



Memorial Hospital

Community Benefit Report 2014  
Community Benefit Implementation Plan 2015

A message from Jon Van Boening, President and CEO of Memorial Hospital, and Tom Smith, Chair of the Dignity Health Memorial Hospital Community Board.

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At Memorial Hospital we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 104 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report its community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Memorial Hospital provided \$41,971,936 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$50,966,150.

Dignity Health's Memorial Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their September 24, 2014 meeting.

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



Jon Van Boening  
President/CEO



Tom Smith  
Chairperson, Board of Directors

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# EXECUTIVE SUMMARY

Memorial Hospital was created to meet the needs of our community, and has grown from a small local facility to a large regional acute hospital serving all of Kern County. Memorial Hospital is a member of Dignity Health, the largest not-for-profit health care provider in California.

Today, Memorial has 418 general acute care beds, nearly 50 intensive care and cardiovascular recovery units, 13 state-of-the-art surgical suites, a full-service Emergency Department with a Joint Commission Certified Stroke Center and the Chest Pain Center. In addition, we offer newly expanded birthing suites, a family care center, and The Lauren Small Children's Medical Center that includes a 31-bed Neonatal Intensive Care Unit, a 20-bed Pediatric Unit, and an 8-bed Pediatric Intensive Care Unit. The hospital also has a full complement of diagnostic laboratory and imaging services, and an outpatient surgery center.

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 45 programs in Bakersfield, Arvin, Shafter, McFarland, Delano, Lost Hills, Ridgecrest, Taft, Wasco, and other outlying communities in Kern County where there is limited access to health care and related services.

With 32 employees and an annual budget of \$ 2,754,931, 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 100 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) 325-2995

### **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 22 people and utilize an average of 415 volunteer hours each month. Services are provided in English and Spanish.

Memorial Hospital's FY 2014 Community Benefit Report and FY 2015 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 2014 is \$41,971,936 which excludes the unpaid costs of Medicare which totaled \$8,994,214.

Following are the highlights of major community benefit activities during FY 2014:

**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 2014, 19 seminars were held in Kern County areas with a Community Need Index (CNI) score of 3 or above (map included in APPENDIX 2). Of

the 147 participants who completed the seminars, 100% of participants completing the program avoided admissions to the hospital or emergency department for the three 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 2014, the CHI enrolled 5,775 children into Medi-Cal and 1,058 individuals were assisted by our Certified Enrollment Counselors with Medi-Cal and Covered California applications.

**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 2014, the program served 13,750 patients through educational classes on high blood pressure, cancer, diabetes, and nutrition. A total of 31,987 blood pressure, cholesterol, glucose and BMI screenings were provided at monthly clinics throughout Kern County.

**Homemaker Care Program** - provides homemaker services to frail elderly and disabled adults 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 2014, the program provided 14,205 hours of services. Of the 68 individuals who completed the training program, 56% found employment.

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

**Sexual Assault Response Team (S.A.R.T.)** - a multi-disciplinary group of county and city agencies brought together for one purpose – to assist sexual assault victims in a more supportive and effective manner. A collaborative team was formed of all the agencies involved to create a process that would be less stressful to the victim and ensure better outcomes in the courts. During FY 2014, 75 sexual assault victims were assisted through the program.

**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 2014, the Prescription Program provided 405 patients with their needed prescriptions/DME and IV Therapy (\$86,830.72).

## **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

Memorial Hospital has a Board of Directors. The Board is responsible for ensuring that community health is one of the major goals in the strategic planning process. The Board of Directors 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. Memorial Hospital's president is committed to the Community Benefit process and accountable to Dignity Health system leadership.

A Community Benefit Committee of the Board 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 Memorial Hospital for final approval. Members of the Community Benefit Committee have remained the same from FY 2013 to FY 2014 with the exception of Mike Bowers, COO, Memorial Hospital, who resigned his position at the hospital. One new member was added: Joanne Border, St. Vincent de Paul. 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 Memorial Hospital 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 Memorial Hospital. Dignity Health grant funds are used to provide services to underserved populations. During FY 2014, the following grants were awarded:

Alzheimer's Disease Association of Kern County - \$33,685	Links for Life - \$40,800
Bakersfield Pregnancy Center - \$15,000	St. Vincent de Paul Center - \$30,000
Bakersfield Association for Retarded Citizens - \$25,000	West Side Community Resource - \$25,000
California Veterans Assistance Foundation, Inc. - \$25,000	United Way of Kern County and Kern County
CASA of Kern County - \$35,000	Homeless Collaborative - \$42,000

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 County Promotoras Network, Kern Comprehensive Cancer Awareness Partnership and Kern County Needs Assessment Committee. Department employees serve on 15 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 vision.

# COMMUNITY

Memorial Hospital serves all of Kern County, including Bakersfield (the county seat) and outlying rural communities such as Lost Hills, Taft, and Wasco. We further define the community served by the hospital's primary service area. This is based on the percent of discharges. 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 24% of private sector jobs. 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 Memorial Hospital's service area demographic data.

- Population: 610,579
- Diversity: Caucasian 33.9%| Hispanic 52.3%| Asian 5.1%| African American 6.0%| Other 2.7%
- Average Household Income: \$61,877
- Uninsured: 22.3%
- No HS Diploma: 28.4%
- Renters: 37.7%
- Medicaid Patients: 20.9%
- 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 Memorial Hospital, other health providers in Bakersfield include: Mercy Hospital Downtown, Mercy Hospital Southwest, Kern Medical Center, Kaiser Permanente, San Joaquin Community Hospital, The Heart Hospital, Good Samaritan Hospital, Clinica Sierra Vista and Omni Family Health. The service area for these providers is also 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 rundown 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 East Bakersfield, 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 Memorial Hospital. 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), 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 Memorial Hospital. The regional Community Benefit Committee is directly involved in selection of priorities for focused interventions 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.

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](http://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 March 2012 and concluded in November 2012. The report development was completed in early 2013.

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

- 1) Heart Disease and Stroke
- 2) Cancer
- 3) Diabetes
- 4) Preventive 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) Preventive 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 Memorial Hospital.

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)	5.0
Lamont (93241 Zip Code)	5.0	Bakersfield (93309 Zip Code)	4.2
Bakersfield (93311 Zip Code)	3.0	Bakersfield (93301 Zip Code)	5.0
Bakersfield (93312 Zip Code)	1.8	Bakersfield (93263 Zip Code)	5.0
Bakersfield (93313 Zip Code)	3.4	Bakersfield (93305 Zip Code)	5.0
Bakersfield (93304 Zip Code)	5.0	Bakersfield (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](http://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](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.

## Health Care Facilities

**H** Fed. Qual. Health Center     **H** Hospital     **H** Rural Health Clinic



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

Each year Department employees present progress reports to the Community Benefit Committee. During FY 2014, 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 board for final approval.

Other stakeholders involved in the selection of priority areas of focus are those organizations with which our hospitals co-sponsor 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, Omni Health Services, Kern County Network for Children, First 5 Kern, Jesus Shack and St. Vincent de Paul.

Each initiative in the Community Benefit Plan for Memorial Hospital 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 disabled adults, as well as 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 preventive 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**

Memorial Hospital 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, Memorial Hospital 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 Memorial Hospital. 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: Preventive 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
- Senior Grocery Bingo
- Shared Christmas
- Homemaker Care Program - Training
- Homework Club
- Operation Back to School
- Cancer Detection Program
- Car Seat 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 the Dignity Health System Office receive 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 Community Benefit Priority Areas</b>	<input checked="" type="checkbox"/> Preventive Screenings <input checked="" type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Heart Disease and Stroke <input checked="" type="checkbox"/> Access to Health Care
<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>	According to the 2013 Kern County Community Health Needs Assessment: <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).</li> <li>• The age-adjusted diabetes death rate in Kern County for the 2008 to 2010 measurement period is 31.2 per 100,000 compared to the State value of 19.7 per 100,000.</li> <li>• The age-adjusted diabetes hospitalization rate in Kern County for the 2008 to 2010 measurement period is 29.9 per 100,000 population.</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>FY 2014</b>	
<b>Goal FY 2014</b>	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
<b>2014 Objectives Measure/Indicator of Success</b>	The objectives for FY 2014 are: <ul style="list-style-type: none"> <li>• Provide 32,000 blood pressure checks, cholesterol, glucose and BMI screenings throughout Kern County.</li> <li>• Provide 12,640 clients with health education through in-home visits and classes/seminars including Empowerment -Chronic Disease and Diabetes.</li> <li>• Achieve an average evaluation score of 4 or higher from attendees at Community Health Education Classes.</li> <li>• 70 percent of clients of the Community Health Screening Clinics will have 2 or more normal or improved screening levels throughout the year.</li> </ul> Enhancement strategies are: <ul style="list-style-type: none"> <li>• Create profiles of four monthly screening clinics. Use profile to develop a customized approach to serving clients to increase participation and client satisfaction.</li> <li>• Create a protocol binder for Health Screenings, including equipment maintenance and calibration, staff training and event procedures.</li> </ul>
<b>Baseline</b>	During FY 2013: <ul style="list-style-type: none"> <li>• Provided 36,675 health screenings.</li> <li>• Provided 12,393 clients with health education.</li> <li>• 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.</li> </ul>
<b>Implementation Strategy for Achieving Goal</b>	Intervention strategies are: <ul style="list-style-type: none"> <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>• Improve 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>Results FY 2014</b>	During FY 14, the Community Wellness Program accomplished the following: <ul style="list-style-type: none"> <li>• Provided 31,987 health screenings. (Goal: provide 32,000 screenings)</li> <li>• Provided 13,750 clients with health education. (Goal: Educate 10,000 clients)</li> <li>• Established community education classes on Asthma, Diabetes, Nutrition, and other topics throughout the county.</li> </ul> Enhancement strategies completed: <ul style="list-style-type: none"> <li>• Added three new monthly clinic sites – Delano Ellington Senior Center; Casa de Eva Senior Complex in Bakersfield; St. Vincent de Paul Homeless Center.</li> </ul>

<b>Hospital's Contribution/Program Expense</b>	The total FY 2014 expense for the Community Wellness Program was \$618,217.39. Of this amount, \$137,567.14 was grant dollars, and \$480,650.25 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>FY 2015</b>	
<b>Goal FY 2015</b>	The Community Wellness Program will increase access to preventive health screenings and education for residents of Kern County.
<b>2015 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2015 are:</p> <ul style="list-style-type: none"> <li>• Provide 33,000 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County.</li> <li>• Provide 12,000 clients with health education through in-home visits and classes/seminars including Empowerment-Chronic Disease and Diabetes.</li> <li>• Achieve an average evaluation score of 4 or higher from attendees at Community Health Education Classes.</li> <li>• Add one monthly Community Screening Clinic in a new rural county location.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Provide mini-education sessions to encourage participation of screening clients in Community Health Education Classes and Empowerment Seminars.</li> </ul>
<b>Baseline</b>	<p>During FY 2014:</p> <ul style="list-style-type: none"> <li>• Provided 31,987 health screenings.</li> <li>• Provided 13,750 clients with health education.</li> <li>• Established community education classes on Asthma, Diabetes, Nutrition, and other topics throughout the county.</li> </ul>
<b>Implementation Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <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>• Improve 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 Community Benefit Priority Areas</b>	<input checked="" type="checkbox"/> Preventive Screenings <input checked="" type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Heart Disease and Stroke <input checked="" type="checkbox"/> Access to Health Care
<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 2013 Kern County Community Health Needs Assessment:</p> <ul style="list-style-type: none"> <li>The age-adjusted diabetes death rate in Kern County for the 2008 to 2010 measurement period is 31.2 per 100,000 compared to the State value of 19.7 per 100,000. Kern has the second highest diabetes death rate in the State.</li> <li>The age-adjusted diabetes hospitalization rate in Kern County for the 2008 to 2010 measurement period is 29.9 per 100,000 population.</li> <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 38.9% with Whites next at 27%.</li> <li>Kern County has the second highest death rate in the State due to Coronary Heart Disease.</li> </ul>
<b>Program Description</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>FY 2014</b>	
<b>Goal FY 2014</b>	<p>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).</p>
<b>2014 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2014 are:</p> <ul style="list-style-type: none"> <li>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.</li> <li>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 three months following their participation in the program.</li> <li>Establish a series of Empowerment-Chronic Disease Seminars within the Cardiac Care department at Memorial Hospital to directly link newly-discharged Cardiac patients into a Seminar program.</li> <li>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.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>Expand access to Empowerment-Chronic Disease and Empowerment -Diabetes self management education to residents of two new Kern County communities with a Community Need Index (CNI) score of 3 or above.</li> </ul>
<b>Baseline</b>	<p>During FY 2013:</p> <ul style="list-style-type: none"> <li>Completed 16 Empowerment-Chronic Disease and Empowerment -Diabetes Seminars in communities with a Community Need Index (CNI) score of 3 or above.</li> <li>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.</li> </ul>
<b>Implementation 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-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.</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>Results FY 2014</b>	<p>During FY 2014, Empowerment accomplished the following:</p> <ul style="list-style-type: none"> <li>Completed 19 Empowerment -Chronic Disease and Empowerment -Diabetes Seminars in Kern County. (Goal 18 seminars) A total of 8 seminars were for Diabetes Self-Management (6 Spanish, 2 English), and 11 seminars were for Chronic Disease Self-Management (10 Spanish, 1 English).</li> <li>100% 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 three months following their participation in the program. (Goal 85%)</li> <li>147 participants completed Empowerment -Chronic Disease and Empowerment -Diabetes seminars.</li> <li>We were unable to link the Empowerment -Chronic Disease Seminars to patients in the Cardiac Care department at Memorial Hospital. Presentations were made to medical care providers and a mailing was sent to former patients by Marketing with no response. The Cardiac Care program coordinator transferred to another position during the year and no further meetings have been held.</li> <li>15 new leaders for Empowerment -Diabetes Seminars were trained during the year – 8 for English Seminars and 7 for Spanish Seminars. (goal 10 leaders trained)</li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>Expanded access with Empowerment -Chronic Disease and Empowerment-Diabetes self management seminars provided in Delano and through the Exceptional Families Center in Bakersfield.</li> </ul>
<b>Hospital's Contribution/Program Expense</b>	Expenses in FY 2014 have been \$68,681.61. Of this amount, \$12,314.86 was grant funded, and Mercy and Memorial Hospitals contributed \$56,366.75 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.
<b>FY 2015</b>	
<b>Goal FY 2015</b>	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).
<b>2015 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2015 are:</p> <ul style="list-style-type: none"> <li>Provide 20 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.</li> <li>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 three months following their participation in the program.</li> <li>Establish a regular system referring hospital-discharged patients to Empowerment seminars.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>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 or to new high-risk communities.</li> <li>Test the use of a Session Zero before Empowerment Seminars to determine impact on retention of participants.</li> </ul>
<b>Baseline</b>	<p>During FY 2014:</p> <ul style="list-style-type: none"> <li>Completed 19 Empowerment -Chronic Disease and Empowerment -Diabetes Seminars in communities with a Community Need Index (CNI) score of 3 or above.</li> <li>100% 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 three months following their participation in the program.</li> <li>Trained 15 new leaders for Empowerment -Diabetes Seminars.</li> </ul>
<b>Implementation Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>Engage clinical health professionals to guide program improvement.</li> <li>Focus on the uninsured and populations covered by Medicaid, Medicare/Medicaid.</li> <li>Encourage and support continuing education for leader development to ensure quality service is provided by the Empowerment Self Management Programs.</li> </ul>
<b>Community Benefit Category</b>	A1-a Community Health Education - Lectures/Workshops

<b>COMMUNITY HEALTH INITIATIVE</b>	
<b>Hospital Community Benefit Priority Areas</b>	<input type="checkbox"/> Preventive Screenings <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Disease and Stroke <input checked="" type="checkbox"/> Access to Health Care
<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>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.</p>
<b>Program Description Community Health Initiative</b>	<p>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 Enrollment Counselors (CECs) and referrals to partner agencies, and works at the local and state levels to help streamline the sometimes-burdensome process of navigating through the public health system.</p>
<b>FY 2014</b>	
<b>Goal FY 2014</b>	<p>With a coalition of Kern County organizations, educate and enroll uninsured adults and children into a health insurance plan through an innovative new plan.</p>
<b>2014 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2014 are:</p> <ul style="list-style-type: none"> <li>• Enroll 18,000 individuals in health insurance through Medi-Cal and Covered California.</li> <li>• Provide enrollment assistance in ten new locations throughout the county.</li> <li>• Establish regular enrollment support in local hospitals, particularly in NICU, maternity units, and emergency departments.</li> <li>• Develop utilization strategies and education methods to reduce the costs of uncompensated hospital care in the county.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Expand the county's network of partner agencies providing enrollment services.</li> <li>• Provide ongoing training and support for the new enrollment practices of Covered California.</li> </ul>
<b>Baseline</b>	<p>During FY 2013:</p> <ul style="list-style-type: none"> <li>• Verified enrollment of 9,519 children into health insurance programs.</li> <li>• Assisted 236 children with in NICU and Labor &amp; Delivery at Memorial Hospital.</li> <li>• Retained 30.2% of children enrolled through SAS at annual renewal.</li> <li>• Conducted trainings for 163 CAAs.</li> <li>• Provided 407 units of support to partner CAAs.</li> <li>• Began analysis of OSHPD data showing costs of uncompensated care of uninsured children in the county.</li> </ul>
<b>Implementation 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 outreach and enrollment services to populations that have been hard-to-reach through our traditional channels.</li> <li>• Continue to work at local, state and federal levels to eliminate barriers and streamline application processes.</li> </ul>
<b>Results FY 2014</b>	<p>During FY 14, the Community Health Initiative accomplished the following:</p> <ul style="list-style-type: none"> <li>• Verified enrollment of 24,539 children and adults into health insurance programs through program employee efforts and partner agencies.</li> <li>• Provided enrollment assistance in 19 new locations throughout the county.</li> <li>• Regular enrollment support was established at Kern Medical Center through a partner agency.</li> <li>• Created utilization services to educate newly-insured individuals about how to maximize their health insurance benefits.</li> </ul> <p>Enhancement strategies completed:</p> <ul style="list-style-type: none"> <li>• Added five new partner agencies to provide enrollment services</li> <li>• Conducted 12 trainings on the new enrollment practices of Covered California for partner agency personnel.</li> </ul>

<b>Hospital's Contribution/Program Expense</b>	The total FY 2014 expense for the Community Health Initiative was \$519,630. Of this amount, \$414,746 was grant dollars, and \$104,884 was contributed by Mercy and Memorial Hospitals. Other hospital contributions include program supervision, strategic planning, evaluation, fundraising support, educational materials, liability insurance for the program, bookkeeping, and human resource support for the program.
<b>FY 2015</b>	
<b>Goal FY 2015</b>	With a coalition of Kern County organizations, educate and enroll uninsured adults and children into a health insurance plan through an innovative new plan.
<b>2015 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2015 are:</p> <ul style="list-style-type: none"> <li>• Enroll 5,000 individuals in health insurance through Medi-Cal and Covered California. 2,000 enrollments will be made by Dignity Health employees, and 3,000 will be verified as enrolled or renewed by partner agencies.</li> <li>• Provide enrollment assistance in five new locations throughout the county, and eight locations previously supported.</li> <li>• Provide Outreach and Enrollment support at six events sponsored by Dignity Health Marketing.</li> <li>• Develop utilization strategies and education methods that result in 20% of assisted clients scheduling their first doctor appointment within six months of enrollment.</li> <li>• 100% of clients who receive enrollment assistance by CHI employees will be offered annual renewal assistance.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Expand the county's network of partner agencies providing enrollment services.</li> <li>• Provide ongoing training and support for the new enrollment practices of Covered California.</li> </ul>
<b>Baseline</b>	<p>During FY 2014:</p> <ul style="list-style-type: none"> <li>• Verified enrollment of 19,916 children and adults into health insurance programs through program employee efforts and partner agencies.</li> <li>• Provided enrollment assistance in 19 new locations throughout the county.</li> <li>• Regular enrollment support was established at Kern Medical Center through a partner agency.</li> <li>• Created utilization services to educate newly-insured individuals about how to maximize their health insurance benefits.</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 outreach and enrollment services to populations that have been hard-to-reach through our traditional channels.</li> <li>• Continue to work at local, state and federal levels to 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 Community Benefit Priority Areas</b>	<input checked="" type="checkbox"/> Preventive Screenings <input checked="" type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input checked="" type="checkbox"/> Heart Disease and Stroke <input checked="" type="checkbox"/> Access to Health Care
<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>	<ul style="list-style-type: none"> <li>In 2013, Kern County's Annual unemployment rate was 10.4% compared to 9.1% 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 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.</li> <li>In 2012, 10.4% 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> </ul>
<b>Program Description Homemaker Care Program</b>	<ul style="list-style-type: none"> <li>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.</li> <li>The Homemaker Care Program provides in-home supportive services to seniors ages 65 and older, as well as adults with disabilities. Case management of the seniors is conducted in the form of wellness checks and home visits to assess client safety, nutrition, and program satisfaction.</li> </ul>
<b>FY 2014</b>	
<b>Goal FY 2014</b>	<ul style="list-style-type: none"> <li>The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce.</li> <li>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.</li> </ul>
<b>2014 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2014 are:</p> <ul style="list-style-type: none"> <li>Achieve an overall grade among training program graduates of 80% or more on total competency exam scores</li> <li>Verify that 65% of training program graduates apply for three jobs within three months following completion of training</li> <li>Provide program seniors with 14,815 hours of in-home supportive services</li> <li>Increase service hours of program seniors who pay full cost to 46% of total hours served</li> </ul> <p>Enhancement strategies:</p> <ul style="list-style-type: none"> <li>Enhance training program employment outcomes by creating opportunities for hiring agencies to recruit potential employees throughout the training program</li> <li>Ensure sustainability of the program by researching grant funding that will support senior services and the training program.</li> </ul>
<b>Baseline</b>	<p>During FY 2013:</p> <ul style="list-style-type: none"> <li>Provided a total of 13,037 hours of service to a monthly average of 74 households</li> <li>38% of total clients served were full pay</li> </ul>
<b>Implementation Strategy for Achieving Goal</b>	<p>Implementation strategies are:</p> <ul style="list-style-type: none"> <li>Provide opportunities for trainees to conduct on-line applications and job search at the Community Wellness Center</li> <li>Track employment retention of training program graduates</li> <li>Conduct continuous recruitment of qualified in-home care attendants to hire into the program</li> <li>Conduct monthly meetings with In-Home Care Attendants to discuss providing safety and quality service to each client</li> </ul>

<b>Results FY 2014</b>	<p>During FY 2014, the Homemaker Care Program accomplished the following:</p> <ul style="list-style-type: none"> <li>• Achieved an overall grade of 92% on total competency exam scores (Goal: score of 80%)</li> <li>• Verified that 87% of graduates applied for a minimum of three jobs post training (Goal: 65%)</li> <li>• Provided 14,205 hours of in-home supportive services to senior and disabled clients (Goal: Provide 14,815 hours).</li> <li>• Increased full pay hours to 44% of total hours served (Goal: Increase full pay hours to 46%)</li> </ul> <p>Enhancement activities:</p> <ul style="list-style-type: none"> <li>• Enhanced employment outcomes for the graduates: <ul style="list-style-type: none"> <li>• Provided 6 job fairs, one at the end of each training session</li> <li>• Included 6 employment recruitment opportunities for 68 students</li> <li>• Conducted 6 application assistance workshops</li> </ul> </li> </ul> <p>Improved sustainability of the program:</p> <ul style="list-style-type: none"> <li>• Submitted two grant proposals to the Catherine McAuley Society and Memorial Hospital Auxiliary</li> <li>• Secured \$123,872 in client revenue. This amount makes up 66% of salaries utilized to provide in-home supportive services.</li> </ul>
<b>Hospital's Contribution /Program Expense</b>	During FY 2014, expenses for the Homemaker Care Program were \$280,369. Of this amount, \$31,971 was grant dollars, \$123,872 was fee for service, and \$124,526 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>FY 2015</b>	
<b>Goal FY 2015</b>	<ul style="list-style-type: none"> <li>• The Homemaker Care Program will provide employment readiness training for individuals transitioning from unemployment into the workforce.</li> <li>• 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.</li> </ul>
<b>2015 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2015 are:</p> <ul style="list-style-type: none"> <li>• Achieve an overall grade among program graduates of 90% or more on total competency exam scores</li> <li>• Verify that 65% of program graduates apply for three jobs within one month following completion of training</li> <li>• Provide 14,000 hours of in-home supportive services to senior and disabled clients</li> <li>• Increase full pay hours to 45% of total hours served</li> </ul> <p>Enhancement strategies:</p> <ul style="list-style-type: none"> <li>• Establish agreements with America's Job Center and Dress for Success to assist training graduates with career coaching, resume building and interview skills</li> <li>• Ensure sustainability of the program through advertising and by researching grant funding that will support senior services and the training program and by marketing to full pay clients</li> </ul>
<b>Baseline</b>	<p>FY 2014:</p> <ul style="list-style-type: none"> <li>• Achieved overall score of 92% on competency exams</li> <li>• 87% of program graduates applied for three jobs within three months post training</li> <li>• 14,205.5 hours of service were provided to senior and disabled clients</li> <li>• 44% of total client hours were provided to full pay clients</li> </ul>
<b>Implementation Strategy for Achieving Goal</b>	<p>Implementation strategies are:</p> <ul style="list-style-type: none"> <li>• Provide opportunities for trainees to conduct on-line applications utilizing the resources at the Community Wellness Center</li> <li>• Track employment rate and retention</li> <li>• Enhance marketing tools for both the training program and in-home supportive services</li> <li>• Conduct continuous recruitment of qualified in-home care attendants to hire into the program</li> <li>• Conduct monthly meetings with In-Home Care Attendants to discuss providing safety and quality service to each client</li> </ul>
<b>Community Benefit Category</b>	E3-d In-kind Assistance - Basic services for individuals F5-c Leadership Dev/Training for Community Members - Career development

<b>ASTHMA MANAGEMENT</b>	
<b>Hospital Community Benefit Priority Areas</b>	<input type="checkbox"/> Preventive Screenings <input type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Asthma <input type="checkbox"/> Heart Disease and Stroke <input checked="" type="checkbox"/> Access to Health Care
<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>	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)
<b>Program Description Asthma Management</b>	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.
<b>FY 2014</b>	
<b>Goal FY 2014</b>	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.
<b>2014 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2014 are:</p> <ul style="list-style-type: none"> <li>• Three employees of the Community Wellness Program (CWP) will become Certified Asthma Educators.</li> <li>• 20 clients will be enrolled into the pilot project.</li> <li>• Protocols for monitoring and intervention will be established.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Work with community partner organizations to identify potential clients for pilot project.</li> <li>• Outcomes will be carefully monitored and compared to other Propeller Health client companies and Dignity Health hospitals that have used the technology.</li> </ul>
<b>Baseline</b>	<p>During FY 2014:</p> <ul style="list-style-type: none"> <li>• This is a new program. There is no baseline.</li> </ul>
<b>Implementation Strategy for Achieving Goal</b>	<p>Intervention strategies are:</p> <ul style="list-style-type: none"> <li>• An agreement will be made with Propeller Health to utilize their proprietary technology monitoring system.</li> <li>• Communication will be established between CWP employees and appropriate hospital personnel to identify patients who are candidates for the pilot project.</li> </ul>
<b>Results FY 2014</b>	We were unable to start a program in FY 2014 as planned due to contractual delays.
<b>Hospital's Contribution/Program Expense</b>	No expense was incurred during FY 2015.
<b>FY 2015</b>	
<b>Goal FY 2015</b>	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.
<b>2015 Objectives Measure/Indicator of Success</b>	<p>The objectives for FY 2015 are:</p> <ul style="list-style-type: none"> <li>• Three employees of the Community Wellness Program (CWP) will become Certified Asthma Educators.</li> <li>• 20 clients will be enrolled into the pilot project.</li> <li>• Protocols for monitoring and intervention will be established.</li> </ul> <p>Enhancement strategies are:</p> <ul style="list-style-type: none"> <li>• Work with community partner organizations to identify potential clients for pilot project.</li> <li>• Outcomes will be carefully monitored and compared to other Propeller Health client companies and Dignity Health hospitals that have used the technology.</li> </ul>
<b>Baseline</b>	<p>During FY 2015</p> <ul style="list-style-type: none"> <li>• This is a new program. There is no baseline.</li> </ul>

<b>Implementation Strategy for Achieving Goal</b>	Intervention strategies are: <ul style="list-style-type: none"> <li>• An agreement will be made with Propeller Health to utilize their proprietary technology monitoring system.</li> <li>• Communication will be established between CWP employees and appropriate hospital personnel to identify patients who are candidates for the pilot project.</li> </ul>
<b>Community Benefit Category</b>	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 Un-sponsored Community Benefit

Memorial Hospital utilizes the Community Benefit Inventory for Social Accountability (CBISA) web-based 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.

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Complete Summary - Classified Including Non Community Benefit (Medicare)  
For period from 7/1/2013 through 6/30/2014

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<b><u>Benefits for Those Living In Poverty</u></b>						
Financial Assistance	5,704	6,515,820	0	6,515,820	2.0	1.7
Medicaid	53,439	115,213,268	81,595,721	33,617,547	10.2	9.0
<b>Community Services</b>						
Community Benefit Operations	2,225	475,073	65,345	409,728	0.1	0.1
Community Building Activities	1,747	23,154	12,615	10,539	0.0	0.0
Community Health Improvement Sen	19,387	578,131	239,104	339,027	0.1	0.1
Financial and In-Kind Contributions	22,706	918,383	79,127	839,256	0.3	0.2
<b>Totals for Community Services</b>	<b>46,065</b>	<b>1,994,741</b>	<b>396,191</b>	<b>1,598,550</b>	<b>0.5</b>	<b>0.4</b>
<b>Totals for Living In Poverty</b>	<b>105,208</b>	<b>123,723,829</b>	<b>81,991,912</b>	<b>41,731,917</b>	<b>12.7</b>	<b>11.2</b>
<b><u>Benefits for Broader Community</u></b>						
<b>Community Services</b>						
Community Building Activities	595	22,713	0	22,713	0.0	0.0
Community Health Improvement Sen	11,718	147,327	27,964	119,363	0.0	0.0
Financial and In-Kind Contributions	168	99,224	1,281	97,943	0.0	0.0
<b>Totals for Community Services</b>	<b>12,481</b>	<b>269,264</b>	<b>29,245</b>	<b>240,019</b>	<b>0.1</b>	<b>0.1</b>
<b>Totals for Broader Community</b>	<b>12,481</b>	<b>269,264</b>	<b>29,245</b>	<b>240,019</b>	<b>0.1</b>	<b>0.1</b>
<b>Totals - Community Benefit</b>	<b>117,689</b>	<b>123,993,093</b>	<b>82,021,157</b>	<b>41,971,936</b>	<b>12.7</b>	<b>11.3</b>
Unpaid Cost of Medicare	18,670	85,715,379	76,721,165	8,994,214	2.7	2.4
<b>Totals with Medicare</b>	<b>136,359</b>	<b>209,708,472</b>	<b>158,742,322</b>	<b>50,966,150</b>	<b>15.5</b>	<b>13.7</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.choosemercyhospital.org](http://www.choosemercyhospital.org)

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

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

## **Success Stories**

### **Community Health Initiative**

Certified Enrollment Counselor Lucy Cortes assisted a 50 year-old woman at an enrollment event. The woman only works 5 hours a day for a local school district, so she isn't eligible for the district's health benefits, and she is paying her daughter's education at Irvine University in Southern California. The woman said that she had some health issues that needed immediate attention, but she couldn't get some needed tests because she was uninsured. The woman qualified for premium assistance through Covered California and cost-sharing reductions. She was very grateful and told Lucy she felt a huge relief knowing about all the benefits she was going to receive. As the woman left, she said she was finally going to her doctor, and she couldn't be more thankful to our team for helping her get coverage.

### **Community Wellness Program**

#### Health Education

Health Education Specialist Angelica Montano held a nutrition class in Wasco early this year. Angelica also lives in Wasco, and recently saw Rose, a participant in the class, at the grocery store. Angelica did not remember Rose at first, but Rose thanked Angelica for the class. She said the tips she learned there helped her make some changes, and that she lost 15 pounds. Rose was very thankful for the class, and Angelica told her that she deserved the credit for her discipline and decision to live a healthier lifestyle. Rose said she had been feeling better and younger since making these changes. Angelica is inspired by stories like these by people who are ready to make a life change and are determined to do so.

#### Empowerment – Diabetes Self-Management Program

Program Specialist Luz Torres made follow-up calls to participants in one of the Diabetes Self-Management seminars held this year. One woman took the seminar because her diabetic husband is living in an assisted living home, and she wanted to help him cook healthier meals. She told Luz how grateful she is to have the textbook from the seminar because it shows the amounts of carbohydrates and fibers contained in various foods. She constantly refers to this information as she chooses the foods for her husband's meals. Before the seminar, it was not unusual for him to have blood sugar levels at 400. His levels are now routinely between 150 and 200, so she knows this information and her attention to his food choices are paying off.

#### Homemaker Care Program

The Homemaker Care program has enabled two sisters, Wendy and Lydia, who have lived together their entire lives, to remain together in their home. Prior to the Homemaker Care Program, they were desperately in need of care, but were too afraid of being separated to ask for help. Now, they have a caregiver they trust and who prepares their favorite pot roast dinner and even gives them soothing manicures for their severely arthritic hands.

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

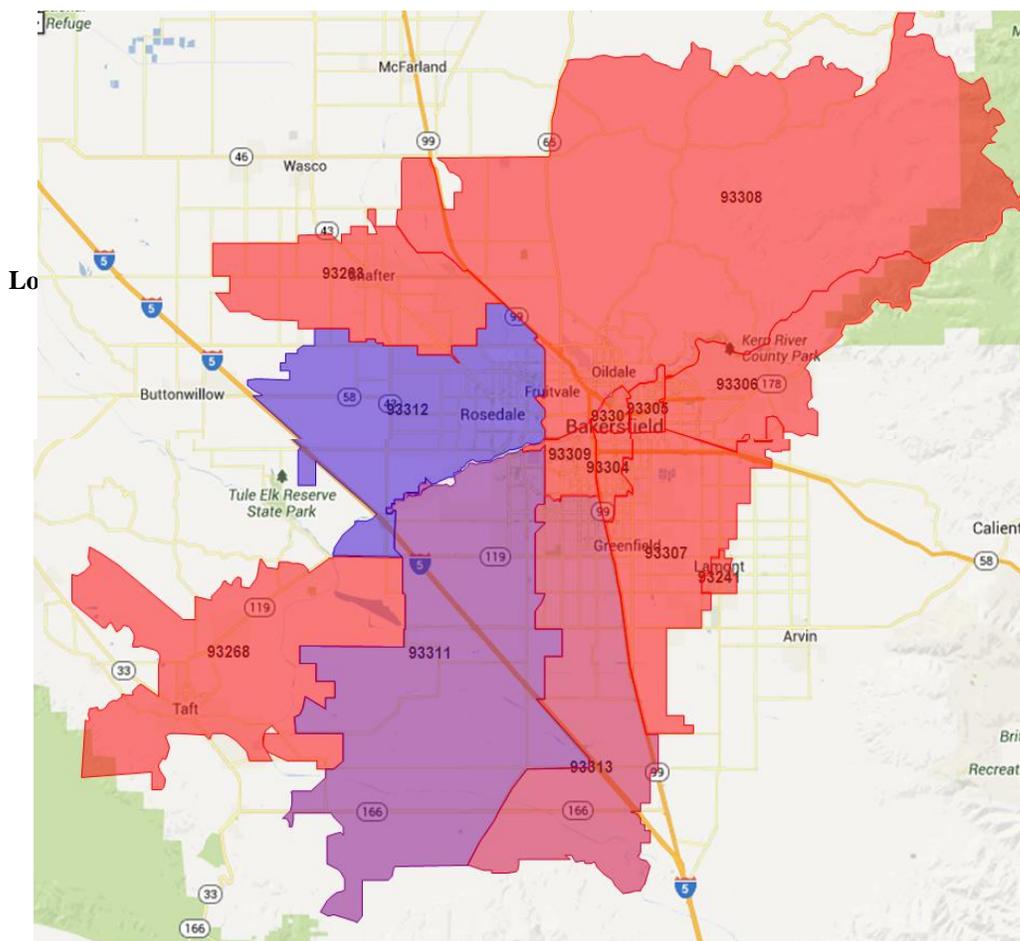


## Department of Special Needs & Community Outreach

### Community Benefit Committee Membership

**Felicia Barraza**, Community Benefit CBISA Coordinator, Mercy & Memorial Hospitals  
**Joanne Border**, Community Volunteer, St. Vincent de Paul  
**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, 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**, Director of Marketing and Member Services, 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, Foundation Financial, Inc.  
**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**, Vice President, Philanthropy, Mercy Hospitals of Bakersfield  
**Jonathan Webster**, Executive Director, Brotherhood Alliance

# Memorial Hospital



Lowest 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
<span style="color: red;">■</span>	93268	4.8	13,620	Taft	Kern	California
<span style="color: red;">■</span>	93241	5	15,357	Lamont	Kern	California
<span style="color: purple;">■</span>	93311	3	42,067	Bakersfield	Kern	California
<span style="color: red;">■</span>	93313	3.4	42,771	Bakersfield	Kern	California
<span style="color: red;">■</span>	93304	5	50,472	Bakersfield	Kern	California
<span style="color: red;">■</span>	93307	5	73,563	Bakersfield	Kern	California
<span style="color: red;">■</span>	93309	4.2	63,712	Bakersfield	Kern	California
<span style="color: red;">■</span>	93301	5	13,818	Bakersfield	Kern	California
<span style="color: red;">■</span>	93305	5	36,313	Bakersfield	Kern	California
<span style="color: red;">■</span>	93306	4.8	60,756	Bakersfield	Kern	California
<span style="color: blue;">■</span>	93312	1.8	61,080	Bakersfield	Kern	California
<span style="color: red;">■</span>	93263	5	19,511	Bakersfield	Kern	California
<span style="color: red;">■</span>	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.