Mercy & Memorial Hospitals

Members of CHW

Bakersfield Memorial Hospital

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Community Benefit Report 2008

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EXECUTIVE SUMMARY

Catholic Healthcare West (CHW) is the largest health provider in California; and the three CHW hospitals in Bakersfield are the largest provider of health services in the Southern San Joaquin Valley, serving a diverse population of urban and rural residents with three hospitals, a cancer center, an urgent care center, a childcare facility, home health services, wound care and two community outreach centers. CHW's hospitals provide a comprehensive range of health services with a strategic emphasis on cardiac services, cancer care, and maternal/child health. Our mission is to provide quality, compassionate health care to our patients and to advocate on behalf of the poor. For FY 2008, the Net Quantifiable Community Benefit of Mercy Hospital/Mercy Southwest Hospital was $19,788,046 and $14,689,452 for Bakersfield Memorial Hospital.

Caring for the community beyond the hospital walls led to the founding, in 1991, of the Department of Special Needs & Community Outreach. Today, the department operates more than 55 programs in Bakersfield, Arvin, Shafter, McFarland, Delano, Lake Isabella, Ridgecrest, Taft, and other outlying communities in Kern County where there is limited access to health care and related services. With 22 employees (20.5 FTEs) and an annual budget of $3,150,128, the department's programs target low-income, uninsured, or underinsured individuals, as well as Kern County citizens with unmet health needs, including migrant farmworkers and other disenfranchised populations. The department frequently collaborates with more than 60 public, private, and nonprofit organizations. Our outreach program completed a national pilot project for Advancing the State of the Art in Community Benefit (ASACB) by demonstrating and researching best practices regarding community benefit programs.

CHW hospitals in the service area include:

Bakersfield Memorial Hospital – 420 34th Street, Bakersfield, CA 93301, (661) 327-4647.
Founded in 1956 in northeast Bakersfield, Memorial Hospital is a 307-bed acute care hospital with an additional 24-bed skilled nursing facility. Memorial Hospital offers comprehensive cardiovascular services, as well as obstetrics, pediatrics, orthopedics, emergency care, outpatient surgery, and wound care/hyperbarics. As part of the hospital's emergency services, a specially trained Sexual Assault Response Team (S.A.R.T.) provides compassionate care to victims of sexual violence. This facility employs 1,381 people.

Mercy Hospital – 2215 Truxtun Avenue, Bakersfield, CA 93301, (661) 632-5000.
Founded in 1910 by the Sisters of Mercy, this acute care hospital in downtown Bakersfield is licensed for 144 beds and an additional 50-bed skilled nursing facility. Mercy Hospital offers a full range of medical/surgical services, including the Florence R. Wheeler Cancer Center. This facility employs 1,096 people.

Mercy Southwest Hospital – 400 Old River Road, Bakersfield, CA 93311, (661) 663-6000.
Mercy Southwest Hospital was built in 1992 and is located in southwest Bakersfield. This 78-bed acute care hospital focuses on outpatient and short-stay services specializing in obstetrics, women's care, and medical/surgical care. A 14-bed emergency room and 8-bed intensive care unit were added in FY 2005. An urgent care center offers treatment for non-life-threatening illnesses and injuries. Two professional medical service office buildings are located on the hospital campus. This facility employs 513 people.

CHW Outreach Centers - **Learning Center**
631 E. California Avenue, Bakersfield, CA 93307, (661) 325-2995
Outreach Center
1627 Virginia Avenue "B", Bakersfield, CA 93307, (661) 323-1691

Located in the economically depressed neighborhoods of southeast Bakersfield, these two family resource centers serve as the hub 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 two outreach centers employ a total of 16 people and utilize an average of 74 volunteers each month.

Highlights of our major Community Benefit activities in FY 2008 include the following:

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 2008, the program served 3,148 patients through educational classes on high blood pressure, cancer, diabetes, and nutrition. A total of 14,440 blood pressure, cholesterol, and glucose screenings were provided at monthly clinics throughout Kern County. Among patients who received at least three screenings with elevated levels, 38 percent experienced improvement in their test results.

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 2008, 73 senior clients received 5,880 hours of homemaker care services, and of the 45 individuals who completed the training program, 51 percent found employment.

Homework Club – provides after-school academic tutoring for low-income children in kindergarten through seventh grades and engages them in structured, academic and cultural/social enrichment activities. In FY 2008, 39 students participated in the program. This year the Homework Club staff began using the Kaufman Test of Educational Achievement (KTEA) to monitor the academic progress of first thru seventh grade students. The KTEA test is also used in the Bakersfield City School District. Results of the KTEA test indicated that 67% of the first thru seventh grade students were reading at or above grade level. 84% of first thru seventh grade students achieved at or above grade level in Mathematics.

Value Enhancement Program - helps at-risk teens develop leadership skills and a sense of self worth while providing needed services to the community. In FY 2008, the VEP Saturday Projects contributed 1,470 hours of community service on 37 projects. Through the Youth Center, participants donated 263 hours of community service by serving dinners to the homeless.

Healthy Promotions Dental Program - provides uninsured adults with free routine dental examinations and preventive care, as well as education, transportation to appointments, and follow-up services when indicated. In FY 2008, program information was shared with 1,466 people and 131 new patients received first care dental visits for a total of 400 visits. Of the patients who needed restorative follow-up care, 50% completed their dental treatment plans.

Children's Health Initiative (CHI) – brings health insurance and a medical/dental home to all Kern County children. Studies show that insured children are less likely to miss school due to illness, more likely to make "well-child" doctor visits, and more likely to receive early treatment that may prevent an illness from becoming more serious. To assist in this effort, CHI staff coordinates the efforts of the Outreach and Enrollment Committee (OEC), a collaborative of 25 individuals from 35 social service and health care organizations, community groups and agencies throughout Kern County. In FY 2008, over 8,600 were enrolled in existing health coverage programs. With the help of First 5 Kern and the Friends of Mercy Foundation, the CHI has generated more than $1 million in grant support for uninsured children during this past year.

Share Mercy Program – a total of 2,000 hours are available through the Share Mercy program each year. These hours may be utilized by any number of employees in fulfilling our mission outside the workplace. Share Mercy will pay an employee up to 80 hours per year of work time as a volunteer with qualified agencies and organized programs that respond to special needs. During FY 2008, 516 Share Mercy hours were used to provide services for the Christian Emergency Relief Team, Camp Blue Jay and the Veterans Home Care Visits. Approximately 3,000 people were served.

Our Mission

Mercy and Memorial Hospitals are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

Delivering compassionate, high-quality, affordable health service;
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.

Our Vision

A growing and diversified health care ministry distinguished by excellent quality and committed to expanding access to those in need.

Our Values

Mercy and Memorial Hospitals are dedicated to providing high-quality, affordable health care to the communities we serve. Above all else we value:

Dignity	Respecting the inherent value and worth of each person.
Collaboration	Working together with people who support common values and vision to achieve shared goals.
Justice	Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.
Stewardship	Cultivating the resources entrusted to us to promote healing and wholeness.
Excellence	Exceeding expectations through teamwork and innovation.

ORGANIZATIONAL COMMITMENT

CHW has a community board for the Mercy Hospitals as well as a fiduciary board for Bakersfield Memorial Hospital. The boards are responsible for ensuring that community health is one of the major goals in the strategic planning process. The Boards of Directors are diverse groups that include community members, physicians, faith-based representatives, and business health executives who also provide a broad spectrum of perspectives on plans presented for their approval. The Mercy and Memorial presidents, responsible for administration of the local facilities, are committed to the Community Benefit process and accountable to CHW system leadership.

While Mercy & Memorial Hospitals are geographically compact with all of their hospitals located within the city of Bakersfield, its programs and services extend throughout Kern County. This arrangement, as well as the operational integration of facilities that has taken place over the past several years, supports a regional approach to planning, budgeting, and implementing community benefit programs. The Department of Special Needs & Community Outreach, directed by Debbie Hull, coordinates these functions and the system-wide social accountability tracking process.

A Community Benefit Committee assists the Department of Special Needs & Community Outreach in prioritizing programs for FY 09-11 which are in line with the hospital's strategic plan. Committee members (APPENDIX 1) include representatives of the hospitals' Executive Management Team, business community, social service agencies, community volunteers, CHW 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 boards of the Mercy Hospitals and Bakersfield Memorial Hospital for final approval. Committee membership has remained consistent for the past three years.

The hospitals' boards are responsible for the following areas regarding the community benefit activities.

- Budgeting Decisions
  - Review community benefit budget for the Department of Special Needs & 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 multi-year goals and objectives.
  - Budget adequate financial resources to hire competent staff to plan, develop, implement, and effectively manage community benefit initiatives.

- Program Content
  - The selection of priority program content areas by community benefit staff 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 salience (i.e., evidence that it is important to diverse community stakeholders)

- Program Target and Design
  - The selection, design, and targeting of specific project activities supported by the hospitals are based upon the following objective 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?)
    - 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?)
- Degree of controversy (i.e., Is this intervention acceptable to the community? Will this intervention offend important constituents?)
- 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.

- 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 staff 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.

On-going efforts continue to align all programs with the five core principles of Advancing the State of the Art in Community Benefit (ASACB):

- Focus on populations with disproportionate unmet health-related needs
- Emphasize primary prevention
- Build a seamless continuum of care
- Increase community capacity
- Strengthen collaborative governance

Every year Mercy and Memorial Hospitals contribute to a fund for the CHW Community Grants Program. This program award grants to nonprofit organizations whose proposals respond to the priorities identified in the health assessment and community benefit plans of our hospitals. CHW grant funds are used to provide services to underserved populations. During FY 2008, the following grants were awarded:

- Alpha House, $20,000
- American Lung Association, $20,000
- Girl Scouts Joshua Tree Council, $20,000
- National Multiple Sclerosis Society, $20,000
- Henrietta Weill Memorial Child Guidance Clinic, $23,452
- West Side Community Resource Center, $25,000
- Kern County's Children's Health Initiative, $25,000
- Links for Life, $20,000

COMMUNITY

A. DEFINITION OF COMMUNITY

Mercy and Memorial Hospitals serve all of Kern County, including Bakersfield (the county seat) and outlying rural communities such as Taft, Arvin and Lake Isabella. The county stretches 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 16.1 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. According to the State of California Employment Development Department, Kern County's annual unemployment rate for 2007 was 8.3 percent compared to 5.4 percent statewide.

According to the California Department of Finance, Kern County's estimated population for 2008 is 817,517, and is the 13th largest county based on population and the 3rd fastest growing within the state's 58 counties. By the year 2020, Kern County is projected to reach 1.1 million in population (California Department of Finance). Bakersfield's population of 323,213 (2008 estimate from the California Department of Finance) makes it the 11th largest city in California and places it among the top 100 largest metropolitan areas in the nation.

Kern County's population is ethnically and culturally diverse with 43 percent white (non-Hispanic/Latino), 42.7 percent Hispanic/Latino, 6.3 percent African American, 4.3 percent Asian/Pacific Islander, 1.7 percent American Indian/Alaskan, and 2 percent multirace. The demographics are dramatically shifting in Kern County as seen in the population of children of the county with nearly sixty percent of the 0 to 5 year old population now being Hispanic. Based on Census 2000, 66.6 percent of persons age 5 years and older speak English at home, 29 percent speak Spanish at home, and 4.4 percent speak other languages at home.

One in five Kern County residents and 16.8 percent of families live in poverty. Approximately 32 percent of adults age 25 years and older in the county have not graduated from high school. According to the 2005 California Health Interview Survey, 17.4 percent of Kern County children did not have health insurance coverage for all or part of the previous year compared to 10.7 percent statewide. During the 2006-07 school year, 35.6 percent of Kern County students tested had unhealthy body composition (obesity) based on individual Body Mass Index (BMI) scores.

Nearly two-thirds of Kern County's residents—and most of its major healthcare providers—are clustered in and around Bakersfield. The United States Department of Health and Human Services divides Kern County into 13 Medical Service Study Areas (MSSA) and may designate professional shortage areas for primary care, mental health, and/or dental care. Among the highlights:

- The Arvin-Lamont MSSA is designated as a shortage area for all three disciplines.
- Eight MSSAs (includes areas such as Taft, McFarland/Delano, Shafter/Wasco, Buttonwillow, Tehachapi, East Bakersfield, Southern portion of East Kern, and Lake Isabella) are designated as a shortage area for two of the three disciplines.
- The remaining four MSSAs (includes Frazier Park area, Northern portion of East Kern/Ridgecrest, North Bakersfield/Oildale, and downtown and Southwest Bakersfield) are designated as a shortage area in one of the three disciplines.

Many of Bakersfield's poorest residents are concentrated in the city's southeast quadrant, the site of our two 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 healthcare and other social services.

B. COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS

Mercy and Memorial Hospitals utilize the following four methods to assess community needs and the effectiveness of our response to these challenges.

1. Staff members of the Department of Special Needs & Community Outreach serve on 17 different boards or committees that respond to a wide variety of community concerns. Each quarter all 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.
2. The Community Benefit Committee helps ensure that our outreach services address identified community needs and are effectively working to improve the overall health status of the community and quality of life for its residents.
3. The community-wide assessment conducted in 2003 by DNA and Company, Inc. provided us with a baseline of demographic, health, and social indicators for Kern County. In 2006, United Way of Kern County, in collaboration with Bakersfield Memorial Hospital, Community Action Partnership of Kern, Delano Regional Medical Center, Kaiser Permanente, Mercy Hospitals of Bakersfield, and San Joaquin Community Hospital, sponsored the most recent Kern County Community Assessment. This report updated countywide statistics and helped to validate the community issues targeted for improvement that resulted from the 2003 Kern County Community Assessment. Another assessment will commence in 2009. The Kern County Network for Children Report Card 2008 is also used to corroborate the focus of our services.
4. The CHW Reporting Sheet for Community Needs Index (CNI) for Kern County prepared by Thomson/CHW (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); i.e., 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.

The 2006 Kern County Community Assessment

The 2006 Kern County Community Assessment compiled multi-faceted data on population demographics, health, education, socioeconomic self-sufficiency, and basic needs from a variety of sources. These sources included: United States Census Bureau's American Fact Finder, California Department of Health Services, California Department of Education, California Employment Development Department, United States Department of Agriculture, Emergency Food and Shelter Program, Kern County Homeless Collaborative, UCLA Center for Health Policy Research, and University of California at Berkeley Center for Social Services. In addition, community input from focus groups and telephone interviews conducted by United Way of Kern County were summarized in this report. (Executive Summary – Appendix 5)

Community Input

In 2006 United Way contracted with Delta Market Research to conduct telephone interviews with 500 adults age 18 years and older in Kern County. The purpose of the survey was to measure awareness, attitudes, perceptions, behaviors, and the importance of several issues related to education, socioeconomic self-sufficiency and basic human needs such as food, clothing and shelter. During the community consultation, participants identified the following aspects of health and basic needs as important considerations in a strong and healthy community:

- Accessible health care
- Affordable health care
- Available good health care
- Health services
- Healthy residents
- Safety and security

- Client Empowerment
- Access to basic needs
- Everyone has enough to eat
- Resources for at-risk adults
- Seniors feeling secure in their homes with adequate resource
- Central networking and availability of support services, linking providers with those looking for help
- Partnerships
- Integrated services for families and individuals (one place)

The following overall issues were ranked in order of importance by Kern County residents:

- Education
- Increasing high school graduation rates
- Basic human needs
- Early childhood development
- Affordable housing
- After-school programs
- Independent living for seniors

Community Needs Index (CNI)

Those communities identified on the CHW Reporting Sheet for CNI for Kern County (2007) prepared by Thomson/CHW with the highest CNI score (rated 1 to 5 with 5 being the most economically disadvantaged and most in need) were the primary focus of programs and services coordinated by Mercy and Memorial Hospitals. The highest scored areas included:

Bakersfield (93305 Zip Code)	5
Bakersfield (93307 Zip Code)	4.8
Wasco	4.8
Shafter	4.8
MC Farland	4.8
Lost Hills	4.8
Lamont	4.8
Delano	4.8
Arvin	4.8
Bakersfield (93304 Zip Code)	4.6
Bakersfield (93301 Zip Code)	4.6
Mojave	4.4
Buttonwillow	4.4
Taft	4.2
Boron	4
Tupman	4
Maricopa	4

COMMUNITY BENEFIT PLANNING PROCESS

A. DEVELOPING THE HOSPITAL'S COMMUNITY BENEFIT REPORT AND PLAN

By virtue of their frequent contact with residents of Kern County's most disadvantaged communities, staff of the Department of Special Needs & Community Outreach is familiar with many of the health and human service issues that affect the residents. As a result, the staff meets regularly to discuss, prioritize, and plan ways to best respond to the many needs. The Community Needs Index (CNI), Kern County Assessment, and other countywide reports are used to help identify appropriate and effective responses. As a result, programs and services may be developed, expanded, or terminated according to the identified needs and these five 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

Each community benefit program is reviewed against these five principles and, where necessary, changes to the program are suggested. Enhancements are made to ensure these community based programs are as beneficial to the community members they serve and as supportive as possible of our hospitals' mission.

Whenever possible, priority is given to the Southeast Bakersfield neighborhoods where we have an established presence by virtue of our two outreach Centers: CHW Learning Center and CHW 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 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, child protection services, family support, and enrollment in low- or no-cost health insurance programs.

Each year Department staff present progress reports to the Community Benefit Committee. The Committee, as well as management and executive staff of each hospital, provide input and, as a result, makes adjustments to programs, services, and the Community Benefit Plan. The Plan is then submitted to the boards for final approval.

Each initiative in the Community Benefit Plan for Mercy & Memorial 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

Selection of priority needs involves collaboration with a variety of internal and external stakeholders. As an adjunct to the organization's Strategic Planning Process, community benefit planning derives input and guidance from administrative leadership and the Boards of Directors. The regional Community Benefit Committee is directly involved in selection of priorities and development of specific program goals and objectives.

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 Department; Southeast Bakersfield Neighborhood Partnership; Greater Bakersfield Legal Assistance; Clinica Sierra Vista; United Way of Kern County; Goodwill Industries of South Central California; Taft College Dental Hygiene Clinic; Community Action Partnership of Kern; Kern Family Health Care; Kern County Department of Human Services; National Health Services; Kern County Network for Children; and First 5 Kern.

The impact of welfare reform and economic instability related to seasonal employment fluctuations in the agricultural industry are felt most deeply in Bakersfield's low-income neighborhoods and in many of Kern County's small rural communities. The Department of Special Needs & Community Outreach has responded to the increased need for food, clothing, and other supportive services through budget adjustments and collaborative endeavors. Programs for job training and job search have been expanded for welfare-to-work persons and the under-or un-employed. While Mercy & Memorial Hospitals continue to address urgent needs for housing, nutrition, social activities, and children's services, it also places significant emphasis on building community capacity by supporting the shared efforts of local residents, businesses, and social service agencies.

Using the criteria outlined above, the following priorities were established and then validated by Mercy Hospitals' Community Board, the Bakersfield Memorial Hospital Board, and the Community Benefit Committee.

- Programs and services for youth
- Childhood obesity
- Primary healthcare and/or access for the uninsured and/or underinsured
- Basic human needs for the uninsured and/or underinsured
- Jobs and training
- Programs and services for seniors

Each goal and objective in this Community Benefit Report and Plan responds to one or more identified need within these priority areas. Because these community concerns represent complex problems that cannot be solved by a single agency, our approach to community benefit programming involves collaborations with other organizations and agencies in the public, private, and nonprofit sectors (identified throughout the plan).

Intervention is achieved through the following seven main programs:

- Community Wellness Program (community health screening clinics; in-home health consultations, education, and monitoring; health education classes; and referrals to other local health care and social service agencies)
- Healthy Promotions Dental Program (free routine dental examinations and preventive care, transportation to appointments, and follow-up services for uninsured adults)
- Value Enhancement Program (leadership development for at-risk teens)
- Homework Club (after-school tutoring and social/cultural enrichment activities)
- Homemaker Care Program (homemaker services for the frail elderly and job training for unemployed adults)
- Children's Health Initiative (access to health care insurance for low-income children age 0 – 18 years and the establishment of a medical and dental health care home for all children in Kern County)
- Empowerment (Chronic Disease Self Management Program)

Because of the education component and 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 don't just apply a band-aid to unmet health-related needs, but are designed to improve health outcomes through changes in each individual situation and the capacity of our community to respond to unmet health-related needs.

B. PLANNING FOR THE UNINSURED/UNDERINSURED PATIENT POPULATION

Mercy & Memorial Hospitals are 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 and Memorial Hospitals strive 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) For patient and family review, posters announcing financial assistance are located in each Emergency Department, patient registration area and various locations throughout each facility. 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 a grant from First 5 Kern, Mercy & Memorial Hospitals coordinate the County's Children's Health Initiative. It serves as a platform for resolving issues around children's health insurance through monthly meetings, website, email, and telephone communication. The Children's Health Initiative conducts outreach to inform and enroll children from low-income families into health insurance, and to build awareness and support in the community at large. The Children's Health Initiative also serves as a fundraiser for Kern County's safety net health insurance, the Healthy Kids Kern County program.

During FY 2008, two new programs were initiated:

Healthy Kids in Healthy Homes:

In partnership with Kohl's stores, the aim of this new program is to address the issue of childhood obesity by offering a series consisting of six classes focusing on nutrition and exercise. Children, ages 8 to 14, will attend the six week series with their parents. This unique aspect of the program not only focuses on the child but includes the parent to create a healthy, accountable environment in the home. The media kick off for the program was January 24, 2008. The goal of this program is to assist families to live a healthier life through good nutrition and consistent exercise.

Empowerment:

This new program is a comprehensive chronic disease self-management program designed to provide patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. Each program session consists of six weekly classes covering a variety of topics including nutrition, exercise, use of medications, communicating with doctors, stress management and evaluating new treatment. The goal of this program is to assist patients by providing tools to manage their disease without readmission to the hospital or visiting the emergency department.

PROGRAM DIGEST- COMMUNITY WELLNESS PROGRAM

Hospital CB Priority Areas	• Primary health care and/or access for the uninsured and/or underinsured • Prevention, education and management of chronic disease • Childhood obesity
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	The Community Wellness Program serves Kern County area residents who are at-risk of hypertension, diabetes, high cholesterol, obesity and other chronic illnesses. According to a recent California Health Interview Survey (2003), 7.3% of Kern County adults are diabetic, 29% have high blood pressure, and 29% are obese. In addition, one in five 6 to 20 year-olds in California's San Joaquin Valley are obese--a precursor condition of diabetes--and 17.7% of Kern County residents do not have health insurance or access to routine screenings. The top four leading causes of death in the county are heart disease, cancer, chronic lower respiratory disease, and stroke. Diabetes is the sixth leading cause of death in the county. Many of these conditions are lifestyle related. By offering convenient and comprehensive screenings and health education, we hope to empower residents with the knowledge and tools they need to become proactive in their health and reduce their chances of developing one of the above-listed conditions.
Program Description	The Community Wellness Program is focused on preventative health care by providing in-home visits and on-site screenings and wellness and health education classes on a variety of topics for residents throughout Kern County.
REPORT FOR FY 2008	
Goal FY 2008	The Community Wellness Program will provide health screenings and education associated with diabetes, hypertension, and stress and cholesterol management to Kern County residents. Classes to improve nutrition, fitness and overall lifestyle will also be offered. Additionally, the program will continue to focus on the enhancement strategies set forth in the Advancing the State of the Art in Community Benefit (ASACB) planning model and to become the premier provider in Kern County for community wellness services.
Results FY 2008	During FY 2008, the Community Wellness Program accomplished the following: • Provided 14,440 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. (Target: 9,600) • 38% of case managed clients saw a decrease in their screening levels. (Target: 50%) • Provided 3,148 clients with health education through in-home visits/on-site classes. (Target: 2,400 clients) • Implemented Childhood Obesity Program "Healthy Kids in Healthy Homes." • Implemented the Chronic Disease Self Management Program "EMPOWERMENT." Enhancement strategies based on ASACB principles were: • Tested location and pilot screening clinic in a DUHN neighborhood in Delano, which is located in northern Kern County. (Target: Add one additional monthly screening clinic in a DUHN neighborhood in northern Kern County) • Worked with "Get Moving Kern" and distributed $5,376 in mini grants for grassroots obesity prevention activities. (Target: Distribute $12,000 in mini grants)
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $427,909 to the Community Wellness Program's annual budget. They also contribute program supervision, employee salaries, office space, strategic planning, evaluation, fundraising support, educational materials, liability insurance for both the program and program's clinic van, bookkeeping, and human resources support for the program.
UPDATE FOR FY 2009	
Goal FY 2009	The Community Wellness Program will continue to provide health screenings and education associated with diabetes, hypertension, and stress and cholesterol management to Kern County residents. Classes to improve nutrition, fitness and overall lifestyle will also continue to be offered. Additionally, the program will continue to focus on the enhancement strategies set forth in the ASACB planning model and become the premier provider in Kern County for community wellness services.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • Provide 15,000 blood pressure, cholesterol, glucose and BMI screenings throughout Kern County. • Provide 4,000 clients with health education through in-home visits/on-site classes. • Decrease the screening levels of case managed clients by 40%. • Continuation of the Childhood Obesity Program "Health Kids in Healthy Homes." • Continuation of the Chronic Disease Self Management Program "EMPOWERMENT." Enhancement strategies based on ASACB principles are: • Develop and implement a model of continuum of care process for at-risk clients by developing a referral process for further follow-up with wellness staff or healthcare provider. • Constantly evaluate, refine and offer comprehensive seminars/health education topics to assist in the primary prevention of prevalent diseases and health issues in Kern County. • Utilize the wellness software programs to create a reporting mechanism to report the impact on hospital utilization patterns by working in an environment of seamless continuum of care among the hospital, the provider and the Community Wellness Program.

COMMUNITY WELLNESS PROGRAM - CONTINUED

UPDATE FOR FY 2009 - continued	
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Accomplish objectives listed in the 2009 Objective section above. • Expand access to the services offered through the Community Wellness Program by offering additional community screenings including on-site screenings for businesses throughout Kern County. • Work with case management, other health care entities, and Mercy and Memorial Hospitals to implement a model continuum of care process. • Report the impact on hospital utilization patterns by working in an environment of seamless continuum of care among the hospital, the provider and the Community Wellness Program.

PROGRAM DIGEST- EMPOWERMENT

Hospital CB Priority Areas	• Chronic disease self-management • Health and human services for the uninsured and/or underinsured • Availability of health and related services
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 a recent California Health Interview Survey (2003), 7.3% of Kern County adults are diabetic, 29% have high blood pressure, and 29% are obese. In addition, 17.7% of Kern County residents do not have health insurance or access to routine screenings. The top four leading causes of death in the county are heart disease, cancer, chronic lower respiratory disease, and stroke. Diabetes is the sixth leading cause of death in the county. Many of these conditions are lifestyle related. By offering convenient and comprehensive screenings and health education, we hope to empower residents with the knowledge and tools they need to become proactive in their health and reduce their chances of developing one of the above-listed conditions.
Program Description	Empowerment is a comprehensive chronic disease self-management program (CDSMP) designed to provide patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. Each program session 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. To support patient efforts, home visits can be coordinated to continue the care of patients who desire ongoing assistance. Additional support tools such as a resource center with books and health literature, patient hotline, monthly staff phone calls, and the "*Empowerment"* newsletter will help patients feel connected and supported. Through the Empowerment program and system of support, we will change the way patients manage their health and restore their sense of control.
REPORT FOR FY 2008	
Goal FY 2008	The Empowerment Program will provide patients who have chronic diseases with the knowledge, tools, and motivation needed to become proactive in their health. The goal of Empowerment is to achieve a 5% decrease in hospital readmissions for participants taking part in this preventative health intervention.
Results FY 2008	During FY 2008, Empowerment accomplished the following: • Provided instructor training/certification for three (3) staff members. • Identified and marketed to a target population. • Completed first session with 100% attendance rate.
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $12,313 to Empowerment's annual budget. They also provide program supervision, office space, strategic planning, evaluation, fundraising support, educational materials, liability insurance, bookkeeping, and human resources support for the program.
UPDATE FOR FY 2009	
Goal FY 2009	The Empowerment Program will continue to provide patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. The goal of Empowerment is to achieve a 5% decrease in hospital readmissions for participants taking part in this preventative health intervention.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • Provide two sessions in English and two sessions in Spanish in Kern County areas with a Community Needs Index (CNI) score of 3 or above. • Create a Health Education Resource Center for program staff and participants. Enhancement strategies based on ASACB principles are: • Develop and implement a model continuum of care process for program participants. • Identify and train one "lay leader" to facilitate additional trainings.
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above. In addition, we will document participant self-reported hospital visits prior to participation in Empowerment.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Expand marketing of Empowerment via flyers, postcard mailings, and awareness campaigns at local health fairs, senior centers, hospitals, and other locations. • Encourage and support continuing education for staff development and on-going success strategies. This will ensure continued quality in offering the Empowerment Program.

PROGRAM DIGEST – HEALTHY PROMOTIONS DENTAL PROGRAM

Hospital CB Priority Areas	• Primary health care and/or access for the uninsured and/or underinsured • Basic human needs for the uninsured and/or underinsured
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	The Healthy Promotions Dental Program provides oral health services to low-income adults who do not have health insurance and/or access to dental health care. According to the 2006 United Way Kern County Assessment, 21% of Kern County adults do not have health insurance. Since those with health insurance are not necessarily covered by dental insurance, we estimate a much higher percentage of adults who do not have dental insurance and, therefore, lack dental services. Unfortunately, no specific data is available for Kern County that supports the severity of oral health disparities in this area. Nationwide statistics, however, do speak to the problem and identify major barriers to good oral health such as lack of dental insurance, the inability to pay out of pocket costs, language differences, lack of transportation, and loss of income because of lost time to obtain dental care.
Program Description	The Healthy Promotions Dental Program assists the traditionally underserved and uninsured residents of Kern County by providing them with access to dental care services and education at no cost to them. The program links adults to a dental hygiene training program to obtain dental cleanings, examinations, x-rays, and preventative dental health education. Patients with advanced dental health treatment needs are then referred to dental treatment and restorative care and further preventative dental health education. The program provides screening, scheduling, transportation, translation, and treatment coverage. It has created the capacity in the county to link existing dental health services to underserved and uninsured populations and the means to channel funding to support such a program. The program provides primary, secondary, and tertiary dental health services to its targeted population.
REPORT FOR FY 2008	
Goal FY 2008	The Healthy Promotions Dental Program will provide primary, secondary, and tertiary dental health services to low-income, uninsured adults who lack access to dental care.
Results FY 2008	During FY 2008, the Healthy Promotions Dental Program accomplished the following: • Provided first dental care visits to 131 new patients. (Target: 95 new patients) • Provided a total of 400 patient visits with oral hygiene services and continuum of care. (Target: 380 visits) • Completed dental treatment plans for 50% of the patients in need of follow up care. (Target: 80%) Enhancement strategies based on ASACB principles were: • Increased the number of dental professionals involved with the program from four to eleven. (Target: four to eight) • Distributed dental hygiene supplies such as toothbrushes, toothpaste, floss, and prevention educational material. (Target: Add a health promotion prevention component) • No new funding has been established. (Target: Establish new funding)
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $53,575 to the Healthy Promotions Dental Program's annual budget. They also contribute fundraising, coordinator's salary, human resource support, project management, office space, information materials, training of staff, phones, transportation van and maintenance, bookkeeping, data collection support, strategic planning, and evaluation support for the program.
UPDATE FOR FY 2009	
Goal FY 2009	The Healthy Promotions Dental Program's goals revolve around being able to increase oral health prevention and treatment for at-risk populations with unmet oral health needs, including increasing the number of patients the program can serve. To ensure community capacity and continuum of care for those needing treatment, the program will work to increase the number of dentists who will help carry out the treatment plans.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • Provide 219 uninsured adult residents of Kern County with preventative care, oral hygiene education, fluoride treatment and x-rays through Taft College Dental Hygiene Clinic for a total of 480 patient visits. • Provide 130 uninsured adults with restorative treatment (extractions, fillings, root canals, crowns and dentures) through our dental partners for a total of 190 patient visits Enhancement strategies based on ASACB principles are: • Collect data to provide a more complete picture of the prevalence, acuity and at-risk dimensions of the oral health of the population. • Continue implementation of health promotions and protection components that help reduce tooth decay (i.e. oral health education materials, toothbrushes, floss and toothpaste). • Develop processes and provide guidelines for all program partners to effectively work together. • Establish funding to pay for treatment to allow for continuum of care. • Engage community-based partner organizations, community dentists and the dental society as active partners in program decision making.

HEALTHY PROMOTIONS DENTAL PROGRAM – CONTINUED

UPDATE FOR FY 2009 - continued	
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above.
Intervention Strategy for Achieving Goal	Intervention strategies are as follows: • Maintain and expand the capacity of the program. • Increase the number of advanced dental treatment professionals involved in the program. • Develop better data tracking systems to project expected case load and costs to help maintain sound funding for the program. • Explore support for clinic space to conduct treatment.

PROGRAM DIGEST – CHILDREN'S HEALTH INITIATIVE

Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	The Children's Health Initiative serves children from low-income neighborhoods who lack health insurance coverage by assisting them with applications for public and private insurance programs that serve the poor. The program also works with elementary schools, employers, churches, local businesses, and government agencies. According to a 2005 California Health Interview Survey, an estimated 31,000 children in Kern County, or 11.3% of total children, were uninsured. Of these children, 27,000 live below 300% of the Federal Poverty Level, and 19,000 of these children may be eligible for Medi-Cal or Healthy Families. This leaves approximately 8,000 low-income children with no access to any form of health insurance coverage.
Program Description	The Children's Health Initiative is focused on preventive health care by meeting the insurance needs of low-income children ages 0 – 18 who otherwise would be uninsured. Having health insurance allows these children to have a medical/dental home and to utilize on-going preventive health services.
REPORT FOR FY 2008	
Goal FY 2008	The Children's Health Initiative will continue to provide health insurance to all children ages 0 – 18 who do not have access to other coverage. The program coordinates the county-wide activities related to this program to provide health education associated with enrollment, utilization and management of health insurance coverage.
Results FY 2008	During FY 2008, the Children's Health Initiative accomplished the following: • Coordinated enrollment of over 8,600 children into health insurance programs. • Provided refresher trainings for 82 Certified Application Assisters (CAAs). • Trained 52 new CAAs. • Raised $730,000 for premiums and operating costs.
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $8,200 to the Children's Health Initiative's annual budget. They also contribute program supervision, office space, fundraising support, bookkeeping, committee supplies, and human resource support for the program.
UPDATE FOR FY 2009	
Goal FY 2009	The Children's Health Initiative will continue to provide health insurance to all children ages 0 – 18 who do not have access to other coverage. The program coordinates the county-wide activities related to this program to provide health education associated with enrollment, utilization and management of health insurance coverage.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • Provide training sessions for 80 CAAs from throughout Kern County. • Educate 100 families about the importance of health insurance for their children. • Raise money for premiums to provide health insurance to 750 children ages 6 – 18 in the Healthy Kids Kern County (HKKC) insurance plan. • Continue to develop relationships with business, community, and local government leaders. • Participate in six community activities to raise awareness of health insurance programs. • Review opportunities to meet other health needs of the children in our community. • Continue development of continuous flow of funding for program sustainability. Enhancement strategies based on ASACB principles are: • Create a formal School Outreach program to identify uninsured children, educate parents, and enroll children into insurance programs. • Establish the School Outreach program in at least three elementary school districts.
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Provide training and education sessions which support the objectives of the program. • Expand fundraising efforts to raise funds for the program. • Work with the HKKC health plan and independent evaluators to analyze utilization of preventive care services among HKKC members.

PROGRAM DIGEST – HOMEMAKER CARE PROGRAM

Hospital CB Priority Areas	• Primary health care and/or access for the uninsured and/or underinsured • Basic human needs for the uninsured and/or underinsured • Jobs and training • Programs and services for seniors
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☐ Seamless Continuum of Care ☒ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	The Homemaker Care Program provides assistance to low-income seniors and disabled adults who are living independently. The program also provides job training for people who are transitioning from unemployment into the workforce and have an interest working with the frail elderly and disabled adults. Kern County's unemployment rate for 2007 was 8.3% compared to 5.4% for the rest of the state. For seniors 65 years or older: 33.1% have a condition limiting basic physical activities; 22.4% have a condition that makes it difficult to leave the home for shopping or doctor appointments; 11.1% have a condition causing difficulty in dressing and bathing; 17% are uninsured; and 12% (33,000) are living in poverty.
Program Description	The Homemaker Care Program provides in-home assistance for the frail elderly and disabled adults who need assistance in living independently and who have a desire to live independently as long as possible. The program also provides job training for people who are transitioning from unemployment into the workforce and who have an interest in working with disabled adults and seniors. Applicants are screened prior to entry into the program. Selected applicants are provided job training, supervision, and job placement assistance.
REPORT FOR FY 2008	
Goal FY 2008	The Homemaker Care Program will provide in-home support services to low-income homebound seniors and disabled adults. The program accomplishes this goal by: identifying and training interested individuals as In-Home Care Attendants; providing seniors and disabled adults with supportive services such as personal care, meal preparation, housekeeping, laundry, errands, and other home activities necessary to assist people to live independently despite advancing age and/or disability; and providing employment assistance to graduates of the Homemaker Care Program.
Results FY 2008	During FY 2008, the Homemaker Care Program accomplished the following: • Completed four training courses in partnership with Goodwill Industries of South Central California. (Target: Complete 4 training courses) • Provided 3,150 hours of training to 51 participants. (Target: Provide 4,200 hours of training to 60 participants) • 88% (45) of participants completed training, and 51% (23) of participants gained employment. (Target: 70% [42] of participants would complete the training program and gain employment) • Provided 5,880 hours of service to 73 senior clients. (Target: Provide 5,200 hours of homemaker services to 90 senior clients) • Provided 40 seniors and disabled adults with healthcare screenings for cholesterol, glucose, and hypertension. (Target: Provide screenings to 30% of clients [27]) • Offered employment in the Homemaker Care Program to 19% (6) of the program graduates. (Target: Offer employment to at least 7% [4] of the program graduates) • 60% of hired graduates were still working in the program three months after hire. (Target: 45% of hired graduates would still be working in the program three months after hire) Enhancement strategies based on ASACB principles were: • Trained and enabled five Homemaker Care staff to provide community outreach to various community events such as the Alzheimer's Disease Symposium and the Kern County Elder Abuse Conference. (Target: Develop a speaker pool of Homemaker Care staff to provide community outreach) • Developed a tool to assess each client's health care needs and in-home supportive services in order to support the health care provider's care plan. (Target: Develop more formal working relationship with the clients' health care provider)
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $36,304 to the Homemaker Care Program's annual budget. They also contribute management, human resource support, office space, fundraising support, bookkeeping, strategic planning and evaluation support for the program.

HOMEMAKER CARE PROGRAM – CONTINUED

UPDATE FOR FY 2009	
Goal FY 2009	The Homemaker Care Program will continue to provide in-home support services to low-income, homebound seniors and disabled adults. The program will accomplish this goal by identifying and training interested individuals as In-Home Care Attendants; providing seniors and disabled adults with supportive services such as personal care, meal preparation, housekeeping, laundry, errands, and other home activities necessary to assist people to live independently despite advancing age and/or disability; and providing employment assistance to graduates of the Homemaker Care Program.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • Provide 2,800 hours of training to 40 individuals during three two-week training sessions, which includes employment development services. • Ensure that 70% (35) of the trainees complete the program. • Provide 5,600 hours of support services (personal care, meal preparation, housekeeping, laundry, errands, and other home activities) to 90 homebound, low-income seniors and disabled adults to help them live independently. • Provide 2,800 hours of support services to seniors with no financial burden to ensure sustainability of the program. • Provide 30% (27) Homemaker Care Program seniors and disabled adults with in-home screenings for cholesterol, glucose, and hypertension provided by homemakers of the program. Enhancement strategies based on ASACB principles are: • Develop recruitment efforts that focus on employing quality individuals to be homemakers who will focus on homebound seniors who require supportive services. • Develop recruitment efforts that focus on enrolling individuals into the training. • Implement a standard living environment assessment tool to assess the client's health care needs.
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Transition each In-Home Care Attendant from being a Goodwill employee to a CHW employee. • Provide seniors and disabled adults with glucose, hypertension, and cholesterol screenings. • Enhance case management practices for trainees to ensure training completion.

PROGRAM DIGEST – VALUE ENHANCEMENT PROGRAM

Hospital CB Priority Areas	• Programs and services for youth • Programs and services for seniors • Childhood obesity • Jobs and training
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	The Value Enhancement Program not only serves the low-income youth who take part in the program, but also seniors and disabled persons in the neighborhoods where these youth live. According to the 2008 Needs Assessment, between 2004 and 2006, the percentage of "disengaged youths" increased from 5.7% to 6.3%. According to the Kern County Network for Children's Report Card 2008, 11% of Kern County's seventh graders, 8% of ninth graders, and 8% of eleventh graders identified themselves as gang members. The Office of Juvenile Justice and Delinquency Prevention has found that too much idle time and too little positive adult supervision are contributing factors to delinquency and risky behaviors among young people.
Program Description	The Value Enhancement Program assists low-income at-risk teens ages 12-18 to develop their sense of pride by encouraging them to become more involved within their community. This is done by involving youth in Saturday residential community clean up activities, providing a youth center with an after-school program, and educating teens about healthy lifestyle choices. Monthly guest speakers present topics appropriate for teens such as domestic abuse, self defense, job opportunities, etc.
REPORT FOR FY 2008	
Goal FY 2008	The Value Enhancement Program will continue to provide youth with community service experience, life skill enhancement activities, and an after-school program. The Youth Center will continue to offer a safe environment for teens to congregate.
Results FY 2008	During FY 2008, the Value Enhancement Program accomplished the following: • Involved 38 youth in 37 community service activities. (Target: Involve 30 youth in 35 community service activities) • 97% of teens achieved 20 out of 25 points on their Attitude/Effort scorecard. (Target: 90% of teens will achieve 20 out of 25 points on their Attitude/Effort scorecard) • 100% of community service activities had an average attendance rate of 79%. (Target: Maintain an average attendance rate of 75% during all community service activities) • 100% of participating teens completed a self-assessment every six months. (Target: 100% of participating teens will conduct a self-assessment every six months) • Two businesses were approached as possible internship sites. (Target: Approach two organizations that would be interested in participating as internship sites for teens) • 33% of teens volunteered with other organizations. (Target: 30% of current teens will volunteer with other organizations) • Teens participating in the Healthy Decision Making/Healthy Living seminars established and completed at least one goal by the end of the program. (Target: Teens participating in the Healthy Decision Making/Healthy Living seminars will establish and accomplish at least one goal by the end of the program • Zero teens participated as interns with local businesses and organizations. (Target: Teens participating as interns will complete 80% of their scheduled internship hours) [Note: The internship portion of the program was discontinued.] Enhancement strategies based on ASACB principles are: • The Healthy Decision Making/Healthy Living seminars were developed and implemented at the Youth Center. (Target: Develop and implement the Healthy Decision Making/Healthy Living seminars at the Youth Center) • The Kern County Public Health Department provided information on the risk of the West Nile virus. (Target: Link hospital-based clinical programs and clinicians with health risk reduction activities) • The Kern County Public Health Department provided tobacco awareness information to program participants and a cancer survivor provided education and shared knowledge of tobacco consequences. (Target: Utilize tobacco awareness professionals and a cancer survivor to provide education on tobacco awareness for program participants)
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $69,522 to the Value Enhancement Program's annual budget. They also provide management, human resource support, office space, fundraising support, bookkeeping, and strategic planning and evaluation support for the program.

VALUE ENHANCEMENT PROGRAM – CONTINUED

UPDATE FOR FY 2009	
Goal FY 2009	The Value Enhancement Program will continue to provide low-income at-risk youth with community service experience, life skill enhancement activities, and an after-school program. The Youth Center will continue to offer a safe environment for teens to congregate.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • Involve 35 youths in 35 community service activities. • 90% of teens will achieve 20 out of 25 points on their Attitude/Effort scorecard. • Maintain an average attendance rate of 75% during all community service activities. • 100% of participating teens will conduct a self-assessment every six months. • Provide teens with life skills classes at the Youth Center. • Of surveyed youths, obtain a 30% increase in healthy lifestyle behaviors. • Of surveyed youths, obtain a 30% decrease of at-risk behavior(s). • 75% of program participants will sign a tobacco free pledge. • Provide 5 teens the opportunity to attend Camp Tulequoia during the summer. • Provide 10 teens the opportunity to attend the annual "Leaders in Life" Conference. • Provide a teen the opportunity to attend the YMCA Leader Development Institute. Enhancement strategies based on ASACB principles are: • Invite additional Healthy Decision Making/Healthy Living guest speakers to address topics relating to at-risk behaviors for teens. • Provide additional opportunities for participants to attend seminars to increase self-awareness, self-esteem and motivation.
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Ensure that data is being kept and tracked by the program staff on a monthly and annual basis. • Provide low-income at-risk teens with community service activities which will build self-worth and appreciation for the community in which they live. • Evaluate each teen's participation, attitude and effort, and lifestyle choices. • Provide an incentive for signing the tobacco-free pledge.

PROGRAM DIGEST – HOMEWORK CLUB

Hospital CB Priority Areas	• Programs and services for youth • Childhood obesity • Primary health care and/or access for uninsured and/or underinsured • Basic human needs for the uninsured and/or underinsured
Program Emphasis	☒ Disproportionate Unmet Health-Related Needs ☒ Primary Prevention ☒ Seamless Continuum of Care ☒ Build Community Capacity ☒ Collaborative Governance
Link to Community Needs Assessment	The Homework Club serves youth from low-income families and is situated at the Learning Center in a low-income neighborhood. The program was created to help increase the academic success of disadvantaged children growing up in Kern County and provide a model for other community service programs in the county that would like to serve youth. During the 2006-07 school year, 31% of Kern County 3rd grade students met California's standards in English Language Arts and 48% met the state's standards in Mathematics. Statewide, 37% of 3rd grade students met the standards in English Language Arts and 58% met the standards in Mathematics. One in five 6 to 20 year olds living in the San Joaquin Valley, where Kern County is located, is considered obese. More than 12% of Kern County's teens are not associated with any after-school program, work, or community activities. 31.5% of Kern County's population lacks a high school diploma.
Program Description	The Homework Club provides a safe, nurturing environment after school for children ages 5 to 13. These children come from the low-income neighborhood where the program is situated. The program works with youth to improve academic proficiency and promote a commitment to community. The Homework Club offers a safe place to socialize after school and concentrate on homework, provides educational experiences through field trips, encourages a commitment to community service, and hosts Boy Scouts, Girl Scouts, and 4-H Club meetings for the youth participating in the Homework Club.
REPORT FOR FY 2008	
Goal FY 2008	The Homework Club will continue to offer after-school tutoring, nutrition education, mentoring, exercise activities, and educational field trips for 30 students ages 5 to 13. Program participants will complete ten community service projects.
Results FY 2008	During FY 2008, the Homework Club accomplished the following: • The cumulative attendance for the after school program was 94% through June 2008. (Target: 85%) • 67% of first through seventh grade students are reading at or above grade level through June 2008. 84% of first through seventh grade students are achieving at or above grade level in Math through June 2008. (Target for both: 75%) • All students were screened for enrollment in a health care plan with the following results: 83% of students are enrolled in a health care plan and have a medical/dental home through a physician or clinic and 17% have applied for and have health insurance pending. (Target: All students screened and encouraged to establish a medical/dental home) • 96% of students who were eligible successfully participated in the "Healthy Kids in Healthy Homes" Program. (Target: 100% of participating students demonstrate knowledge of making healthy food choices) • 88% of students participated in an exercise activity a minimum of 3 times per week. (Target: 83%) • 93% of students participated in eleven community service projects through June 2008. (Target: 80%) Enhancement strategies based on ASACB principles were: • Submitted contract for recruiting volunteer tutors from California State University, Bakersfield (CSUB) to CHW Risk Management where it remains. (Target: Develop relationship with CSUB to increase capacity for recruitment of tutors for Homework Club) • Made initial contact with Child Development Department at Bakersfield College (BC). Awaiting response. (Target: Establish relationship with BC for recruitment of tutors for Homework Club) • Enrollment process for health insurance coverage is in place and established as part of the Homework Club enrollment and participation process. (Target: Develop process for enrollment, retention, and utilization of health care coverage)
Hospital's Contribution/Program Expense	Mercy and Memorial Hospitals contribute $28,693 to the Homework Club's annual budget. They also contribute fundraising, human resource support, project management, office space, information materials, training of staff, phones, bookkeeping, data collection support, strategic planning, and evaluation support for the program.

HOMEWORK CLUB – CONTINUED

UPDATE FOR FY 2009	
Goal FY 2009	The Homework Club will continue to offer after-school tutoring, nutrition education, mentoring, exercise activities, and educational field trips for 30 students ages 5 to 13. Program participants will complete 12 community service projects.
2009 Objectives Measure/Indicator of Success	The objectives for FY 2009 are: • 85% of students will attend the after-school program on a consistent basis. • 75% of students will achieve at least grade level outcomes on the KTEA Reading and Math Assessments in a nine-month period. • All students will be screened for enrollment in a health care plan and will be encouraged to establish a medical and dental home. • All students will demonstrate their knowledge of making healthy food choices and their understanding of the importance of daily exercise. • 83% of students will participate in a 20-minute exercise activity a minimum of three times per week. • 80% of the students will participate in 12 community service projects offered through the program. Enhancement strategies based on ASACB principles are: • Continue to pursue and develop relationship with CSUB and BC to increase capacity for recruitment of Homework Club tutors. • Develop relationship with the University of Phoenix to build capacity for recruitment of Homework Club tutors. • Develop relationship with Kern County Network for Children to explore feasibility of replicating the Homework Club into other underserved neighborhoods. • Investigate possibility of developing a process for Homework Club students to transition to the after-school program and Value Enhancement Program at the Outreach Center. • Develop case management component for enrollment in a health insurance program and utilization of health care services, including assistance with making appointments.
Baseline	The current situation in the county is provided in the Link to Community Needs Assessment above.
Intervention Strategy for Achieving Goal	Intervention strategies are: • Develop case management for health insurance enrollment and utilization of health care services. • Provide a safe, nurturing environment for youth involved with after-school programs. • Provide after-school tutoring, nutrition education, mentoring, exercise activities, and educational field trips for youth. • Provide meaningful community service projects that youth can accomplish and that encourage involvement/participation of parents. • Maintain data collection and evaluation records for students on a monthly and annual basis to include individual and Homework Club cumulative grade point averages (GPA). • Hold quarterly parent group meetings to encourage input from families.

COMMUNITY BENEFIT AND ECONOMIC VALUE

A. Classified Summary of Un-Sponsored Community Benefit Expense

Mercy and Memorial Hospitals utilize 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 multi-year period and allows data to be updated as needed to develop trending information. The Classified Summary of Un-Sponsored Community Benefit Expense is included as Appendix 4a and 4b.

Costs for our patients are determined by utilizing the HBOC Cost Accounting System.

B. Non-quantifiable Benefits

The mission of Mercy and Memorial Hospitals and our status as the largest health care provider in Kern County dictate that we occupy a leadership role in building a healthier community. It is a responsibility that we eagerly embrace as a defining characteristic of our organization. This Community Benefit Report and Plan contains examples of the programs and initiatives we have undertaken that make a positive, measurable impact on the community we serve (i.e., dollars spent on indigent medical care, children fed and clothed, victims served, and families taught to manage chronic disease).

Mercy and Memorial Hospitals make many additional contributions to improve the health status of our community. These non-quantifiable benefits take many forms including: nurturing grassroots community-based initiatives; lending the expertise of our employees to community collaboratives and boards; opening our facilities for meetings; and actively advocating for the poor, wounded, and underserved. We are an enthusiastic participant in a number of collaborative efforts that bring together diverse organizations from the public, private, and nonprofit sectors. By participating in efforts such as Kern County's Assessment Process, Vision 2020 Health Care "Vision Force," and community Health Fairs, as well as coordinating programs for victims of trauma such as the Sexual Assault Response Team (S.A.R.T.) at Bakersfield Memorial Hospital, we join other community leaders and partners in problem solving and health planning.

Our commitment to building healthier communities is most evident in our role to increase the number of children who have health insurance. In 2004, the Department of Special Needs & Community Outreach was chosen to coordinate and facilitate countywide efforts to increase outreach and enrollment for all uninsured children in Kern County. As a result, the Children's Health Initiative was created to develop a course of action and facilitate this task. Monthly meetings average 20-25 people in attendance representing 35 social service and health care organizations, community groups, and agencies throughout the county. Mercy and Memorial Hospitals serve as the staff and convener of this important collaborative.

Increasing the capacity of the community to help itself is another important focus. We have provided management expertise and organizational assistance to several small grass-roots organizations to help them build their service capacity and achieve self-sufficiency. Three such organizations include the Greenfield Collaborative (which provides economic development in Southeast Bakersfield), the Kern County Immunization Coalition (which is working to increase immunization rates), and Kern Comprehensive Cancer Awareness Partnership (which promotes cancer prevention, detection, treatment and survivorship). We also share resources with larger organizations to better serve those most in need such as offering dental treatments to residents of the Bethany Homeless Shelter and partnering with businesses to offer on-site health education to employees, many of whom are uninsured or unable to access traditional healthcare services.

Our facilities are host to several support groups, including Breast Cancer Support Group, Prostate Support Group, Gastric Bypass Support Group and Mom to Mom Support Group. These facilities, provided at no charge, are also regular meeting sites for a variety of neighborhood coalitions and

community groups. In opening our doors to the community, we also open doors for opportunities to exchange ideas, share experiences, and learn more about the needs and concerns of our community.

Our employees are also encouraged to become directly involved in our community. Many serve as volunteers, advisors and board members for dozens of organizations including the American Cancer Society; American Heart Association; American Red Cross; Kern Coalition for End of Life Choices; First 5 Kern; Kern Association for the Education of Young Children; Juvenile Diabetes Research Foundation; Bakersfield Adult School Advisory Board; Children's Miracle Network; Kern County Immunization Initiative; Kern Palliative Care Collaborative; Kern County Preschool for All; Kern Community College District; Girl Scouts; Southeast Neighborhood Partnership; United Way of Kern County and Villages of Vision, Inc.

Among the most significant benefits the community receives as a result of our efforts involve an array of "intangibles." Through our programs we provide love, nurturing, and protection to underprivileged children. We give comfort and support to the lonely and frail elderly. We help at-risk teens develop self-respect and a sense of community. We feed the indigent and give them hope. We offer assistance to immigrants and the disenfranchised. We create opportunities for the needy to empower themselves so that they can improve their health, their families' well being, and the quality of their community.

C. Telling the Story

Success story: **Homemaker Care Program**

Tom is confined to a wheelchair due to severe diabetes that has affected his kidneys. He attends dialysis three times a week which leaves him tired and weak. Tom lives with his parents who are his primary caregivers. His 83 year-old mother prepares meals at the dining table because the arthritis in her legs makes it too painful to stand in the kitchen. His 86 year-old father provides personal care, general cleaning and meals for his son. Tom and his parents were thrilled when they found the Homemaker Care Program. Now a caregiver from the program visits the home daily assisting Tom with his personal care needs and specialized meals and helping the family with laundry and general housecleaning services. Caring for the entire family unit is what providing "quality" care is about.

Success story: **Community Wellness Program**

Ashley likes to read books, listen to music with her friends, and help her mother tend to their garden. Ashley seems like a normal teenager except that she weighs 230 lbs. and suffers from incredibly low self-esteem. Through our Community Wellness Program, Ashley and her mother are learning the importance of nutrition, exercise and lifestyle choices in managing obesity. Staff is visiting Ashley at her home, monitoring her weight on a regular basis, and providing her mother with recipes and meal plans for the entire family. While Ashley is still wary that she will not be able to lose the necessary weight, she said that she will give 110 percent effort to achieve a healthier way of life.

Success story: **Healthy Promotions Dental Program**

Wendell was introduced to the Healthy Promotions Dental Program while staying at the Bakersfield Rescue Mission. He had wanted to repair his teeth for some time, but didn't have the means to do so by himself. After basic preventative treatment at Taft College Dental Hygiene Clinic, Wendell received advanced treatment at Clinica Sierra Vista. Although his treatment hasn't been completed yet, Wendell's demeanor has changed dramatically since beginning the program. With renewed confidence and self-esteem, he has found employment which he attributes directly to the dental program and his new smile. When we first met Wendell, he was a timid man down on his luck. Now, because of our help, Wendell is someone who is full of aspiration and happiness.

Success story: **Children's Health Initiative**

Ana asked for our help to get through the complicated public health insurance system. Her four children, including a 4 year-old with asthma, were effectively uninsured. Her children had been granted Medi-Cal, but Ana and her husband had to pay over $2,000 per month, per child, before the coverage would start to pay the medical bills. When Ana applied for the Healthy Families insurance program, she was initially denied. Fortunately, Ana called the Children's Health Initiative of Kern County (CHI) for assistance. A staff member met with Ana and assisted her in completing the appropriate paperwork resulting in two of her children receiving health insurance. We will continue to help Ana until all of her children are covered by health insurance.

The Community Benefit Report and Plan of Mercy and Memorial Hospitals is the result of research and input from a number of sources. The draft document is widely circulated for comments and suggestions.

The comments and suggestions received are summarized as follows:

- Excellent progress being made in all programs
- Expand information on specific parts of programs i.e., CPR training, HIV, STD & sexual health information
- Have a transition process between age specific programs
- Programs are definitely serving the target populations
- Develop and implement customer satisfaction surveys for all programs
- Separate persons served for home visits from health education classes
- Focus on improving performance instead of adding more clients
- Very creative, interactive seminar topics for the Healthy Decisions, Healthy Living Program
- Beautiful report

The final report will be publicized and distributed to our partner agencies, elected officials, and faith-based organizations throughout the county. A summary report will be produced for public distribution via community meetings and our outreach centers. An annual report will also be posted on the facilities websites.

Mercy & Memorial Hospitals
Members of CHW

Department of Special Needs & Community Outreach

Community Benefit Committee
Membership

Elena Acosta, Program Director, Kern County Department of Human Services

Morgan Clayton, President, Tel-Tec Security Systems, Inc.

Teasha Fleming, Reporting Coordinator, Department of Special Needs & Community Outreach, CHW

Rita Flory, Administrative Coordinator, Department of Special Needs & Community Outreach, CHW

Judith Harniman, Chief Financial Officer, First 5 Kern

Mikie Hay, Director of Community Affairs, Jim Burke Ford

Debbie Hull, Regional Director, Department of Special Needs & Community Outreach, CHW

Sherri Johnson, Director of Mission Integration and Palliative Care, CHW - Bakersfield Memorial Hospital

Kevin Klockenga, Chief Operating Officer, Mercy Hospitals

Patty Mallard, TEAMM Consulting, LLC

Anne Meert, TEAMM Consulting, LLC

Gloria Morales, Services Coordinator, Mercy Services, Corp.

Sister Judy Morasci, Vice President, Mission Integration, Mercy Hospitals

Genie Navarro, Property Manager, Mercy Services Corp.

Edward Paine, President, Edward Paine & Associates

Gary Romriell, Manager, Kern County Food Bank

Joan Van Alstyne, R.N., Director, Quality Management, CHW-Bakersfield Memorial Hospital

Cindy Wasson, Director of Public Health Nursing, Kern County Department of Public Health

Stephanie Weber, Executive Director, Friends of Mercy Foundation, CHW-Mercy Hospital

Jonathan Webster, Executive Director, Kern Family Living Center

Thomson/CHW Reporting Sheet for CNI

APPENDIX 2

Market Name: Kern County **Market 2007 Population:** 795,433

Market Summary (average of all ZIPs)				3.8	4.05	3.86	3.62	3.98	3.27	12%	22%	45%	32%	58%	10%	12%	28%	36%
<< Enter ZIP Codes Below	Post Office Box Name	County	State	CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank	Poverty 65+	Poverty Children	Poverty Single w/kids	No High School	Minority	Limited English	Unemployed	Uninsured	Renting
00016	Sequoia Nati	Kern	Califo	2.2	1	5	1	1	3	0%	0%	0%	33%	14%	0%	0%	0%	33%
93203	Arvin	Kern	Califo	4.8	5	5	5	5	4	25%	33%	68%	74%	92%	38%	29%	40%	44%
93205	Bodfish	Kern	Califo	3	3	4	1	5	2	9%	22%	21%	29%	14%	0%	12%	32%	23%
93206	Buttonwillow	Kern	Califo	4.4	4	5	5	4	4	10%	29%	26%	56%	75%	19%	13%	27%	45%
93215	Delano	Kern	Califo	4.8	5	5	5	5	4	22%	32%	55%	53%	92%	25%	31%	35%	42%
93224	Fellows	Kern	Califo	3	5	4	1	4	1	11%	21%	50%	30%	17%	1%	12%	22%	19%
93225	Frazier Park	Kern	Califo	3	4	3	2	4	2	8%	14%	44%	16%	22%	1%	10%	22%	25%
93226	Glennville	Kern	Califo	3.4	5	3	2	5	2	11%	31%	75%	20%	23%	0%	8%	39%	25%
93238	Kernville	Kern	Califo	3.4	5	3	2	5	2	9%	32%	59%	20%	25%	0%	2%	35%	29%
93240	Lake Isabell	Kern	Califo	3.2	4	4	1	5	2	15%	22%	43%	31%	15%	1%	11%	32%	27%
93241	Lamont	Kern	Califo	4.8	5	5	5	5	4	19%	37%	60%	72%	94%	31%	21%	38%	48%
93243	Lebec	Kern	Califo	2.6	1	4	3	2	3	14%	3%	0%	25%	32%	6%	5%	14%	31%
93249	Lost Hills	Kern	Califo	4.8	5	5	5	4	5	7%	29%	55%	81%	95%	52%	23%	22%	62%
93250	MC Farland	Kern	Califo	4.8	5	5	5	5	4	12%	37%	71%	57%	91%	27%	23%	37%	44%
93251	MC Kittrick	Kern	Califo	3.8	5	4	2	4	4	19%	17%	56%	31%	24%	2%	9%	28%	39%
93252	Maricopa	Kern	Califo	4	4	5	3	4	4	8%	18%	49%	32%	38%	6%	10%	28%	40%
93255	Onyx	Kern	Califo	3.4	5	4	2	5	1	12%	32%	62%	27%	23%	2%	13%	35%	17%
93263	Shafter	Kern	Califo	4.8	5	5	5	5	4	13%	30%	62%	52%	80%	19%	21%	33%	40%
93268	Taft	Kern	Califo	4.2	5	4	3	5	4	10%	26%	57%	27%	31%	3%	12%	34%	38%
93276	Tupman	Kern	Califo	4	4	5	2	5	4	0%	7%	50%	35%	19%	2%	6%	36%	41%
93280	Wasco	Kern	Califo	4.8	5	5	5	5	4	10%	30%	57%	46%	86%	16%	21%	31%	42%
93283	Weldon	Kern	Califo	3.4	5	5	1	5	1	16%	31%	43%	40%	17%	1%	13%	33%	19%
93285	Wofford Heig	Kern	Califo	2.6	4	3	1	4	1	9%	25%	37%	18%	14%	1%	9%	27%	18%
93287	Woody	Kern	Califo	3.4	5	3	2	5	2	13%	35%	67%	19%	22%	0%	10%	40%	24%
93301	Bakersfield	Kern	Califo	4.6	5	4	4	5	5	8%	36%	59%	30%	57%	4%	11%	43%	63%
93304	Bakersfield	Kern	Califo	4.6	5	5	4	5	4	11%	30%	52%	37%	75%	10%	13%	38%	46%
93305	Bakersfield	Kern	Califo	5	5	5	5	5	5	15%	41%	62%	49%	82%	17%	19%	43%	53%
93306	Bakersfield	Kern	Califo	3.8	4	4	4	4	3	8%	20%	41%	27%	61%	8%	8%	23%	33%
93307	Bakersfield	Kern	Califo	4.8	5	5	5	5	4	20%	32%	53%	54%	84%	15%	16%	39%	39%
93308	Bakersfield	Kern	Califo	3.6	4	4	2	4	4	8%	19%	50%	23%	21%	2%	8%	29%	39%
93309	Bakersfield	Kern	Califo	3.4	3	3	3	4	4	6%	17%	34%	17%	49%	4%	7%	26%	49%
93311	Bakersfield	Kern	Califo	2	2	1	3	2	2	8%	5%	20%	8%	42%	2%	4%	11%	27%
93312	Bakersfield	Kern	Califo	1.6	2	2	2	1	1	9%	4%	19%	10%	28%	2%	4%	8%	11%
93313	Bakersfield	Kern	Califo	2.8	3	4	4	2	1	10%	11%	31%	22%	57%	5%	5%	14%	16%
93314	Bakersfield	Kern	Califo	1.6	2	2	2	1	1	5%	6%	24%	13%	26%	2%	5%	8%	10%
93501	Mojave	Kern	Califo	4.4	5	4	4	5	4	14%	38%	65%	27%	45%	7%	14%	39%	41%
93505	California C	Kern	Califo	3.6	5	3	3	4	3	15%	20%	58%	17%	46%	1%	9%	24%	33%
93516	Boron	Kern	Califo	4	5	4	2	5	4	17%	24%	54%	24%	22%	3%	11%	37%	38%
93518	Caliente	Kern	Califo	3	4	4	1	5	1	21%	20%	33%	24%	17%	1%	6%	33%	14%
93519	Cantil	Kern	Califo	2.6	1	4	2	4	2	13%	0%	0%	27%	19%	1%	6%	29%	23%
93523	Edwards	Kern	Califo	2.4	2	1	2	2	5	13%	5%	19%	8%	33%	1%	4%	10%	76%
93527	Inyokern	Kern	Califo	2.6	4	3	1	4	1	3%	18%	36%	15%	14%	2%	11%	22%	19%
93528	Johannesburg	Kern	Califo	2	1	1	1	5	2	0%	0%	0%	3%	11%	0%	14%	34%	27%
93531	Keene	Kern	Califo	2.8	5	1	2	5	1	0%	32%	100%	6%	23%	3%	3%	37%	19%
93554	Randsburg	Kern	Califo	2.4	1	4	2	3	2	0%	0%	0%	30%	18%	5%	0%	24%	21%
93555	Ridgecrest	Kern	Califo	3	4	2	2	4	3	6%	16%	38%	13%	27%	3%	7%	22%	34%
93560	Rosamond	Kern	Califo	3.6	4	4	3	4	3	14%	14%	46%	24%	49%	4%	9%	21%	30%
93561	Tehachapi	Kern	Califo	3.2	4	3	3	4	2	13%	11%	36%	18%	36%	3%	6%	22%	26%

Catholic Healthcare West
CHW

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CATHOLIC HEALTHCARE WEST
SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY
(June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial 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, CHW 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 CHW's procedures for obtaining financial 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 Financial Assistance:

- Eligibility for financial 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 financial 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 CHW 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 financial assistance and a determination of financial need occur prior to rendering of services. The need for financial 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 financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial 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 determination 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 CHW 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 CHW 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 CHW facility.

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

Communication of the Financial Assistance Program to Patients and the Public:

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW 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 CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.

- Patient financial 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:

- CHW system management shall develop policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW 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, CHW MANAGEMENT AND CHW FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.

Bakersfield Memorial Hospital
Classified Summary of Quantifiable Benefits
For period from 7/1/2007 through 06/30/2008
Classified as to Low Income and Broader Community

Exhibit A

	Persons Served	Total Expense	Offsetting Revenue	Net Community Benefit	% of Total Expense	% of Total Revenue
Benefits for Low Income						
Traditional Charity Care	2,383	$ 2,576,296	$ 182,241	$ 2,394,055	1.2%	1.0%
Unpaid Costs of Medicaid/Medi-Cal	28,591	40,269,979	34,632,792	5,637,187	2.7%	2.4%
Other Public Programs						
Community Services:						
Community Benefit Operations	202	72,807	-	72,807	0.0%	0.0%
Community Building Activities	28,581	196,087	59,990	136,097	0.1%	0.1%
Community Health Improvement Service	9,398	310,387	35,961	274,426	0.1%	0.1%
Financial and In-Kind Contributions	13,370	171,970	3,500	168,470	0.1%	0.1%
Health Professions Education						
Subsidized Health Services						
Totals for Community Services	**51,551**	**751,251**	**99,451**	**651,800**	**0.3%**	**0.3%**
Totals for Low Income	**82,525**	**43,597,526**	**34,914,484**	**8,683,042**	**4.2%**	**3.7%**
Benefits for Broader Community						
Community Services:						
Community Benefit Operations	132	44,487	-	44,487	0.0%	0.0%
Community Building Activities	10,061	244,187	64,998	179,189	0.1%	0.1%
Community Health Improvement Service	5,121	66,480	19,884	46,596	0.0%	0.0%
Financial and In-Kind Contributions	496	16,391	-	16,391	0.0%	0.0%
Health Professions Education	24,382	671,460	-	671,460	0.3%	0.3%
Subsidized Health Services						
Research						
Totals for Community Services	**40,192**	**1,043,005**	**84,882**	**958,123**	**0.5%**	**0.4%**
Totals for Broader Community	**40,192**	**1,043,005**	**84,882**	**958,123**	**0.5%**	**0.4%**
Grand Total excluding unpaid cost of Medicare:	**122,717**	**44,640,531**	**34,999,366**	**9,641,165**	**4.7%**	**4.1%**
Unpaid Costs of Medicare	14,950	83,049,067	78,000,780	5,048,287	2.4%	2.1%
Grand Total including unpaid cost of Medicare:	**137,667**	**$ 127,689,598**	**$ 113,000,146**	**$ 14,689,452**	**7.1%**	**6.2%**

FY08 Community Benefit Report approved by _____ Date: 8/21/08
Chief Financial Officer

Calculation was derived by Cost-to-Charge Ratio

Mercy Hospitals Bakersfield
Classified Summary of Quantifiable Benefits
For period from 7/1/2007 through 06/30/2008
Classified as to Low Income and Broader Community

Exhibit A

	Persons Served	Total Expense	Offsetting Revenue	Net Community Benefit	% of Total Expense	% of Total Revenue
Benefits for Low Income						
Traditional Charity Care	3,839	$ 2,838,347	$ 21,847	$ 2,816,500	1.2%	1.0%
Unpaid Costs of Medicaid/Medi-Cal	18,044	17,217,399	12,895,386	4,322,013	1.8%	1.6%
Other Public Programs						
Community Services:						
Community Benefit Operations	222	79,775	-	79,775	0.0%	0.0%
Community Building Activities	31,809	245,276	69,724	175,552	0.1%	0.1%
Community Health Improvement Service	6,228	270,130	39,764	230,366	0.1%	0.1%
Financial and In-Kind Contributions	16,441	444,647	4,687	439,960	0.2%	0.2%
Health Professions Education	-	-	-	-	0.0%	0.0%
Subsidized Health Services		-	-	-	0.0%	0.0%
Totals for Community Services	**54,700**	**1,039,828**	**114,175**	**925,653**	**0.4%**	**0.3%**
Totals for Low Income	**76,583**	**21,095,574**	**13,031,408**	**8,064,166**	**3.4%**	**2.9%**
Benefits for Broader Community						
Community Services:						
Community Benefit Operations	161	105,693	-	105,693	0.0%	0.0%
Community Building Activities	13,423	219,007		219,007	0.1%	0.1%
Community Health Improvement Service	27,842	1,747,322	299,549	1,447,773	0.6%	0.5%
Financial and In-Kind Contributions	9,648	110,944	3,298	107,646	0.0%	0.0%
Health Professions Education	18,083	302,702	-	302,702	0.1%	0.1%
Subsidized Health Services	-	-	-	-	0.0%	0.0%
Research	-	-	-	-	0.0%	0.0%
Totals for Community Services	**69,157**	**2,485,668**	**302,847**	**2,182,821**	**0.9%**	**0.8%**
Totals for Broader Community	**69,157**	**2,485,668**	**302,847**	**2,182,821**	**0.9%**	**0.8%**
Grand Total excluding unpaid cost of Medicare:	**145,740**	**$ 23,581,242**	**$ 13,334,255**	**$ 10,246,987**	**4.3%**	**3.7%**
Unpaid Costs of Medicare	16,948	74,854,241	65,313,182	9,541,059	4.0%	3.4%
Grand Total including unpaid cost of Medicare:	**162,688**	**$ 98,435,483**	**$ 78,647,437**	**$ 19,788,046**	**8.3%**	**7.1%**

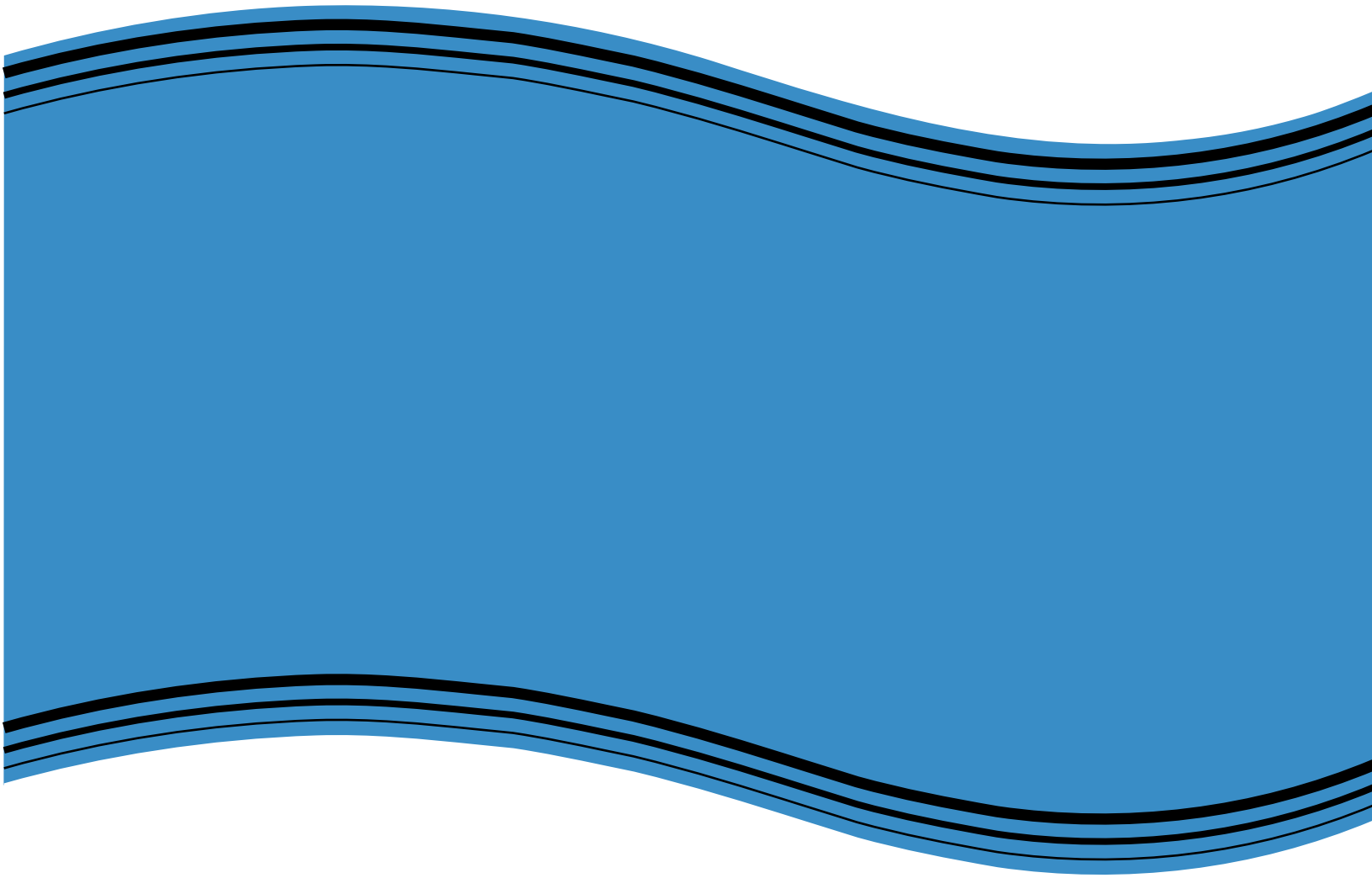
FY08 Community Benefit Report approved by _____ Date: 8/15/08
Chief Financial Officer

Calculation was derived by Cost-to-Charge Ratio

2006

Community Assessment Executive Summary

FOR: *Kern County*



Executive Summary

United Way of Kern County gratefully acknowledges the following sponsors for their financial support of the 2006 Kern County Assessment (sponsors are listed alphabetically): Bakersfield Memorial Hospital, Community Action Partnership of Kern, Delano Regional Medical Center, Kaiser Permanente, Mercy Hospitals of Bakersfield, and San Joaquin Community Hospital.

This Executive Summary provides highlights from the 2006 Kern County Assessment. Sections featured in the full report include information on population demographics, health, education, socioeconomic self-sufficiency and basic needs. The report features detailed information on both Kern County and California. In addition, a listing of sources for further information, provided at the end of each of these sections of the full report, may be useful to readers interested in supplemental information.

The findings presented in this report will be used by agencies throughout Kern County to help improve the quality of life for its residents.

Introduction

This 2006 Kern County Assessment compiles multi-faceted data on population demographics, health, education, socioeconomic self-sufficiency, and basic needs from a variety of sources. These sources include: United States Census Bureau's American Fact Finder, California Department of Health Services, California Department of Education, California Employment Development Department, United States Department of Agriculture, Emergency Food and Shelter Program, Kern County Homeless Collaborative, UCLA Center for Health Policy Research, and University of California at Berkeley Center for Social Services. In addition, community input from focus groups and telephone interviews conducted by United Way of Kern County are summarized in this report.

Population Demographics

This section uses data from the United States Census Bureau's American Fact Finder and includes 2005 estimates for Kern County's total population, population by sex, age group, race, and disability status; place of birth, language spoken at home, linguistic isolation, and educational attainment of adults.

To assist readers in providing context to these Kern County population demographics, a description of California's demographics is provided below.

Among the highlights:

- In 2005, Kern County's total population was estimated at 724,206 persons, with 50.3 percent females and 49.7 percent males. In the same year, California's total population was estimated at 35,278,768 persons, with 50.4 percent females and 49.6 percent males.

- In 2005, approximately 35 percent of Kern County's population was under 20 years of age, 56 percent were ages 20 to 64 years, and 9 percent were 65 years and older. In 2005, approximately 37 percent of Californians were under 20 years of age, 52 percent were ages 20 to 64 years, and 11 percent were 65 years and older.

- In Kern County, approximately 44 percent of the population were Hispanic or Latino (may be of any race), 44 percent were White non-Hispanic, 5 percent were Black non-Hispanic, 4 percent were Asian/Pacific Islander non-Hispanic, 1 percent were American Indian/Alaskan Native non-Hispanic, and 2 percent were of two or more races. In California, approximately 35 percent were Hispanic or Latino (may be of any race), 43 percent were White non-Hispanic, 6 percent were Black non-Hispanic, 13 percent were Asian/Pacific Islander non-Hispanic, less than 1 percent were American Indian/Alaskan Native non-Hispanic, and 2 percent were of two or more races.

- Among persons at least five years old in Kern County in 2005, 16 percent reported a disability. The likelihood of having a disability varied by age – from 6 percent of people 5 to 15 years old, to 14 percent of people 16 to 64 years old, and to 46 percent of those 65 years and older. Compared to Kern County, a lower percentage of Californians at least 5 years and older (13 percent) reported having a disability.

- In 2005, 80 percent of those living in Kern County were native born and 20 percent were foreign born. In California, 73 percent were native born and 27 percent were foreign born in 2005.

- Among people at least 5 years and older living in Kern County in 2005, 63 percent spoke English only at home and 37 percent a language other than English, with Spanish being the most common language other than English. In California, 58 percent spoke English only at home and 42 percent spoke a language other than English, with Spanish being the most common language other than English.

- In Kern County, 32 percent of households that spoke Spanish at home were linguistically isolated, 30 percent of households that spoke Asian and Pacific Islander languages were linguistically isolated, and 11 percent of households that spoke other Indo-European languages were linguistically isolated. A linguistically isolated household is one in which all adults have some limitation in communicating in English. In California, 29 percent of households that spoke Spanish were linguistically isolated, 30 percent of households that spoke Asian and Pacific Islander languages were linguistically isolated, and 17 percent of households that spoke other Indo-European languages were linguistically isolated.

- In 2005, 15 percent of people 25 years and older in Kern County have less than a 9th grade education, 13 percent have a 9th to 12th grade education but no diploma, and 72 percent have at least graduated from high school. Adults in California have achieved higher educational attainment when compared to Kern County – 10 percent of adults have less than a 9th grade education, 9 percent have a 9th to 12th grade education but no diploma, and 81 percent have at least graduated from high school.

Health

This section uses data from the California Health Interview Survey (CHIS) as conducted by the UCLA Center for Health Policy Research and various health statistics published by the California Department of Health Services and the Office of Statewide Health Planning and Development to examine four aspects of health – access, health behaviors and conditions, leading causes of death, and maternal and infant health.

To assist readers in providing context to these health statistics, Kern County's experience is compared to national benchmarks, known as Healthy People 2010 objectives. Prepared by the U.S. Department of Health and Human Services, Healthy People 2010 outlines a nationwide agenda focused on promoting health and preventing illness, disability, and premature death. Healthy People 2010 builds on initiatives pursued over the past two decades. (Note: The health section of the full report also includes comparisons to California.)

Among the highlights:

- Access to health services often depends on whether a person has health insurance. Based on results from the 2005 CHIS, 82 percent of persons under age 65 years in Kern County are insured (88 percent of children age 0 to 17 years and 79 percent of adults age 18 to 64 years are insured). Kern County did not meet the Healthy People 2010 objective of increasing the proportion of persons under age 65 years with health insurance to 100 percent.

- Overweight and obesity are primary concerns locally and in the United States where poor diet and physical inactivity is now the second leading cause of preventable deaths following tobacco. Kern County statistics indicate that children and teens did not engage in vigorous physical activity with regularity and were overweight or obese based on physical fitness scores. Kern County did not meet the Healthy People 2010 objectives related to physical activity in children and overweight and obesity in children and adolescents. Based on results from the 2003 CHIS, 29 percent of adults in Kern County are obese. Kern County adults did not meet the Healthy People 2010 objective of reducing the proportion of adults who are obese to no more than 15 percent.

- Diabetes is a serious and growing health problem, currently affecting both children and adults. In Kern County, 7.3 percent of adults were diagnosed with diabetes in 2003, according to results of the California Health Interview Survey. This rate was almost three times higher than the Healthy People 2010 objective of reducing the proportion of adults who have clinically diagnosed diabetes to only 2.5 percent of the population.

- Asthma is considered to be a critical public health issue due to its negative impact on quality of life, high morbidity and mortality, related disparities in care and outcomes, and substantial economic costs. Though there is no cure for asthma, but it can be effectively controlled with proper diagnosis, treatment, management and prevention. In Kern County, hospitalizations for asthma were highest among children under age 5 years (31 asthma hospitalizations per 10,000 children). This experience did not meet the Healthy People 2010 objective of reducing asthma hospitalization in children to 25 per 10,000.

- Leading causes of death in Kern County are (in rank order): heart disease, cancer, chronic lower respiratory disease, stroke, unintentional injuries, diabetes, pneumonia and influenza, chronic liver disease and cirrhosis, Alzheimer's disease, drug-induced deaths, suicide, and homicide, based on review of deaths among Kern County residents during the three-year period from 2002 to 2004.

- When comparing Kern County experiences to Healthy People 2010 objectives related to selected leading causes of death, Kern County met the national objectives related to stroke and prostate cancer; Kern County did not meet the national objectives related to the following causes: coronary heart disease, cancer (all sites) and lung cancer, colorectal cancer, and female breast cancer; unintentional injuries (all types) and motor vehicle crashes, homicide, suicide, chronic liver disease and cirrhosis, and drug-induced deaths. (Note: There are no objectives established for diabetes as a leading cause of death, pneumonia and influenza, and Alzheimer's disease.)

- Prenatal care is more likely to be effective if women begin receiving care early in pregnancy. During the three-year period from 2002 to 2004, an average of 84 percent of births were to mothers with early (first trimester) prenatal care. Kern County mothers did not meet the Healthy People 2010 objective of increasing early prenatal care to 90 percent of live births.

- During the three-year period from 2001 to 2003, there were an average of 6.0 infant deaths per 1,000 live births. Kern County did not meet the Healthy People 2010 objective of reducing infant mortality to no more than 4.5 deaths per 1,000 live births.

- Comments from the community consultation related to health included the importance of accessible affordable and available health care and services and healthy residents.

Education

This section uses data from Children Now and the California Department of Education to describe measures related to education of students and includes indicators on the availability of licensed child care in Kern County as well as kindergarten through grade 12 (K-12) student demographics, description of schools and student performance; and postsecondary preparation.

To assist readers in providing context to these education statistics, Kern County's experience is compared to California targets or California's experience.

Among the highlights:

- In 2004, there were 20,479 licensed child care spaces in Kern County, with 54 percent of the spaces in licensed child care centers and 46 percent of the spaces in licensed family child care homes. A family child care home provides care to no more than 14 children in a home-like environment and a child care center provides supervision in a group setting, usually located in a commercial building. California's 999,664 licensed child care spaces were 64 percent licensed child care centers and 26 percent licensed family child care homes.

- In 2006, 170,362 students attended kindergarten through grade 12 in 248 public schools in Kern County. Statewide, 6,312,103 students attended kindergarten through grade 12 in 9,553 schools.

- In 2006, race/ethnicity of students attending kindergarten through grade 12 public schools in Kern County was described as follows: the majority of students are Hispanic (54 percent), 32 percent are White, 7 percent are Black, 4 percent are Asian/Pacific Islander, 1 percent are American Indian, and 2 percent are of multiple races or unknown. In California, 48 percent of students attending public schools are Hispanic, 30 percent are White, 11 percent are Asian/Pacific Islander, 8 percent are Black, 1 percent are American Indian, and 2 percent are of multiple races or unknown.

- Researchers often link English proficiency to student success, particularly on standardized tests. In 2006, an estimated 38 percent of students attending K-12 in Kern County are non-native English-speaking students. In comparison, 43 percent of students statewide are non-native English-speaking students.

- In the 2005 school year, approximately 62 percent of students were enrolled in free/reduced fee meal programs in Kern County; a significantly lower percentage of students (49 percent) were enrolled in free/reduced fee meal programs in California.

- California Standards Tests (CSTs) are conducted each school year for various subject areas (English language arts, mathematics, history/social science, and science) and various grades (2 through 11). These tests are based on the state's academic content standards and are scored by one of five performance levels – advanced, proficient, basic, below basic, and far below basic. The California target is for all students to score at proficient or above. In 2006, students in Kern County as well as California did not meet the California targets for the CSTs at any grade level in the subject areas tested.

- California Achievement Tests, Sixth Edition Survey (CAT/6 Survey) measure students in grade 3 and grade 7 in reading, language, mathematics and spelling. Because the test is norm referenced, students in California can be compared with other students across the country. In 2006, students in Kern County in both grade 3 and grade 7 tested at or slightly above the national sample in spelling and below the national sample in reading, language, and mathematics in the two grades tested.

- California Alternate Performance Assessment (CAPA) is administered to students with severe disabilities who are unable to take the CSTs. The CAPA is organized by subject area – English language arts and mathematics – into five levels, representing specific grade spans; most students take the level corresponding to their enrollment grade. The California target is for all students to score at proficient or above. In 2006, students with severe disabilities in Kern County who took the CAPA tests did not meet the California targets at any CAPA level in the subject areas tested.

- The California High School Exit Exam (CAHSEE) is divided into two sections – English language arts and mathematics, with students required to pass both sections. Students take the test for the first time in grade ten and have additional opportunities in grade 11 and grade 12 to pass the exam. Beginning with the class of 2006, California students must pass the CAHSEE in order to receive their high school diplomas. In 2006, 50 percent of students in high school in Kern County passed the English language arts section and 48 percent passed the mathematics section of the CAHSEE. California students scored higher on this exam when compared to Kern County, with 61 percent of students passing the English language arts section and 59 percent passing the mathematics section.

- In 2005, an estimated 3.2 percent of high school students in Kern County dropped out before graduation, according to the California Department of Education. California's experience is comparable to the experience in Kern County, with a drop-out rate of 3.1 percent.

- High school students completed a number of different tests in preparation for college. In 2005, approximately 22 percent of Kern County high school graduates successfully completed courses required for University of California and/or California State University entrance (UC/CSU), 22 percent of students completed the Scholastic Achievement Tests (SATs) and approximately 10

percent of students enrolled in grades 11 and 12 completed Advanced Placement (AP) exams with a score of 3 or higher. AP courses enable students who pass them to skip certain introductory-level college courses. Statewide, a higher percentage of students completed tests for college preparation when compared to Kern County – 35 percent completed courses required for UC/CSU entrance, 36 percent completed the SATs, and 21 percent of students enrolled in grades 11 and 12 completed AP exams with a score of 3 or higher.

- Comments from the community consultation related to education included the importance of quality education and good schools, well-educated youth engaged in positive activities, after-school programs, high levels of parental involvement, mentoring, and an educated work force.

Socioeconomic Self-Sufficiency

This section uses data from the United States Census Bureau's American Fact Finder, the California Employment Development Department and the most recent Census of Agriculture conducted by United States Department of Agriculture to describe measures related to socioeconomic self-sufficiency and includes indicators on per capita and household income, housing characteristics, costs and affordability; labor force and employment and the importance of an agricultural economy in Kern County. The full report includes additional statistics related to the agricultural economy – including indicators such as the market value of goods sold, leading agricultural commodities, and a description of farms and agricultural and migrant labor.

To assist readers in providing context to these statistics related to socioeconomic self-sufficiency in Kern County, a description of California's socioeconomic statistics is provided below.

Among the highlights:

- In 2005, per capita income in Kern County was estimated at $18,636. In comparison, per capita income in California was 44 percent higher than in Kern County, at $26,800.

- In 2005, average household income in Kern County was estimated at $54,418 and median household income was estimated at $40,224. Median household income is the level at which half the incomes are higher and half the incomes are lower. In the same year, 32 percent of households have an annual income of less than $25,000 in Kern County. In California household income figures were higher, with an average household income of $74,013 and median household income of $53,629. In 2005, 23 percent of households in California have an annual income of less than $25,000.

- In 2005, approximately 21 percent of the population in Kern County was below the poverty level. The rate of persons below the poverty level was highest among those under age 18 years (29 percent), followed by those age 18 to 64 years (19 percent) and lowest among those age 65 years and older (10 percent). In comparison, approximately 13 percent of the population in California was below the poverty level.

- In 2005, there were an estimated 254,226 housing units in Kern County. The majority of housing units are characterized as single-unit structures (75 percent), followed by multi-unit structures (17 percent), mobile homes (8 percent) and boats, recreation vehicles or vans (less than 0.2 percent). There are an estimated 13 million households in California.

- Of the 231,566 occupied housing units in Kern County in 2005, 63 percent are owner-occupied and 37 percent are renter-occupied. In comparison, 58 percent of California's occupied housing units are owner-occupied and 42 percent are renter-occupied.

- In Kern County, 8 percent of the occupied housing units have no car, truck or van vehicles available for private use and 5 percent have no telephone service in 2005, according to the United States Census Bureau. In California, a similar proportion of occupied housing units have no car, truck or van vehicles available (8 percent) and 3 percent have no telephone service available.

- Median monthly housing costs varied in Kern County in 2005: housing costs were highest for owners with a mortgage ($1,216 a month), followed by renters ($663 a month), and lowest for owners without a mortgage ($335 a month). California's median monthly housing costs were higher than those in Kern County – $1,912 a month for owners with a mortgage, $973 a month for renters, and $388 for owners without a mortgage.

- Households paying more than 30 percent of their gross income for housing are considered cost burdened and may have difficulty meeting other important financial obligations. In 2005 in Kern County, 46 percent of renters, 39 percent of owners with mortgages, and 12 percent of owners without mortgages spent 30 percent or more of household income on housing. In California, higher proportions of household incomes are spent on monthly housing costs compared to Kern County – 52 percent of renters, 47 percent of owners with mortgages, and 15 percent of owners without mortgages spent 30 percent or more of household income on housing.

- In 2005, the median home sales price in Kern County was $268,300. The county's housing price was 6.7 times greater than its household income in that year. In 2000, the county's housing affordability indicator was estimated at 2.3. Relative to the year 2000, housing has become three times less affordable in Kern County. California's housing price in 2005 was 10.2 times greater than its household income, with a median home sales price of $548,430 in 2005.

- Affordable rental housing is essential for residents who choose to live in rental housing or who cannot afford to buy a home. In Kern County, fair market rent is estimated at $624 a month for a two-bedroom apartment and $902 a month for a three-bedroom apartment. Household incomes required to afford these apartments are $24,960 and $36,080, according to the National Low Income Housing Coalition. In California, fair market rent is estimated at $1,149 a month for a two-bedroom apartment and $1,598 a month for a three-bedroom apartment. Household incomes required to afford these apartments are $45,950 and $63,901.

- In 2005, 91.7 percent of the labor force was employed in Kern County and 8.3 percent of the labor force was unemployed, according to figures from the California Employment Development Department. The proportion of unemployed persons in Kern County was highest in the months of January through March and lowest in the months of September and October of that year. In comparison, 94.6 percent of the labor force was employed in California and 5.4 percent of the labor force was unemployed.

- Of those employed Kern County in 2005, 84 percent were employed in nonfarm industry classifications such as government, education, leisure and hospitality and professional and business services; 16 percent were employed in farm-related industries. In contrast, only 2 percent of the labor force in California was employed in farm-related industries, noting the importance of the agricultural economy in Kern County.

- Comments from the community consultation related to socioeconomic self-sufficiency included the importance of a strong economy, low cost of living, job stability, affordable fair and decent housing, stable families, and civic participation.

Basic Needs

This section uses data from the Emergency Food and Shelter Program, Kern County Homeless Collaborative, UCLA Center for Health Policy Research, and University of California at Berkeley Center for Social Services to describe measures related to basic needs and includes indicators on emergency food and shelter, food insecurity, homeless persons, and family safety.

To assist readers in providing context to these statistics related to basic needs, Kern County's experience is provided in a historical context (when available).

Among the highlights:

- Congress established an Emergency Food and Shelter Program (EFSP) in 1983 to help meet the needs of hungry and homeless people by allocating federal funds for the provision of food and shelter. Over the years, the program has disbursed over $2 billion to over 11,000 local providers in more than 2,500 counties and cities. In Fiscal Year 2006, EFSP dollars awarded in Kern County were $575,925, a significant decrease from the prior fiscal year award of $710,399.

- In Fiscal Year 2006, monies awarded from the EFSP in Kern County were used for food (53 percent), shelter (28 percent), rent and mortgage assistance (14 percent), utilities assistance (4 percent) and administrative costs (2 percent).

- An estimated 45 percent of adults with incomes less than 200 percent of the Federal Poverty Level (FPL) were food insecure in Kern County in 2003, based on findings from the California Health Interview Survey. In the survey, food insecurity was defined as not being able to afford enough food. In the same year, an estimated 39 percent of adults with incomes less than 200 percent of the FPL in the San Joaquin Valley were food insecure.

- On the night of January 30, 2003, the Kern County Homeless Collaborative conducted its first ever census of the homeless population in Kern County and estimated that 1,555 persons were homeless (uses strict McKinney definition of homeless). Of those sheltered, the majority were in metro Bakersfield and of the unsheltered homeless, the majority were in rural west and east Kern.

- On the night of January 25, 2006 the Kern County Homeless Collaborative conducted a count of homeless persons in metropolitan Bakersfield and estimated that 1,020 persons were homeless (uses strict McKinney definition of homeless). An estimated 68 percent were sheltered in emergency shelters or transitional housing and 32 percent were unsheltered.

- Child abuse and neglect are found in families across the social spectrum, and cases are becoming more complex, with more entrenched risk factors. Social isolation, family disorganization, and financial stress and poverty can also trigger abuse. Abused children often experience higher rates of suicide, depression, substance abuse, difficulties in school, and other behavioral problems in later life. Abused children are also at greater risk of becoming delinquents, mistreating their own children, and becoming involved in violent partner relationships as teens and adults. In 2005, there were 4,614 substantiated cases of child abuse referrals in Kern County, an incidence rate of 20.7 per 1,000 children age 0 to 17 years. Kern County's experience did not meet the Healthy People 2010 objective of reducing the incidence of child maltreatment to no more than 10.3 per 1,000 children.

- Comments from the community consultation related to basic needs included the importance of safety and security, client empowerment, access to basic needs, resources for at-risk adults, central networking and availability of support services.