



**ADVENTIST HEALTH
BAKERSFIELD**

2022 COMMUNITY HEALTH
IMPLEMENTATION STRATEGY

APPROVED APRIL 27, 2023

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Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Adventist Health Bakersfield conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Adventist Health Well-Being team, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, Adventist Health Bakersfield intentionally developed a strategic plan to address the needs of our community.

In this CHIS, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 Adventist Health Bakersfield CHNA:

Access to Care

Health Conditions – Physical Health

Mental Health

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. This report was reviewed and approved by our Hospital Board as well as the Adventist Health System Board on April 27, 2023. The entire report is published online and available in print form by contacting community.benefit@ah.org.

Blue Zones Project Bakersfield

Across the globe lie blue zones areas – places where people are living vibrant, active lives well into their hundreds at an astonishing rate—and with higher rates of well-being. Attaining optimal well-being means that our physical, emotional, and social health is thriving. Blue Zones Project works with communities to make sustainable changes to their environment, policies, and social networks to support healthy behaviors. Instead of a focus on individual behavior change, it is an upstream solution focused on making healthy options easy in all the places people spend most of their time. Blue Zones Project is committed to measurably improving the well-being of community residents and through their proven programs, tools and resources, utilizes rigorous metrics to inform strategies and track progress throughout the life of the project. This includes well-being data, community-wide metrics, sector-level progress and outcome metrics, transforming community well-being by making changes to environment, policy, worksites and social networks that create healthy and equitable opportunities for all.

Adventist Health Bakersfield proudly sponsors Blue Zones Project Bakersfield (BZPB). The BZPB team wakes up each morning focused on partnering and collaborating with community leaders and organizations active in the sectors of built environment, education, economic and workforce development, mental and physical well-being, policy and public health. Together the BZPB team and sector leaders develop a community Blueprint that strategically aligns and leverages the actions and resources of the sectors where we live, learn, work and play to help advance the efforts around the community's biggest Social Determinant of Health challenges while connecting them to Health-Related Social Needs organizations.

Equity is a strategic priority woven throughout the Blueprint and programs. Policies and initiatives are developed in a way that honors the local culture that is focused on reaching out to all populations. Each year BZPB sector leads come together to evaluate and update the Blueprint to ensure community alignment.

To learn more about Blue Zones Project Bakersfield and how to get involved visit: bakersfield.bluezonesproject.com



What if ...

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Getting to know our Bakersfield CHNA service area*

The city of Bakersfield in Kern County is recognized for its history of agricultural roots, its famous Bakersfield Sound — a sub-genre of country music — and culture of old-fashioned warmth. Our Bakersfield service area is geographically large, with a population of nearly 780,000 people. Of those, 57% are of Hispanic heritage.

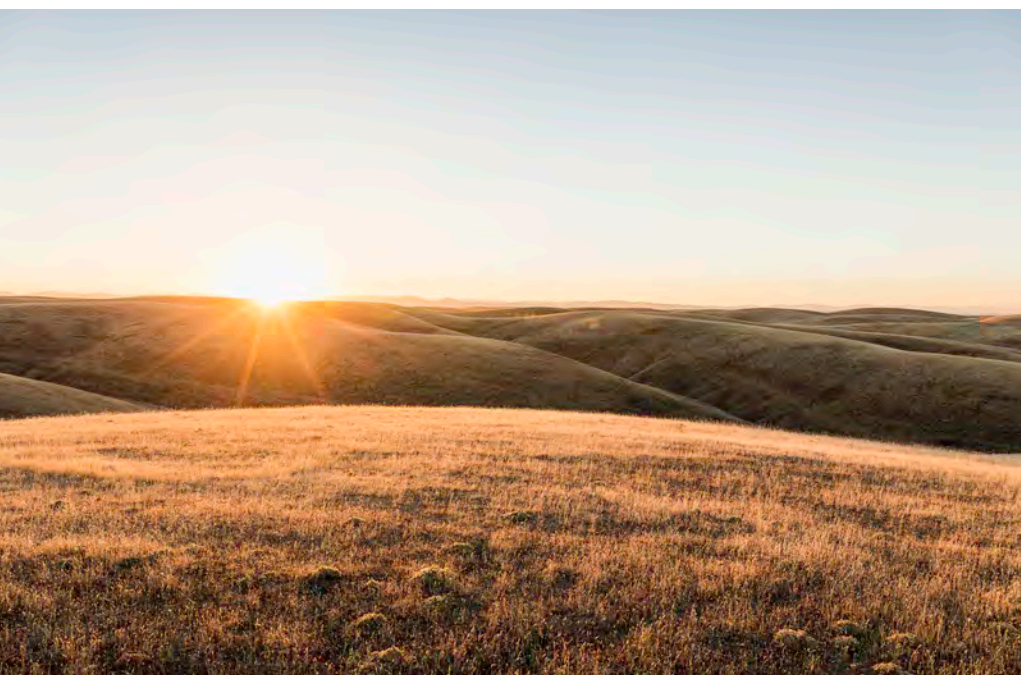
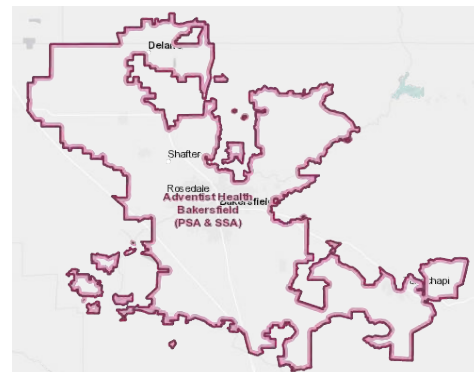
Part of what makes the Bakersfield service area unique is the age of its residents, with 68% of the population being younger than 44. Of this population, 27.58% of children live in poverty, and 2.48% of students are unhoused, compared to the state average of 4.25% and the national average of 2.77%.

On average, households in Bakersfield service area spend 55.96% of their income on housing and

transportation. Despite this challenge, the community still manages to cultivate a vibrant culture of music, movies in the park, walking, fishing and tubing down Kern River.

For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit adventisthealth.org/about-us/community-benefit. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.

**This service area represents Adventist Health Bakerfield's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Bakersfield CHNA service area*



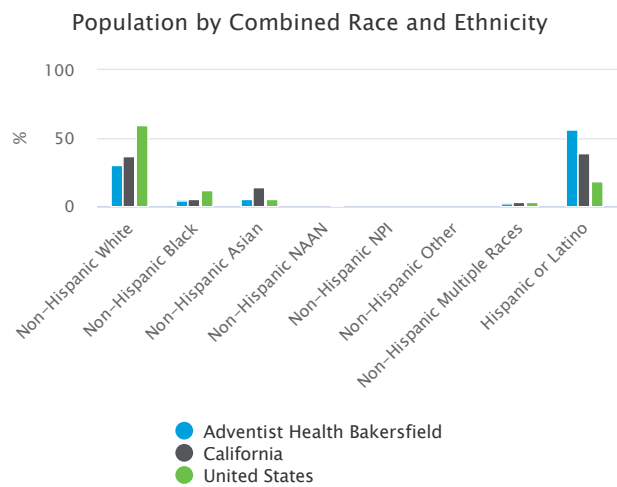
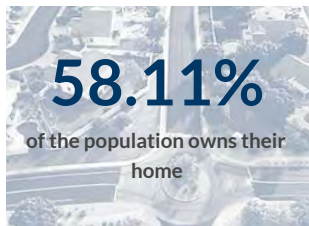
What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

Who We Serve

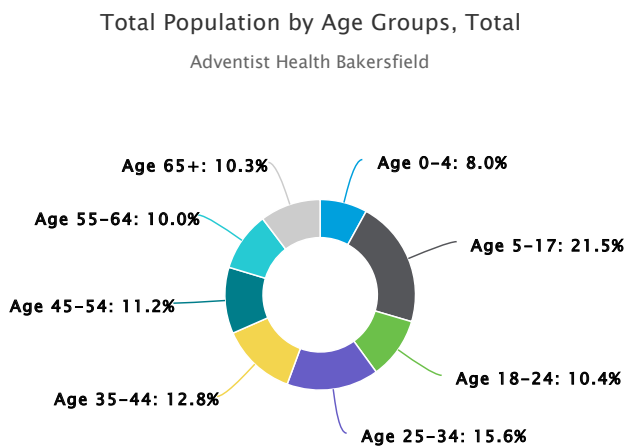
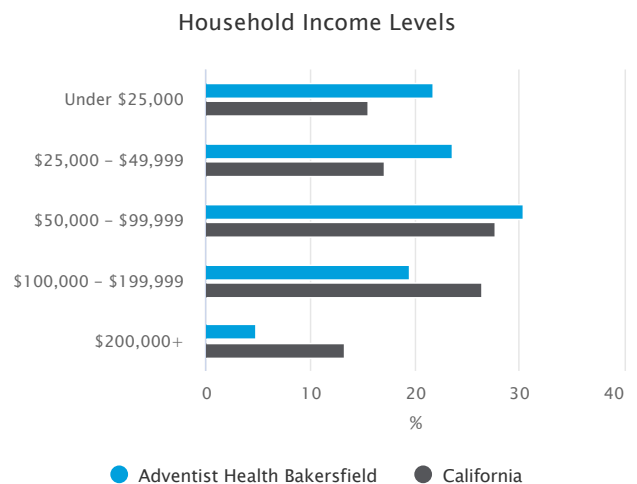
DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health Bakersfield's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The Adventist Health Bakersfield CHNA market has a total population of 779,739 (based on the 2020 Decennial Census). The largest city in the service area is Bakersfield, with a population of 347,609. The service area is comprised of the following zip codes: 93203, 93561, 93241, 93307, 93306, 93314, 93311, 93263, 93280, 93312, 93313, 93301, 93309, 93215, 93308, 93305, 93304, 93268.



Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.



About Us

Adventist Health Bakersfield

Adventist Health Bakersfield is a 254-bed hospital in Bakersfield that serves the residents across Kern County, California. Ensuring the community has the best health care possible has been the guiding spirit of Adventist Health Bakersfield throughout its history. This vision inspired the medical center's founders more than a century ago, and this same commitment remains embedded in the medical center's mission today as expanded services include a comprehensive Heart Institute, a nationally-certified stroke center, and AIS Cancer Center.

Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.



Adventist Health's Approach to CHNA & CHIS

Adventist Health prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA's to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings the Adventist Health Bakersfield CHNA Steering Committee (see page 19 for a list

of CHNA Steering Committee sector participants) identified as their top priority health needs, or as we refer to them in this report, their 'High Priority Needs'. The High Priority Needs are addressed in this Community Health Implementation Strategy.

High Priority Needs

The following pages highlight the High Priority Needs that will be addressed in this Community Health Implementation Strategy.

Access to Care

COMMUNITY VOICES

- People noted it can take months to see a primary care doctor, and specialty care is viewed as extremely difficult to arrange.
- Some residents don't attend scheduled doctor's appointments because they may need to wait hours at the doctor's office, interviewees stated.
- Some residents believe financial struggles require people to choose which priorities they can pay for.
- The Central Valley has difficulty recruiting adequate physician coverage, including behavioral health, medical services, and specialty areas, community leaders said.



Bakersfield is a vibrant city with a deep history, friendly people and a wide variety of outdoor activities. This activity might suggest that our Bakersfield service area is thriving, but for many residents, receiving health care is a challenge.

Residents face a shortage of primary care providers, with about 33% fewer providers available than is seen at the state and national levels. One-third of the Bakersfield service area population lives in a "Health Profession Shortage Area (HPSA)," which underscores the need for additional health care providers. Residents in our service area also experience challenges accessing

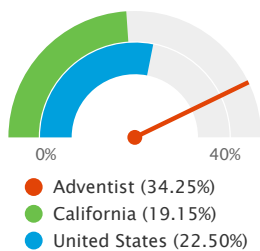
public transportation, further limiting opportunities for some to access healthcare.

About 19% of the Bakersfield service area has Limited English Proficiency, which combined with lower rates of educational attainment, means this community may experience added challenges in accessing, navigating and understanding an often complex health care system.

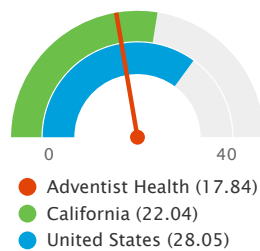
Residents shared concerns and their voices were heard. The focus now? Respond to what has been learned and work toward brighter futures.

SECONDARY DATA INFOGRAPHIC STATS:

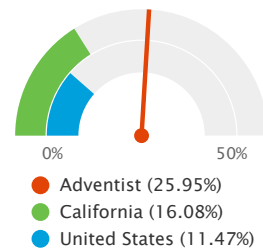
Percentage of Population Living in an Area Affected by a HPSA



Intensive Care Unit Hospital Beds, Rate per 100,000 Population



Population Age 25+ with No High School Diploma, Percent



Financial Stability

COMMUNITY VOICES

- Focus group participants said low wages for hourly jobs make it very difficult for many to afford to live the area.
- Daily expenses like food, gas, car, and clothing items are seen as difficult for many to afford.
- Limited employment opportunities and higher unemployment rates leave residents feeling hopeless, they said.
- One of the things that key informants see as affecting healthcare is the high poverty rate. One in three kids is believed to live below the poverty level.
- Poverty makes it harder to access healthcare and healthy food options, community leaders that were interviewed stated.

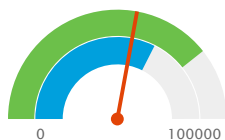


Financial instability is a phrase many families haven't heard of, and yet it is often a driving force in how they live. For our Bakersfield service area, financial instability can refer to many things, including youth aged 18 and younger living in poverty and high unemployment rates. Another challenge, median household incomes fall behind the rest of the state by almost \$23,000 per year. These underserved families are facing instability that isn't temporary.

Residents in our Bakersfield service area are more likely to have debt in collections than other Californians. They are also more likely to spend over 30% of their income on housing than other Americans. Residents shared that they can't afford daily expenses – food, gas, clothing – and low wages prevent them from securing life-sustaining jobs. With 76% of Central Valley residents surveyed selecting financial instability as a health concern, the need is extreme but not beyond hope.

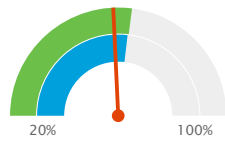
SECONDARY DATA INFOGRAPHIC STATS:

Median Household Income



● Adventist (\$55,775)
 ● California (\$78,672)
 ● United States (\$64,994)

Labor Force Participation Rate



● Adventist (58.82%)
 ● California (63.29%)
 ● United States (62.97%)

Employment – Unemployment

Report Area	Labor Force	Number Unemployed	Unemployment Rate
Adventist Health Bakersfield	336,060	29,335	8.73%
Kern County, CA	381,634	34,847	9.13%
Tulare County, CA	204,090	20,214	9.90%
California	19,875,973	1,229,079	6.18%
United States	164,759,496	8,870,516	5.38%

Mental Health

COMMUNITY VOICES

- The generational impact of mental health needs was noted, especially when parental mental health problems interfere with adequate support for their children.
- Mental illness is seen as a major driver of homelessness.
- The limited number of mental health providers is seen as a problem.
- It is believed that long-term housing instability leads to chronic mental health problems.
- COVID, and the impact of remote learning, are seen as a big contributing factors to greater mental health needs for area youth.



Bakersfield has deep roots in the agricultural industry, and families that cherish the welcoming warmth of their community.

But like many communities today, real concerns impact people of all ages and stages. Mental health is one that looms large, with a high percentage of adults reporting poor mental health. However, access to care is hard to come by. One resident noted that when parents struggle with their mental health, a domino effect is set in motion that

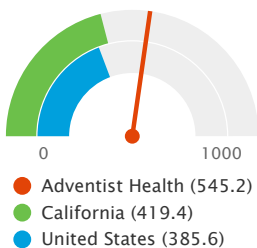
impacts the children.

Bakersfield has high levels of violent crime compared to state and national data. There are fewer than 100 mental health providers for 100,000 people, whereas the state average is 150 per 100,000.

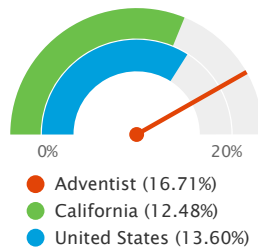
Nearly half of the residents surveyed selected mental health as a Top Health Concern. The struggles are very real, but with new awareness, lives can change.

SECONDARY DATA INFOGRAPHIC STATS:

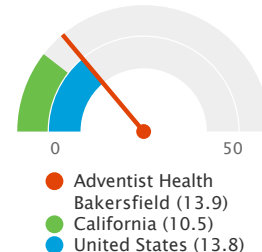
Violent Crime Rate per 100,000 Pop.



Percentage of Adults with Poor Mental Health



Suicide, Age-Adjusted Death Rate (Per 100,000 Pop.)





Action Plan for Addressing High Priority Needs

Committee members drew upon a broad spectrum of expertise and possible strategies to improve the health and well-being of vulnerable populations within the community.

The following pages reflect the goals, strategies, actions, and resources identified to address each selected High Priority Need.

ADDRESSING HIGH PRIORITY: ACCESS TO CARE

GOAL	Collaborate with partners to connect community members with basic healthcare services.
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Priority Area:	Access to Care	Sub-Category:	Availability – Primary Care	Defining Metric:	Primary Care Shortage Area
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Strategy 1:	Advance primary care mobile health units to connect underserved populations with healthcare.
Population Served:	Total Population
Internal Partners:	Manager for Mobile Health Initiatives
External Partners:	McFarland Unified School District, First Five Kern, community-based organizations

Actions: Program/Activity/Tactic/Policy	Organization
Connect underserved residents with primary care via mobile health clinics.	Adventist Health
	Health Net
	Children’s Cabinet of West Kern
	Kaiser
	Kern Medical

YEAR ONE	YEAR TWO	YEAR THREE
Initiate quarterly mobile health events and track participation.	Raise awareness of the importance of primary care among the area population. Troubleshoot mobile health clinics as needed.	Identify strengths of mobile health clinics and leverage opportunities for further patient engagement. Share learning outcomes with stakeholders.

Strategy 2:	Immunize children in need via mobile health clinics to increase immunization rates.
Population Served:	Uninsured and underinsured children in Kern County
Internal Partners:	Manager for Mobile Health Initiatives
External Partners:	First Five Kern, community-based organizations

Actions: Program/Activity/Tactic/Policy	Organization
Connect underserved children with immunizations via mobile health units.	Adventist Health
	First Five Kern

YEAR ONE	YEAR TWO	YEAR THREE
Initiate quarterly mobile health clinics and track participation.	Raise awareness of the importance of youth vaccinations. Troubleshoot mobile health clinics as needed.	Achieve 848 patients immunized annually; 360 hemoglobin tests.

Strategy 3:	Reduce tobacco use and secondhand smoke exposure through targeted activities and policy change.
Population Served:	Bakersfield residents
Internal Partners:	Blue Zones Project Bakersfield team
External Partners:	Students Working Against Tobacco, Bakersfield City Council

Actions: Program/Activity/Tactic/Policy	Organization
Shift tobacco control activities and policies toward a Bakersfield tobacco retail licensing ordinance, increased education and awareness, and expanded youth leadership and involvement.	Blue Zones/Adventist Health
	Blue Zones/Sharecare
	Students Working Against Tobacco (SWAT)
	Bakersfield City Council

YEAR ONE	YEAR TWO	YEAR THREE
Connect with each City Council member about tobacco prevention.	Identify and connect lead constituents with each City Council member.	Work with partner organizations to support a unanimous recommendation for a retail tobacco license policy from the Safe Neighborhoods and Public Relations Committee on City Council.

ADDRESSING HIGH PRIORITY: FINANCIAL STABILITY

GOAL	Advocate for and collaborate with internal and external partners to connect community members to resources that improve financial literacy, lessen financial burden, and/or promote economic development.				
Priority Area:	Financial Stability	Sub-Category:	Employment	Defining Metric:	Unemployment
Strategy 1:	Leverage pipeline programs for healthcare careers to develop clinical workforce.				
Population Served:	Total Population				
Internal Partners:	Director of Finance, Director of HR, Clinical Education Team, Patient Care Executive, & Manager of COPE Health Scholars				
External Partners:	CSU Bakersfield, Bakersfield College, Kern Medical, Kern County Bank of America, Clinica Sierra Vista, & Dignity Health				
Actions: Program/Activity/Tactic/Policy			Organization		
Create a school-to-work pipeline for healthcare careers, focusing on high school and college students. A multidisciplinary committee includes vocational and nursing college leadership, industry partners, and interested parties who may assist in underwriting the work.			Adventist Health		
			CSU Bakersfield		
			Bakersfield College		
			Kern Medical		
			KC Bank of America		
			Clinica Sierra Vista		
			Dignity Health		
YEAR ONE		YEAR TWO		YEAR THREE	
Identify enrollment baseline and track program enrollment for Year 1.		Record enrollment change from baseline over the course of two years. Report to internal and external stakeholders and troubleshoot enrollment process as needed.		Transition program participants in Year 3 into local residency vacancies within Adventist Health.	

Strategy 2:	Partner with and drive the Better Bakersfield & Boundless Kern initiative in order to promote economic prosperity in our service area.
Population Served:	Countywide initiative, including CHNA service area community members
Internal Partners:	Network President, Partnerships Executive
External Partners:	B3K Leadership Council: Kern County, City of Bakersfield, Valley Strong Credit Union, Tejon Ranch Co., Tel-Tec Security Systems, Bolthouse Properties, Kern Energy, Cornerstone Engineering, Countryside Corporation, CA Resources Corporation, Dignity Health, Greater Bakersfield Chamber, United Farm Workers, & California State University Bakersfield

Actions: Program/Activity/Tactic/Policy	Organization
Create 100,000 more quality jobs by 2031 by developing resources and pathways to access them.	Adventist Health
	B3K Leadership Council

YEAR ONE	YEAR TWO	YEAR THREE
Prioritize economic development and cluster-building efforts in four opportunity industry sub-sectors through the development of implementation teams covering carbon management and renewable fuels production and innovation; aerospace; advanced manufacturing; and “second office” business services.	Development of strategic plan to create 100,000 quality jobs, including a focus on talent-to-industry workforce development programs and the Kern Community Economic Resilience Fund.	Grow or upgrade 30 percent of Kern County’s existing jobs base with a target wage of \$21.80 per hour, or \$45,344 per year.

Strategy 3:	Drive economic and job development by creating a widespread workplace culture and environment that supports and optimizes improved wellbeing and reduces chronic work absenteeism related to illness or wellness.
Population Served:	Bakersfield workforce
Internal Partners:	Blue Zones Project team
External Partners:	Community employers

Actions: Program/Activity/Tactic/Policy	Organization
Enhance the well-being of Bakersfield’s workforce using a settings approach by engaging employers in the Blue Zones Project approval process.	Blue Zones/Adventist Health
	Blue Zones Project

YEAR ONE	YEAR TWO	YEAR THREE
At least five employers become Blue Zones Project Approved.	At least 13 additional employers become Blue Zones Project Approved (for a total of 18).	At least 13 additional employers become Blue Zones Project Approved (for a total of 31).

ADDRESSING HIGH PRIORITY: MENTAL HEALTH

GOAL	Improve population-level mental health in service area as a quality of life measure.
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Priority Area:	Mental Health	Sub-Category:	Risk Factors – Access to Care	Defining Metric:	Substance Use Disorders
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Strategy 1:	Connect community members with substance misuse disorders to substance use navigators.
Population Served:	Adults with substance misuse disorders
Internal Partners:	AH emergency department and hospital inpatient setting
External Partners:	Drug-Free Kern and community-based organizations

Action: Program/Activity/Tactic/Policy	Organization
Provide medically assisted treatment and patient navigation services together for individuals with opioid use disorders or overdose history.	Adventist Health
	Drug-Free Kern

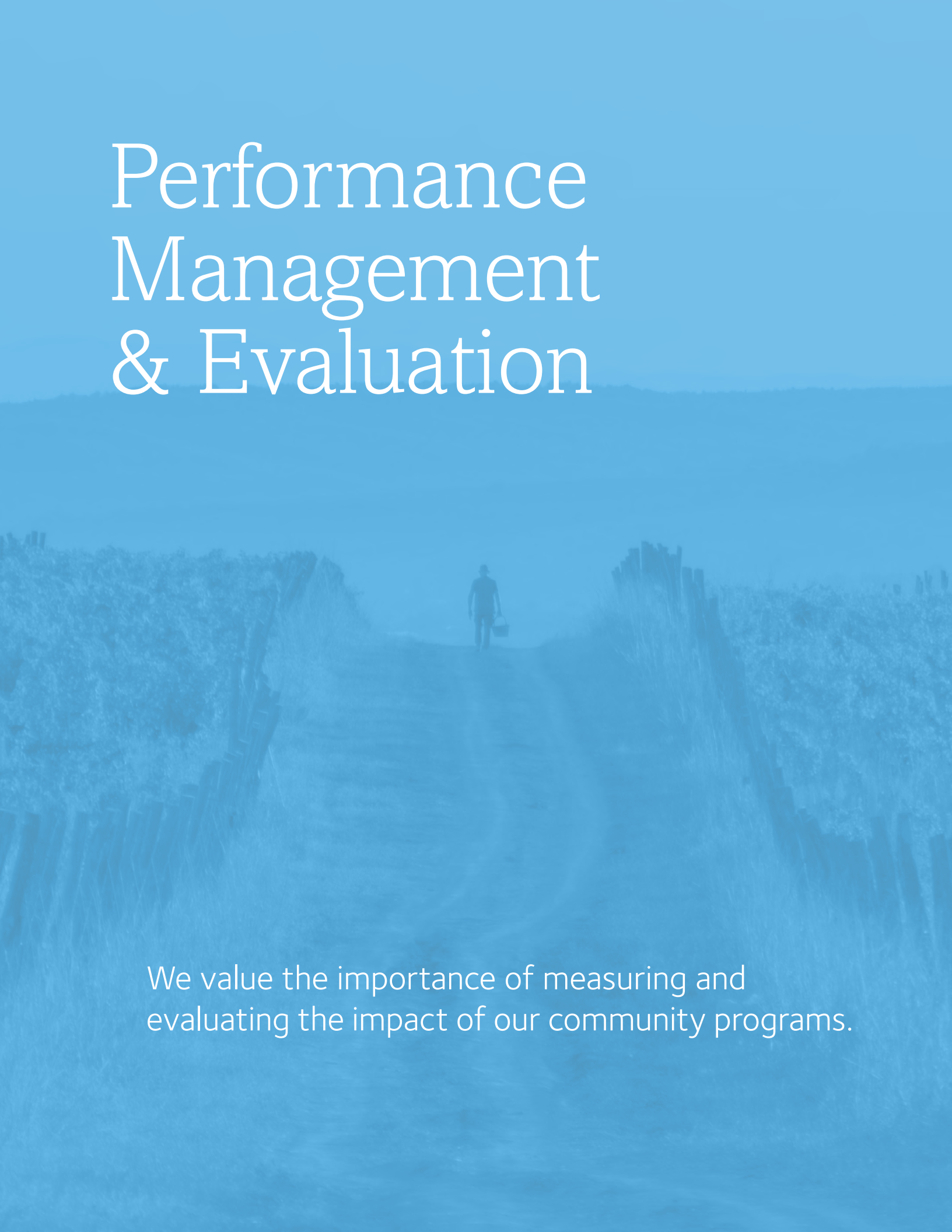
YEAR ONE	YEAR TWO	YEAR THREE
Track the percentage of eligible patients served in Year one.	Conduct community outreach to connect residents in need to services.	Record change in percentage of eligible patients served and report delta to partners. Solicit pathways and implement opportunities for further patient engagement.

Strategy 2:	Create school environments for students, staff and parents that transform their physical and mental health.
Population Served:	School-aged youth
Internal Partners:	Blue Zones Project Bakersfield team
External Partners:	Bakersfield public schools and community-based organizations

Action: Program/Activity/Tactic/Policy	Organization
Align school environments in our service area with settings-based well-being principles through the Blue Zones Project approved framework.	Blue Zones/Adventist Health
	Blue Zones/Sharecare
	Superintendent of Schools
	Grimm Family Education Foundation
	Valley Children’s Healthcare

YEAR ONE	YEAR TWO	YEAR THREE
Five public schools become Blue Zones Project Approved.	17 additional public schools become Blue Zones Project Approved (total of 22).	17 additional public schools become Blue Zones Project Approved (total of 39).

Performance Management & Evaluation

A person is walking away from the viewer on a dirt path that leads into a field of tall, dry grass. The person is carrying a basket and is wearing a hat. The entire image is overlaid with a semi-transparent blue color. The text 'Performance Management & Evaluation' is written in white, serif font in the upper left quadrant.

We value the importance of measuring and evaluating the impact of our community programs.

Performance Management & Evaluation

Adventist Health will support the High Priority Need action plans identified in this CHIS by monitoring progress on an ongoing basis and adjusting the approach as needed over the course of the next three years. There are several resources in place to aid in this. All CHIS programs and initiatives will include a completed logic model to identify intended activities, outputs, and short and long-term outcomes. Establishing core metrics for each program or initiative will allow for the ongoing collection of

performance management data. Actively tracking metric performance leads to the identification of strengths and challenges to the work, the local hospital, the Adventist Health Community Benefit team, and external consultants. Together, we will work to share successes and create performance improvement plans when necessary.

In addition, Adventist Health hospitals where High Priority Needs are shared will have the opportunity

to join a collaborative held by the Adventist Health Well-Being team. The collaborative will be centered on building a common approach that aligns and maximizes community benefit, thus reducing the need to manage this work independently at each hospital. Along with that, where appropriate, evaluation activities designed to measure the overall strength and success of this work at the community level will be incorporated into performance management tracking.

CHIS Development

The development of the CHIS was directly built from the CHNA, whose goal focused on leveraging community stakeholders and data to address the most significant health needs of our community over the next three years. Members of the CHNA Steering Committee—comprised of healthcare, civic, public, and business leaders—led the process of identifying and addressing health needs for a healthier community, completing the final report in fall of 2022.

Collaborating with CHNA Steering Committee members again in early

2023, Adventist Health Community Well-Being Directors facilitated a multi-step process to outline goals and strategies for the CHIS that foster change and positive impact in each of the High Priority Need areas. Each community relied on existing programs and services, and, where necessary, identified new opportunities to pursue collectively.

Once an approach received a consensus, the Community Well-Being Directors worked with Adventist Health leadership and expert consultants to set major

annual milestones for each approach, generating outputs and outcomes that allow for ongoing performance management of this work. For further information on how success will be tracked, refer to the Performance Management and Evaluation section above.

Finally, the CHIS was presented to Adventist Health local Hospital Boards for review and feedback. In addition to this collaborative effort, we also welcome feedback at community.benefit@ah.org.



Scan the QR code for the full Secondary Data Report



Significant Identified Health Needs

The Adventist Health Community Well-Being team and community partners collectively reviewed all relevant significant health needs identified through the CHNA process. Using a community health framework developed for this purpose, 12 significant health needs were initially considered. The list of significant needs are as follows:

- Access to Care
- Community Safety
- Community Vitality
- Education
- Environment & Infrastructure
- Financial Stability
- Food Security
- Health Conditions
- Health Risk Behaviors
- Housing
- Inclusion & Equity
- Mental Health

From this group of 12, several high priority health needs were established for Adventist Health Bakersfield. High priority health needs were chosen as they had demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period.

Using the criteria mentioned above, we were able to determine which needs were high priority, as compared to those that were significant needs. The High Priority Needs are the focus of this CHIS. The remaining significant health needs are not addressed directly but will likely benefit from the collective efforts defined in this report. The following table provides additional information on all the significant health needs that were considered.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Access to Care	See Sections III.C - E
Financial Stability	See Sections III.C - E
Mental Health	See Sections III.C - E
Lower Priority Needs	
Community Vitality 211kerncounty.org/category/income-employment/	Fiscal challenges, especially in home ownership, decrease economic and civic engagement. High crime and rates of substance use problems are also seen as factors limiting community vitality.
Housing 211kerncounty.org/category/housing/	The limited housing stock, and high housing costs, push many into an unstably housed environment. Service needs for this group are very high, and the overall cost of living makes stable housing unrealistic for some community residents.
Food Security 211kerncounty.org/category/food/	With 74% of students receiving free or reduced-priced lunches, and nearly 20% of the community living in low food access neighborhoods, food security is an ongoing problem for many.
Health Conditions 211kerncounty.org/category/health-care/	35% of the population meets the medical criteria for obesity, and liver disease mortality rates are much higher than state averages. Focus group members also called out limited access to specialist healthcare providers as an ongoing difficulty.
Public Safety 211kerncounty.org/category/government/	Key informants noted that there has been an increase in crime in the area during COVID, especially among youth.
Health Risk Behaviors 211kerncounty.org/category/mental-health/ 211kerncounty.org/category/substance-abuse/	The area has smoking and substance use disorder rates higher than state averages. Key informants note that illicit drug use is prevalent and service needs exceed availability.
Education 211kerncounty.org/category/education/	24% of the community has an associates degree or higher. Focus group members said there are inadequate childcare options, both in quantity and quality.
COVID 211kerncounty.org/category/health-care/	46% of surveyed residents identified COVID as a community health need.

*The data presented to the local Steering Committee for prioritization was Kern County data, which is reflected in this table. Throughout the CHNA you'll see hospital-specific data included.



Scan the QR code for the full Secondary Data Report



Community Health Financial Assistance for Medically Necessary Care Commitment

Adventist Health understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information or contact a financial assistant counselor, please visit <https://www.adventisthealth.org/patient-resources/financial-services/financial-assistance/>.



Glossary of Terms

COMMUNITY ASSET

refers to community organizations, programs, policies, activities or tactics that improves the quality of community life.

DEFINING METRIC

this is the metric used to define the extent of the problem faced by the target population.

FUNDING

can be provided by (but not limited to) government agencies, public organizations, grants and philanthropic giving.

GOAL

there may be several overarching goals to address each prioritized health need. This is the overarching impact we want to achieve.

PARTNERS

describe any planned collaboration between the hospital and other facilities or organizations in addressing health needs.

POPULATION SERVED

who is included within the group to receive services of the program.

**PRIORITIZED HEALTH NEED/
PRIORITY AREA/SIGNIFICANT
HEALTH NEEDS**

a health need that was identified in a community health needs assessment and was then selected by committee as a high priority need to be addressed.

STAKEHOLDER- INTERNAL

colleagues and or board members who work for or with the hospital.

STAKEHOLDER- EXTERNAL

community members or organizations who regularly collaborate with the hospital.

STRATEGY

a specific action plan designed to achieve the expected outcome.

SUB-CATEGORY

if needed, a more granular focus within the identified priority area may be called out.

Approval Page

2023 CHIS Approval

In response to the 2022 Community Health Needs Assessment, this Community Health Implementation Strategy was adopted on April 27, 2023 by the Adventist Health System/West Board of Directors.

The final report was made widely available on May 31, 2023.

2615 Chester Ave. Bakersfield, CA 93301
Lic # 120000187
adventisthealth.org



Thank you for reviewing our 2023 Community Health Implementation Strategy.
We are proud to serve our local community and are committed to making it a healthier place for all.

Jason Wells, MBA, CMPE, FACHE

President, Adventist Health Central California Network

