with Whites next at 27%. • Kern County has the second highest death rate in the State due to Coronary Heart Disease.
Program Description	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.
FY 2013	
Goal FY 2013	By offering evidence-based chronic disease management (CDM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).
2013 Objectives Measure/Indicator of Success	The objectives for FY 2013 are: • Provide 16 EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above. • Provide an appropriate mix of seminars by type (Chronic Disease, Diabetes) and by language (English, Spanish). • 85% of all participants completing EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes seminars will avoid admissions to the hospital or emergency department for the six months following their participation in the program. • Increase CHF patient referrals from Mercy and Memorial Hospitals to the Community Wellness Center and improve follow-up and tracking process. Enhancement strategies are: • Expand access to EMPOWERMENT-Chronic Disease and EMPOWERMENT-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. • Continue to work toward increasing provider referral processes for program participants.
Baseline	During FY 2012: • 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. • Completed four English and five Spanish EMPOWERMENT-Diabetes seminars in Kern County areas with a Community Index (CNI) score of 3 or above. • 94.8% of participants completing the EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Seminars avoided admissions to the hospital or emergency department for the six months following their participation in the program.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Engage clinical health professionals in the expansion of the program. • Focus on the uninsured and populations covered by Medicaid, Medicare/Medicaid. • Expand awareness and access of EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Self Management Programs by increasing partnership with community organizations serving residents with chronic conditions, i.e., Arthritis Foundation, MS Society, etc. • Encourage and support continuing education for staff development to ensure quality service is offered by the EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Self Management Programs.

Results FY 2013	During FY 2013, EMPOWERMENT accomplished the following: • Completed 16 EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Seminars in Kern County. (Goal 16 seminars) A total of 10 seminars were for Diabetes Self-Management (6 Spanish, 4 English), and 6 seminars were for Chronic Disease Self-Management (4 Spanish, 2 English). • 93.2% of participants with chronic diseases who completed the EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes seminars avoided admissions to the hospital or emergency department for the six months following their participation in the program. (Goal 85%) • 136 participants completed EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes seminars. • The process for referring CHF patients to the Community Wellness Center is still in development. (Goal Increase CHF patient referrals) Enhancement strategies completed: • Expanded access to EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes self management education at four new locations throughout the county (Taft Heritage Apartments, Shafter Parent Resource Center, Christ the King Church, and Patriots Park). • Trained 5 new Leaders to facilitate EMPOWERMENT-Chronic Disease English Seminars.
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals have contributed $46,235 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.
FY 2014	
Goal FY 2014	By offering evidence-based chronic disease management (CDM) programs, Mercy and Memorial Hospitals will be effective in avoiding hospital admissions for two of the most prevalent ambulatory care sensitive conditions in our community (Diabetes and Congestive Heart Failure).
2014 Objectives Measure/Indicator of Success	The objectives for FY 2014 are: • Provide 18 EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes seminars in Kern County areas with a Community Need Index (CNI) score of 3 or above to ensure that underserved persons throughout the county will have access to the Seminars. • 85% of all participants with chronic diseases who complete EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes seminars will remain healthier after their seminars, as measured by those who avoid admissions to the hospital or emergency department for the six months following their participation in the program. • Establish a series of EMPOWERMENT-Chronic Disease Seminars within the Cardiac Care department at Memorial Hospital to directly link newly-discharge Cardiac patients into a Seminar program. • Train 10 new leaders for EMPOWERMENT-Diabetes Seminars in English and Spanish to ensure that an adequate number of seminars will be available for the community. Enhancement strategies are: • Expand access to EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes self management education to residents of two new Kern County communities with a Community Index (CNI) score of 3 or above.
Baseline	During FY 2013: • Completed 16 EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Seminars in communities with a Community Index (CNI) score of 3 or above. • 93.2% of participants with chronic diseases who completed the EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Seminars avoided admissions to the hospital or emergency department for the six months following their participation in the program.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Engage clinical health professionals in the expansion of the program. • Focus on the uninsured and populations covered by Medicaid, Medicare/Medicaid. • Expand awareness and access of EMPOWERMENT-Chronic Disease and EMPOWERMENT-Diabetes Self Management Programs by increasing partnership with community organizations serving residents with chronic conditions, i.e., Arthritis Foundation, MS Society, etc. • Encourage and support continuing education for staff development to ensure quality service is offered by the Empowerment Self Management Programs.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops

COMMUNITY HEALTH INITIATIVE	
Hospital CB Priority Areas	☐ Preventative Screenings ☐ Diabetes ☐ Asthma ☐ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	Kern County is strong in children enrolled in health insurance according to the newest figures from the California Health Interview Survey (CHIS). The indicators for Kern County, based on 2011-2012 data, show that 91% of children have health insurance. However, 25% of adults ages 19-64 are uninsured, according to the same survey. The Affordable Care Act (ACA) is providing new opportunities for low-income adults to have access to health insurance. The partner agencies of the Community Health Initiative (CHI) are already putting the collective expertise developed over the past nine years to good use in developing new, innovative methods to reach these adult populations.
Program Description Community Health Initiative	The Community 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 Community Health Initiative works to provide access to health care for children for whom no insurance program is available. The Community 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.
FY 2013	
Goal FY 2013	The Community 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.
2013 Objectives Measure/Indicator of Success	The objectives for FY 2013 are: • Assist applications that result in the enrollment or renewal of 10,625 children into health insurance programs. • Assist applications that result in the enrollment or renewal of 100 adults into Affordable Care Act (ACA) bridge to Medi-Cal programs. • Establish on-site application assistance in two hospital departments (i.e., Maternity units, ERs). • Retain 35% of children enrolled through the SAS program at annual renewal in Medi-Cal and Healthy Families. • Conduct trainings for 350 participants through certification and refresher trainings, CAA Network meetings and conferences. • Provide support and guidance to 24 agencies to improve their rate of success when assisting applications. • 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. Enhancement strategies based on ASACB principles are: • Develop the capabilities and/or certification needed to assist families in making health plan decisions through the Health Care Benefits Exchange by October, 2013.
Baseline	During FY 2012: • Verified the enrollment or renewal of 10,119 children into a health insurance program • 374 Certified Application Assisters received training • 27% of children enrolled through SAS program were retained in a health plan • 24 Enrollment Entity partner agencies received technical assistance and support
Intervention Strategy for Achieving Goal	Intervention strategies are: • Continue development of continuous flow of funding for program sustainability. • Provide training and education sessions that support the objectives of the program, targeting populations that have been hard-to-reach through our traditional channels. • Eliminate barriers and streamline application processes.

Results FY 2013	During FY 13, the Community Health Initiative accomplished the following: • Verified enrollment of 9,519 children into health insurance programs. • Assisted 236 children with applications for Medi-Cal and California Children's Services in NICU and Labor & Delivery at Memorial Hospital. • Retained 30.2% of children enrolled through SAS at annual renewal. • Conducted trainings for 163 CAAs. • Provided 407 units of support to partner CAAs. • Began analysis of OSHPD data showing costs of uncompensated care of uninsured children in the county. Enhancement strategies completed: • Facilitated expanded network of agencies to support enrollment of adults through Covered California Health Benefit Exchange.
Hospital's Contribution/Program Expense	The total FY 2013 expense for the Community Health Initiative was $371,698. Of this amount, $335,589 was grant dollars, and $36,109 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program and program's clinic van, bookkeeping, and human resource support for the program.
FY 2014	
Goal FY 2014	With a coalition of Kern County organizations, educate and enroll uninsured adults and children into a health insurance plan through an innovative new plan.
2014 Objectives Measure/Indicator of Success	The objectives for FY 2014 are: • Enroll 18,000 individuals in health insurance through Medi-Cal and Covered California. • Provide enrollment assistance in ten new locations throughout the county. • Establish regular enrollment support in local hospitals, particularly in NICU, maternity units, and emergency departments. • Develop utilization strategies and education methods to reduce the costs of uncompensated hospital care in the county. Enhancement strategies are: • Expand the county's network of partner agencies providing enrollment services. • Provide ongoing training and support for the new enrollment practices of Covered California.
Baseline	During FY 2013: • Verified enrollment of 9,519 children into health insurance programs. • Assisted 236 children with in NICU and Labor & Delivery at Memorial Hospital. • Retained 30.2% of children enrolled through SAS at annual renewal. • Conducted trainings for 163 CAAs. • Provided 407 units of support to partner CAAs. • Began analysis of OSHPD data showing costs of uncompensated care of uninsured children in the county.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Continue development of continuous flow of funding for program sustainability. • Provide outreach and enrollment services to populations that have been hard-to-reach through our traditional channels. • Continue to work at local, state and federal levels to eliminate barriers and streamline application processes.
Community Benefit Category	A3-d Health Care Support Services - Enrollment Assistance

HOMEMAKER CARE PROGRAM	
Hospital CB Priority Areas	☒ Preventative Screenings ☒ Diabetes ☐ Asthma ☒ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	• In 2013, Kern County's Annual unemployment rate was 12.1% compared to 9.0% in the state. One effect of high unemployment is that the labor force is not able to supply appropriate skills to employers. • In 2012, Kern County's high school dropout rate was 5.1%. 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. • In 2011, 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.
Program Description Homemaker Care Program	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. 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 assess client safety, nutrition, and program satisfaction.
FY 2013	
Goal FY 2013	The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce. 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.
2013 Objectives Measure/Indicator of Success	The objectives for FY 2013 are: • Enroll 90 individuals during six two-week training sessions, which includes employment development services. • Ensure 90% of program participants complete the course. • Ensure 70% of program graduates gain employment within six months following completion of training. • Enhance 17 of the training components, focusing on curriculum content and classroom delivery. • Provide 9,840 hours of in-home supportive services to senior and disabled clients. Enhancement strategies based on ASACB review are: • Develop hands-on training opportunities that will enhance employment outcomes. • Ensure sustainability of the program by increasing the number of hours of service provided, focusing on full pay households. • Ensure client awareness of program updates. • Enhance recruitment efforts of the program by following our marketing plan.
Baseline	During FY 2012: • 83 individuals participated in four Homemaker Care Training sessions • 76 of 83, or 92%, completed the training • Provided a total of 8,847 hours of service to a monthly average of 63 households • 27 new clients, or 100%, received health screenings
Intervention Strategy for Achieving Goal	Intervention strategies are: • Establish agreements with three senior focus agencies or facilities to allow hands-on training by the training participants. • Provide opportunities for trainees to conduct on-line applications and job search at the Wellness Center. • Conduct monthly visits to businesses and agencies that serve the senior population. • Conduct monthly meetings with In-Home Care Attendants to discuss safety and quality service for each client. • Conduct monthly wellness checks and home visits to ensure meeting the needs of each client.

Results FY 2013	During FY 2013, the Homemaker Care Program accomplished the following:
	• Enrolled 120 individuals during six two-week trainings. (Goal: Enroll 90 individuals)
	• Ensured that 94% of trainees completed the program. (Goal: 90% completion)
	• Ensured that 66% of trainees gained employment. (Goal: 70% gain employment)
	• Enhanced 32 training components. (Goal: Enhance 17 training components)
	• Provided 13,037.5 hours of in-home supportive services to senior and disabled clients (Goal: Provide 9,840 hours).
	
	Enhancement strategies completed:
	• Secured three hands-on training opportunities that prepared students for client interaction.
	• Improved the sustainability of the program:
	  • Employed three new caregivers.
	  • Increased full pay household hours to 4,975.5, which is 38% of total hours served.
	  • Secured $116,525 in client revenue. This amount makes up 74% of salaries utilized to provide in-home supportive services.
	• Improved client awareness of program updates by conducting Program Supervisor home visits. As a result, 26 home visits were conducted.
	• Enhanced recruitment by focusing our efforts on the three major referral sources: current clients, hospital employees, and community marketing. As a result, 25 new households were secured.

Hospital's Contribution/Program Expense	During FY 2013, expenses for the Homemaker Care Program were $266,561. Of this amount, $13,142 was grant dollars, $116,525 was fee for service, and $136,893 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, human resource support, office space, fundraising support, bookkeeping, strategic planning, and evaluation support for the program.
FY 2014	
Goal FY 2014	The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce. 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.
2014 Objectives Measure/Indicator of Success	The objectives for FY 2014 are: • Achieve an overall grade among program graduates of 80% or more on total competency exam scores. • Verify that 65% of program graduates applying for three jobs within three months following completion of training. • Provide 14,815 hours of in-home supportive services to senior and disabled clients. • Increase full pay hours to 46% of total hours served. Enhancement strategies based on ASACB review are: • Enhance employment outcomes by creating opportunities for hiring agencies to recruit potential employees throughout the training program. • Ensure sustainability of the program by researching grant funding that will support senior services and the training program.
Baseline	As of June 30, 2013: • 120 individuals participated in six Homemaker Care Training sessions • 94% of participants completed the training • 13,037.5 hours of service were provided to senior and disabled clients
Intervention Strategy for Achieving Goal	Intervention strategies are: • Provide opportunities for trainees to conduct on-line applications and job search at the Wellness Center. • Track employment retention of training program graduates • Conduct continuous recruitment of qualified in-home care attendants to hire into the program • Conduct monthly meetings with In-Home Care Attendants to discuss providing safety and quality service to each client.
Community Benefit Category	F5-c Leadership Dev/Training for Community Members - Career development E3-d In-kind Assistance - Basic services for individuals

ASTHMA MANAGEMENT (NEW IN FY 2014)	
Hospital CB Priority Areas	☐ Preventative Screenings ☐ Diabetes ☒ Asthma ☐ Heart Disease and Stroke ☒ Access to Health Care
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	Approximately 123,000 children and adults in Kern County, or 15.6% of the population, have been diagnosed with asthma in their lifetime, and 11.9% currently have active asthma. Asthma diagnoses, deaths, Emergency Department visits and hospitalizations occur at a higher rate in Kern than in California as a whole. Asthma is considered to be a manageable condition with appropriate medical intervention and consistent use of medication. Unfortunately, one-third of diagnosed Kern residents (32.3%) have not received a written self-management plan from a health care provider. (Source: 2009 California Health Interview Survey)
Program Description Asthma Management	The Asthma Management project's goal is to bring a new level of asthma education and management to Kern County families, and to reduce repeated hospitalizations due to uncontrolled asthma. Certified Asthma Educators provide education to individuals and small groups throughout our county. Education is supported by state of the art technology that monitors a client's usage of both rescue and controller medications. This technology also notifies our educators when direct intervention is needed to help a client avoid an asthma crisis.
FY 2013	
Goal FY 2013	No goals were established in FY2013 – this is a new program for FY2014
2013 Objectives Measure/Indicator of Success	
Baseline	
Intervention Strategy for Achieving Goal	
Results FY 2013	
Hospital's Contribution/Program Expense	
FY 2014	
Goal FY 2014	An Asthma Management pilot project will be established as a part of the Community Wellness Program, and 20 clients will be monitored and supported for the one-year project period.
2014 Objectives Measure/Indicator of Success	The objectives for FY 2014 are: • Three employees of the Community Wellness Program (CWP) will become Certified Asthma Educators. • 20 clients will be enrolled into the pilot project. • Protocols for monitoring and intervention will be established. Enhancement strategies are: • Work with community partner organizations to identify potential clients for pilot project. • Outcomes will be carefully monitored and compared to other Propeller Health client companies and Dignity Health hospitals who have used the technology.
Baseline	During FY 2013: • This is a new program. There is no baseline.
Intervention Strategy for Achieving Goal	Intervention strategies are: • An agreement will be made with Propeller Health to utilize their proprietary technology monitoring system. • Communication will be established between CWP employees and appropriate hospital personnel to identify patients who are candidates for the pilot project.
Community Benefit Category	A1 – Community Health Education

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 Unsponsored Community Benefit

Mercy Hospitals 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.

7/30/2013
322 Mercy - Mercy Hospital Baker
Complete Summary - Classified Including Non Community Benefit
For period from 7/1/2012 through 6/30/2013

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Living in Poverty						
Financial Assistance	5,580	6,731,319	0	6,731,319	2.6	2.5
Medicaid	29,793	52,307,706	36,572,791	15,734,915	6.1	5.8
Community Services						
Community Benefit Operations	634	650,474	0	650,474	0.3	0.2
Community Building Activities	2,524	57,188	0	57,188	0.0	0.0
Community Health Improvement Servic	23,215	573,087	14,940	558,147	0.2	0.2
Financial and In-Kind Contributions	17,453	298,095	58,863	239,232	0.1	0.1
Subsidized Health Services	32,301	1,130,531	0	1,130,531	0.4	0.4
Totals for Community Services	76,127	2,709,375	73,803	2,635,572	1.0	1.0
Totals for Living in Poverty	111,500	61,748,400	36,646,594	25,101,806	9.7	9.2
Benefits for Broader Community						
Community Services						
Community Building Activities	569	11,578	0	11,578	0.0	0.0
Community Health Improvement Servic	12,525	1,595,829	702,214	893,615	0.3	0.3
Financial and In-Kind Contributions	388	260,524	0	260,524	0.1	0.1
Research	0	101,381	0	101,381	0.0	0.0
Totals for Community Services	13,482	1,969,312	702,214	1,267,098	0.5	0.5
Totals for Broader Community	13,482	1,969,312	702,214	1,267,098	0.5	0.5
Totals - Community Benefit	124,982	63,717,712	37,348,808	26,368,904	10.2	9.7
Unpaid Cost of Medicare	16,025	59,140,543	49,803,763	9,336,780	3.6	3.4
Totals with Medicare	141,007	122,858,255	87,152,571	35,705,684	13.9	13.1
Grand Totals	141,007	122,858,255	87,152,571	35,705,684	13.9	13.1

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 www.choosemercymemorial.org

Note: The needs assessment report can be found on www.healthykern.org. The reports will also be posted on the Dignity Health website, www.DignityHealth.org.

Success Stories

Community Wellness Program

Diabetes Self-Management Program:
Ray is a man who attended one of our EMPOWERMENT – Diabetes Seminars. Ray told the group that he had cancer and had been recently diagnosed with type 2 Diabetes. At the beginning of the seminar, he said his life needed to change. He needed to lose weight, and he hoped the class would help him accomplish his goals. During the six weeks of the seminar, other members commented on the changes they saw in Ray, but he would respond that he did not see much change on the scale. However, during the last session, Ray expressed his gratitude to the group for supporting him, and revealed that he lost a total of 23 pounds in the six weeks! He said he was writing a journal with his new food recipes so his family can use them. He was proud that the change that started with him can have an effect on his entire family. During a follow up call, Ray said his last A1C test was very close to normal. He now recognizes the triggers that raise his glucose, and is thankful for the exercise tips he learned. He also said he was very thankful to his peers and the opportunity to take the seminar.

In-Home Health Education:
Our Health Educators meet with the parents (and children when possible) referred to our program for health education. We often find families who are unwilling to make changes in their habits to help make their child become healthier. Sylvia, a Bilingual In-Home Health Educator, had a rewarding experience at a visit in June. She went to the home to provide nutrition education for a 14-year-old overweight boy, Adam. Adam's mother told Sylvia that her son is very motivated to lose weight, and that he already had taken it upon himself to start decreasing his portion size. He also began exercising every night. Adam's mother is very proud of his determination. Adam admits he is feeling much better because of these changes. His mother is also grateful for the additional education and information Sylvia provided so that she is better able to support her son's determined efforts.

Homemaker Care Program
In-Home Care Attendant Luvnique cares for Candace, a disabled client who is visually impaired. When Candace began service with the Homemaker Care Program she was very apprehensive about having someone new in her home. Previously, Candace's caregivers were not trustworthy. However, almost immediately, Luvnique's dependability and consistency made Candace feel safe and comfortable. Recently, while Luvnique was on duty, Candace fell and broke her leg. Luvnique called the paramedics, rushed to inform the staff of the independent living center where Candace lives, then proceeded to the hospital to assist Candace with answering questions. Luvnique ensured that during the whole process Candace's needs and concerns were addressed. Luvnique has grown to be Candace's eyes, ears, and hands, taking care of many things that we take for granted. Most importantly, Luvnique is providing trusting companionship.

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

Dignity Health
Mercy & Memorial Hospitals

Department of Special Needs & Community Outreach

Community Benefit Committee Membership

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

Michael Bowers, Vice President, Operations, Mercy Hospitals of Bakersfield

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, Community Member

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, 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

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

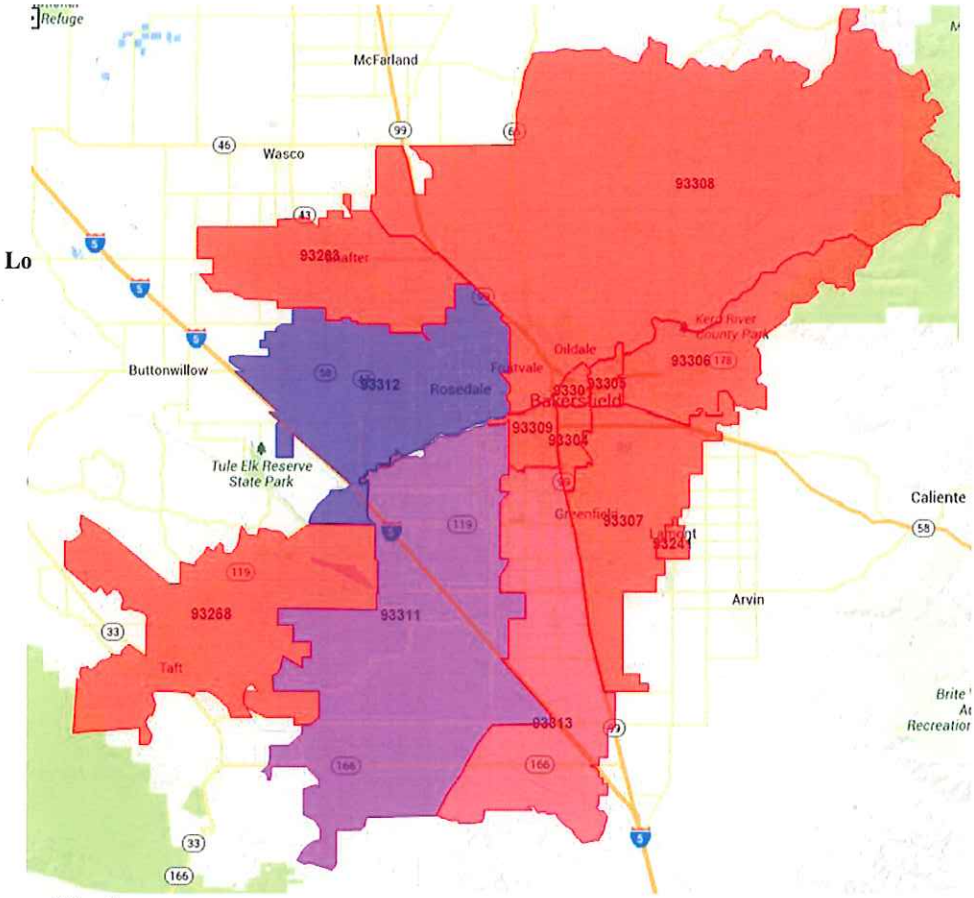
Sandra Serrano, Chancellor, Kern Community College District

Joan Van Alstyne, Director, Quality Management, Bakersfield Memorial Hospital

Stephanie Weber, Executive Director, Friends of Mercy Foundation

Jonathan Webster, Executive Director, Brotherhood Alliance

Mercy Hospitals



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**

	Zip Code	CNI Score	Population	City	County	State
	93268	4.8	13,620	Taft	Kern	California
	93241	5	15,357	Lamont	Kern	California
	93311	3	42,067	Bakersfield	Kern	California
	93313	3.4	42,771	Bakersfield	Kern	California
	93304	5	50,472	Bakersfield	Kern	California
	93307	5	73,563	Bakersfield	Kern	California
	93309	4.2	63,712	Bakersfield	Kern	California
	93301	5	13,818	Bakersfield	Kern	California
	93305	5	36,313	Bakersfield	Kern	California
	93306	4.8	60,756	Bakersfield	Kern	California
	93312	1.8	61,080	Bakersfield	Kern	California
	93263	5	19,511	Bakersfield	Kern	California
	93308	4.6	49,283	Bakersfield	Kern	California

CNI Score Median: 4.8

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.