St. Bernardine Medical Center

Hospital HCAI ID:106361339

Community Benefit 2025 Report and 2026 Plan

Adopted October 2025

Dignity Health.
A member of CommonSpirit

A message from

Douglas Kleam, President, St. Bernardine Medical Center.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social drivers of health.

St. Bernardine Medical Center shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2025 Report and 2026 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2025 (FY25), St. Bernardine Medical Center provided $66,041,718 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $3,210,157 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education.

The hospital's board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its October 2025 meeting.

Thank you for taking the time to review this report and plan. We welcome any questions or comments, which can be submitted using the contact information in the At-a-Glance section of this report.

Douglas Kleam

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President

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At-a-Glance Summary

Hospital HCAI ID:106361339

Report Period Start Date: July 1, 2024 **Report Period End Date:** June 30, 2025

Community Served	Dignity Health – St. Bernardine Medical Center is located at 1805 Medical Center Drive, San Bernardino, California 92411. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. For the purposes of this report, the hospital defines its primary service area to include 31 ZIP Codes in 17 cities within San Bernardino County.
Economic Value of Community Benefit	$66,041,718 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $3,210,157 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education Community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: • Access to health care • Behavioral health (mental health and substance use) • Chronic diseases, including overweight and obesity • Housing and homelessness • Preventive practices • Safety and Violence • Sexually Transmitted Infections
FY25 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • Family Focus Center • Baby & Family Center • Community Health Navigator • Community Health Improvement Grants Program • Transitional Care Clinic • Community Health Education

	• Emergency Department Syphilis/HIV/HCV Screening Program (EDSP) • Violence and Human Trafficking Prevention and Response
FY26 Planned Programs and Services	FY26 programs will continue with adjustments made for critical significant health needs that are addressed in the 2025 CHNA, namely Access to Care.

This document is publicly available online at:
https://www.dignityhealth.org/socal/locations/stbernardinemedical/about-us/serving-the-community/community-health-needs-assessment-plan

Written comments on this report can be submitted to the St. Bernardine Medical Center Community Health Department, 2101 N. Waterman Ave., San Bernardino, CA 92404 or by e-mail to Christian Starks at christian.starks@commonspirit.org.

Our Hospital and the Community Served

About St. Bernardine Medical Center

St. Bernardine Medical Center is a Dignity Health hospital. Dignity Health is a member of CommonSpirit Health. Founded as a faith based hospital in 1931 by the Sisters of Charity of the Incarnate Word, Dignity Health – St. Bernardine Medical Center is a highly-regarded 342 bed, nonprofit, tertiary acute care hospital located in San Bernardino, California. The hospital offers a full continuum of services, including the Inland Empire Heart and Vascular Institute, the largest heart program in the Inland Empire, an Emergency Department that treats over 72,000 patients per year, an award-winning Orthopedics program and a high volume Surgical program and outpatient surgical center.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

The hospital serves 31 ZIP Codes in 17 cities, 8 of which are located in the City of San Bernardino A summary description of the community is provided below, and additional details can be found in the CHNA report online.

The population of the hospital service area is 1,233,495. Children and youth, ages 0-17, make up 27.1% of the population, 61.9% are adults, ages 18-64, and 11% of the population are seniors, ages 65 and older. Most of the population in the service area identifies as Hispanic/Latino (62%). 21.3% of the population identifies as White/Caucasian, 8.3% as Black/African American. 5% as Asian and 2.5% of the population identifies as multiracial (two-or-more races), 0.2% as American Indian/Alaskan Native, and 0.2% as Native Hawaiian/Pacific Islander. Those who are of some other race represent 0.4% of the service area population. In the service area, 52.2% of the population, ages 5 and older, speak only English in the home. Among the area population, 42.73% speak Spanish, 3.4% speak an Asian/Pacific Islander language, and 1.1% speak an Indo-European language in the home.

Among the residents in the service area, 14.6% are at or below 100% of the federal poverty level (FPL) and 35.6% are at 200% of FPL or below. In San Bernardino County 12.2% of the population experienced food insecurity in 2022. Among children in San Bernardino County, 17.9% lived in households that experienced food insecurity. According to the California Department of Social Services, 81.8% of eligible households in San Bernardino County participated in the CalFresh food stamp program. Educational attainment is a key driver of health. In the hospital service area, 22% of adults, ages 25 and older, lack a high school diploma, which is higher than county (18.6%) and state (15.6%) rates.

A summary description of the community is below. Additional details can be found in the CHNA report online.

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in November 2025. The hospital makes the CHNA report widely available to the public online and a written copy is available upon request.

CHNA web address:

https://www.dignityhealth.org/socal/locations/stbernardinemedical/about-us/serving-the-community/community-health-needs-assessment-plan

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Community Groups that Attended or Engaged with the CHNA:

- Arrowhead Grove Community Resident Council
- Community Hospital of San Bernardino Young Adult Volunteers
- St. Bernardine Medical Center and Community Hospital of San Bernardino Diaper Bank Recipients

Vulnerable Populations Represented by These Groups:

- Racial and ethnic groups experiencing disparate health outcomes,
- People with disabilities
- People identifying as lesbian, gay, bisexual, transgender, or queer
- Individuals with limited English proficiency

This community benefit report also includes programs delivered during fiscal year 2025 that were responsive to needs prioritized in the hospital's previous CHNA report.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific

health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Health Care	90.6% of St. Bernardine Medical Center's service area's population has health insurance coverage which is lower than the Healthy People 2030 objective of 92.4% and lower than the county and State rates of insured. Certain communities in the service area are far below these insurance coverage rates for adults ages 19-64, especially parts of Fontana and San Bernardino with under 80% insured adults. When examined by race and ethnicity, Hispanic and other race adults are the least insured. Over 50% of adults report that it is very difficult to find an affordable health plan through an insurance company or HMO and over 30% found it very difficult to find an affordable health plan through Covered California. Over 25% of the population at or below 100% of the Federal Poverty Level (FPL) visited an emergency room from 2020-2022. Less patients are seeking care at local and regional FQHCs than previously. A third of adults do not have dental insurance.	X
Housing & Homelessness	40.7% of owner and renter occupied households in the service area spend 30% or more of their income on housing, which is designated as "cost burdened" by the U.S. Department of Housing and Urban Development. Some areas of San Bernardino have over 50% of households designated as cost burdened. 11% of households in the service area live in overcrowded or severely overcrowded conditions. Over 70% of the 4,255 homeless individuals in San Bernardino County (last counted in January of 2024) are unsheltered and over 50% are chronically homeless adults.	X
Mental Health	Adults in the hospital service area experience frequent mental distress more than in the county and in California. (18.1%, compared to 16.2% and 14.4% respectively.) In San Bernardino County, more adults have been told they have a depressive disorder, compared to California. And more adults in San Bernardino sought help and did not receive treatment, compared to California. More teens and youth were counted among hospital discharges in San Bernardino County, compared to California. San Bernardino	X

Significant Health Need	Description	Intend to Address?
	County has less mental health providers per person, as compared to California.	
Substance Use & Misuse	Adults in San Bernardino County have higher alcohol use, compared to California, higher hospitalization rates for opioid overdose (excluding heroin), and higher opioid prescriptions per 1,000 persons. Cigarette smoking is highest among Black or African American, non-Latino and White, non-Latino populations.	X
Chronic Diseases	St. Bernardine Medical Center's service area has higher rates of stroke death when adjusted for age, compared to the county and California. And, San Bernardino County has higher rates of cancer deaths for all cancers, than the California rate. The service area has higher rates of mortality due to diabetes, liver disease and kidney disease, compared to both the county and California. Adults report being in poor health in the service area compared to the county and California. More people in the service area are hospitalized for diabetes, heart failure and hypertension in San Bernardino County, compared to California. The prevalence of heart disease in adults is higher in Community Hospital of San Bernardino's service area than in the county and California. Asthma is more prevalent in adults in the St. Bernardine Medical Center area than in the county and in California. More seniors in St. Bernardine Medical Center's service area are living with disability, compared to the county and California	X
Food Insecurity	Food insecurity is an economic and social indicator of the health of a community. The US Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire foods in socially-acceptable ways. In San Bernardino County, 12.2% of the population experienced food insecurity in 2022. Among children in San Bernardino County, 17.9% lived in households that experienced food insecurity. Feeding America estimates that 74% of those experiencing food insecurity in San Bernardino County, and 67% of county children experiencing food insecurity, are income-eligible for nutritional programs such as SNAP/CalFresh.	X

Significant Health Need	Description	Intend to Address?
Overweight & Obesity	More teens in San Bernardino County are overweight, than in California. In San Bernardino County, 77.4% of Latino adults, 72.5% of non-Latino Black/African American, 67.7% of non-Latino multiracial, 64.5% of non-Latino White, and 41.9% of non-Latino Asian adults are overweight or obese. The rates for all groups for whom rates are available are higher than state rates. 27.2% of service area adults had not engaged in any leisure-time physical activity, which is a higher rate of being sedentary / no physical activity outside of work than seen at the county (26%) or state (20.1%) level.	X
Preventative Practices	The Healthy People 2030 objective is for 70% of the population to receive a flu shot. 33.5% of San Bernardino County adults received a flu shot during the 2021 survey year. For mammograms, the Healthy People 2030 objective is for 80.3% of women, between the ages of 50 and 74, to have a mammogram in the past two years. In the service area, 75.7% of women had obtained mammograms in the prior two years, which did not meet this goal. For colorectal cancer screenings, the Healthy People 2030 objective for adults, ages 50 to 75 years old, is for 68.3% to obtain a screening (defined as a blood stool test in the past year, sigmoidoscopy in the past five years plus blood test in the past three years, or colonoscopy in the past ten years). 55% of service area residents, aged 50-75, met the colorectal cancer screening guidelines.	X
Sexually Transmitted Infections (e.g. HIV)	Sexually transmitted infections (STIs) usually pass from one person to another through sexual contact. Common STIs include syphilis, gonorrhea, and chlamydia.	X
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition.	X

Significant Health Need	Description	Intend to Address?
Environmental Health	Environmental health centers on the relationships between people and their environment. When people are exposed to hazards like polluted air and lead in their drinking water, they can develop serious conditions, such as asthma, heart disease, cancer and dementia	

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, St. Bernardine Medical Center will not directly address environmental health in the 2025 Community Benefit Implementation Strategy. Knowing that there are not sufficient resources to address all the community health needs, St. Bernardine Medical Center has chosen to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise.

2025 Report and 2026 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY25 and planned activities for FY26, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included:

- Community Health
- Care Coordination
- Clinicians
- Nurses
- Health Equity Liaison
- Mission
- Social Work
- Quality

Community input to this Implementation Strategy includes the prioritization process embedded in the 2025 Community Health Needs Assessment. Stakeholder interview participants included a broad range of stakeholders concerned with health and wellbeing in San Bernardino County who spoke to issues and needs in the communities served by the hospital. Stakeholders included individuals who are leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have "current data or other information relevant to the health needs of the community served by the hospital facility." In addition to hour-long interviews, stakeholders responded to an electronic survey, to rank each identified need. Responses were noted as those that identified the need as having severe impact on the community, had worsened

over time, and had insufficient or absent resources available in the community. The results were used in prioritizing the Health Focus Areas for this Implementation Strategy.

The programs and initiatives described here were selected on the basis of:

- existing programs with evidence of success/impact;
- research into effective interventions
- expanding or adapting a partner's program;
- access to appropriate skills or resources;
- ability to measure impact;
- goal to address a vital condition;
- goal to address an urgent service need.

Community Health Core Strategies

The hospital intends that program activities to help address significant community health needs reflect a strategic use of resources. CommonSpirit Health has established three community health improvement core strategies to help ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Implement and sustain evidence-based health improvement program initiatives.
- Strengthen community capacity to achieve equitable health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment. They are organized by health need and include statements of goals and anticipated impact, and any collaboration with other organizations in their delivery.

Health Need:	Access to Care				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Family Focus Center	Presents health care topics and local resources for at risk youth and young adults.	●	●	●	VC: Basic Needs for Health and Safety
Baby & Family Center	Presents health care topics and local resources for new/expectant mothers and families including childbirth preparation and lactation support.	●	●	●	VC: Lifelong learning
Community Health Education	Addresses a variety of access to health care topics, identifies local resources for primary and preventive care and navigates the health care system.	●	●	●	VC: Lifelong learning
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide health care access	●		●	VC: Basic Needs for Health and

Health Need:	Access to Care				
Program	programs and services.				Safety
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to social service agencies.	●	●	●	VC: Basic Needs for Health and Safety
Emergency Department Syphilis/HIV/HCV	Provides inpatient and community education on sexually transmitted infection prevention and management (e.g.syphilis, HIV, Hep C).	●	●		US: Acute Care for Illness and Injury
Financial assistance for the uninsured or under-insured	Provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	●	●	●	US: Acute Care for Illness and Injury
Graduate Medical Education (GME)	Expands and diversifies the physician workforce in Inland Southern California/City of San Bernardino in partnership with University of California Riverside. Offers innovative and high-quality training programs in the most critically needed specialties and teaches the skills, cultural competence and community health-based orientation that the changing landscape of health care needs requires.	●	●	●	VC: Basic Needs for Health and Safety
Substance Use Navigator Program	Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. Utilizes trained navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.	●	●		US: Addiction Treatment
Transitional Care Clinic	Assists persons to identify and secure a medical	●	●	●	VC: Basic Needs for

Health Need:	Access to Care				
	home and provides connections to local social service agencies.				Health and Safety
Planned Resources:	The hospital will provide health care providers, enrollment counselors, health educators, community health navigators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: University of California, Riverside, Lestonnac Free Clinic, CHAISR (Community Health Association Inland Southern Region), community-based organizations (Family Assistance Program, Mary's Mercy Center and others), schools and school districts, faith groups, public health and local cities.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased access to health care for the medically underserved and reduced barriers to care.	Activities and Participation	Program Data
Increased access to vital community resources and health education	Activities and Participation	Program Data

Health Need:	Behavioral Health Services (Mental Health and Substance Use)				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants	Offers grants to nonprofit community organizations that provide mental health and	●	●	●	VC

Health Need:	Behavioral Health Services (Mental Health and Substance Use)				
Program	substance use programs and services.				
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to behavioral health service agencies.	●	●	●	VC
Substance Use Navigator Program	Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. Utilizes trained navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.	●	●		US
Planned Resources:	The hospital will provide community health navigators, social workers, philanthropic cash grants, outreach communications, program management support for these initiatives and referrals to local mental health care providers.				
Planned Collaborators:	Key partners include: behavioral health providers, schools and school districts, community-based organizations, Dignity Health Southern California Hospitals, San Bernardino City Unified School District's Making Hope Happen Foundation, law enforcement, and regional collaboratives that seek to support individuals' mental health, substance use and case management needs.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased access to mental health and substance use services in the community.	Activities and Participation	Program Data
Improved screening and identification of mental health and substance use needs.	Activities and Participation	Program Data

Health Need:	Chronic Diseases (including Overweight and Obesity)				
Population(s) of Focus:	Vulnerable Populations and Broader Communities				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Education	Provides community education on a variety of chronic disease-related health care topics, including: Chronic Disease Self-Management, and Diabetes Empowerment Education Program.	●	●	●	VC
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide chronic disease-focused programs and services.	●	●	●	VC
Emergency Department Syphilis/HIV/HCV	Provides inpatient and community education on sexually transmitted infection prevention and management (e.g.syphilis, HIV, Hep C).	●	●		VC
Replate Program	Redirects surplus hospital food to local communities in need.				US: Unemployment and Food Assistance
Support Groups	Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and	●	●		VC

Health Need:	Chronic Diseases (including Overweight and Obesity)				
	psychoeducation.				
Transitional Care Clinic	Assists recently discharged patients to develop individualized treatment plans based on medication compliance, diet, exercise, and lifestyle changes. Assists patients to identify and secure a medical home and provides connections to local social service agencies.	•	•		VC
Planned Resources:	The hospital will provide health care providers, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: public health, community clinics, community-based organizations, American Heart Association, maternal health organizations, American Cancer Society and American Diabetes Association.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased identification and treatment of chronic diseases.	Activities and Participation	Program Data
Improved healthy eating and active living.	Activities and Participation	Program Data

Health Need:	Housing and Homelessness				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**

Health Need:	Housing and Homelessness				
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to social service agencies.	●	●		VC
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.		●	●	VC
Planned Resources:	The hospital will provide health care providers, health navigators, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned Collaborators:	Key partners include: Center for Community Investment, homeless service agencies, housing programs, public health, faith community, community clinics, community-based organizations,				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved health care delivery to persons experiencing homelessness (PEH).	Activities and Participation	Program Data
Increased access to community-based services for PEH.	Activities and Participation	Program Data

Health Need:	Preventive Practices				
Population(s) of Focus:	Vulnerable Populations and Broader Community				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Education	Provides community education on a variety of preventive care topics.	●	●	●	VC
Community Health Improvement Grants Programs	Offers grants to nonprofit community organi-zations that provide preventive care programs and services.	●	●	●	VC
Community Health Navigator	Assists frequent users of the Emergency Department with preventive education and resources.	●	●		VC
Eye Clinic	A collaboration between SBMC, Lestonnac Free Clinic, and Western University of Health Sciences, provides free eye exams and glasses to the community on a monthly basis.	●	●		VC
Family Focus Center	Presents health care topics and local resources for at risk youth and young adults.	●	●	●	VC
Substance Use Navigator Program	Supports the emergency department as a primary access point for the treatment of substance use disorders and co-occurring mental health conditions. Utilizes trained	●	●		VC

Health Need:	Preventive Practices				
	navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.				
Vaccines	Provides free vaccines in the community.	●	●		VC
Planned Resources:	The hospital will provide health care providers, health educators, philanthropic cash grants, outreach communications, and program management for this initiative				
Planned Collaborators:	Key partners include: public health, faith community, community clinics, community-based organizations, Lestonnac Free Clinic, and Western University of Health Sciences. .				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
increased access to preventive care services in the community.	Activities and Participation	Program Data

Health Need:	Safety and Violence				
Population(s) of Focus:	Vulnerable Populations and Broader Community				
Strategy or Program	**Summary Description**	**Strategic Alignment**			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants Programs	Offers grants to nonprofit community organi-zations that provide preventive care programs and services.	●	●	●	VC
Family Focus Center	Provides a safe, supervised environment for youth and young adults that supports their development through academic assistance, enrichment activities, and social-emotional learning	●	●	●	VC
Violence and Human Trafficking Prevention and Response Taskforce	Ensures that trafficked persons are identified in health care settings and assisted with trauma-informed patient care and services.	●	●	●	VC
Planned Resources:	The hospital will provide health care providers, health educators, philanthropic cash grants, outreach communications, and program management for this initiative				
Planned Collaborators:	Key partners include: Family Focus Center, Family Assistance Program (Open Door), health care providers, etc.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source

Decreased rates of inpatient and community violence.	Activities and Participation	Program Data

Health Need:	Sexually Transmitted Infections (e.g. HIV)				
Population(s) of Focus:	Vulnerable Populations and Broader Community				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Navigator	Assists community residents and discharged patients with preventive sexually transmitted infection education and resources.	●	●	●	VC
Emergency Department Syphilis/HIV/HCV	Provides inpatient and community education on sexually transmitted infection prevention and management (e.g.syphilis, HIV, Hep C).	●	●		US
Transitional Care Clinic	Assists recently discharged patients to develop individualized treatment plans based on medication compliance, diet, exercise, and lifestyle changes. Assists patients to identify and secure a medical home and provides connections to local social service agencies.	●	●		VC
Planned Resources:	The hospital will provide health care providers, health navigators, outreach communications, and program management for this initiative				
Planned Collaborators:	Key partners include: public health, community clinics, community-based organizations, and St.				

Health Need:	Sexually Transmitted Infections (e.g. HIV)
	Bernardine Transitional Care Clinic.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
increased access to preventive care services in the community.	Activities and Participation	Program Data
Decreased rates of Sexually Transmitted Infections in hospital service area.	Activities and Participation	Program Data

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding restricted financial grants to non-profit organizations working to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY25, St. Bernardine Medical Center and Community Hospital of San Berardino awarded the grants below totaling $389,000. Some projects also may be described elsewhere in this report. St. Bernardine's portion of the grant award expenses included in its community benefit was $236,696. The figures below represent the total sum of the grants.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Catholic Charities	Solution-Focused Teletherapy Counseling Services for Low-Income San Bernardino County Residents	Behavioral Health (mental health and substance abuse) Access to Care	$20,000
CSUSB Philanthropic Foundation	CSUSB Nursing Street Medicine Clinic Program	Behavioral Health (mental health and substance abuse) Access to Care	$25,000
Building a Generation	Holistic Adolescent Wellness	Behavioral Health (mental health and substance abuse)	$50,000
Family Assistance Program	Employment Opportunities for Victims of Sex and Labor Exploitation	Housing & Homelessness Humantrafficking	$70,000
Inland Harvest	Inland Harvest	Access to Care Food Insecurity	$49,000
Rescue a Generation	Expansion	Behavioral Health (mental health and substance abuse)	$60,000
San Bernardino Fatherhood	Black Dads Supporting Moms & Caring for Babies	Maternal Child Health Access to Care	$70,000

Step Up	ECM/CS Programs in the Inland Empire	Behavioral Health (mental health and substance abuse) Access to Care	$45,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Dignity Health Community Health Improvement Grants	
Significant Health Needs Addressed	• Access to Care • Preventive Practices • Chronic Diseases, Including Overweight and Obesity • Housing and Homelessness • Safety & Violence • Behavioral Health, including Substance Use and Mental Health
Program Description	Award funds to local non-profit organizations to be used to effect collective impact, addressing the significant health priorities established by the most recent Community Health Needs Assessment. Awards will be given to agencies with a formal collaboration and link to the hospital.
Population Served	Underserved and marginalized populations.
Program Goal / Anticipated Impact	Focused attention on health priorities and the underserved in the community will provide connections to needed medical care and social services, thereby providing more appropriate care to the individual and improving the health of the community.
FY 2025 Report	
Activities Summary	Funding was awarded to Catholic Charities, California State University of San Bernardino Philanthropic Foundation, Building a Generation, Family Assistance Program, Inland Harvest, Rescue a Generation, San Bernardino Fatherhood and Step Up.

Performance / Impact	Funding in FY5 addressed the following health needs: Access to Healthcare, Behavioral Health, Chronic Diseases, Housing and Homelessness, Preventative Practices, and Safety and Violence. Agencies have reported that they are on-track to meet goals established in their respective proposals
Hospital's Contribution/ Program Expense	St. Bernardine Medical Center and Community Hospital of San Bernardino granted $389,000 in cash awards to recipients.
FY 2026 Plan	
Program Goal / Anticipated Impact	Focused attention on health priorities and the underserved in the community will provide connections to needed medical care and social services, thereby providing more appropriate care to the individual and improving the health of the community.
Planned Activities	Awardees will have an established collaboration with the hospital which will allow for better connection for community and patients who are discharged and who may be able to benefit from services offered by the non-profit agencies

Transitional Care Clinic

Significant Health Needs Addressed	• Access to Care • Preventive Practice • Chronic Diseases, including Overweight and Obesity
Program Description	The Transitional Care Clinic provides follow up care for patients after their discharge from the hospital to focus on reducing the readmission rate of patients and meet immediate concerns of recently discharged patients. The clinic sees patients up to seven days after discharge from both St. Bernardine Medical Center and Community Hospital of San Bernardino.
Population Served	Vulnerable populations
Program Goal / Anticipated Impact	Assists discharged patients with follow up care and identifying medical and social services as appropriate.
FY 2025 Report	
Activities Summary	Healthcare providers assist patients with follow-up primary medical care.
Performance/ Impact	A total of 1,993 persons were directly served through the Transitional Care Clinic.

Hospital's Contribution/ Program Expense	St. Bernardine Medical Center provided staffing, land use, and other related programming expenses in FY25.
FY 2026 Plan	
Program Goal / Anticipated Impact	Assist the frequent users of the Emergency Department (ED) and San Bernardino County residents in locating medical and social services as appropriate.
Planned Activities	The Transitional Care Clinic will continue to provide follow up care for patients after their discharge from the hospital to focus on reducing the readmission rate of patients and meet immediate concerns of recently discharged patients.

Community Health Navigator	
Significant Health Needs Addressed	• Access to Care • Preventive Practice • Chronic Diseases, including Overweight and Obesity • Housing and Homelessness
Program Description	The Community Health Navigator follows up by phone to patients who are high utilizers of the Emergency Department who are seen for diagnoses that could be addressed in an outpatient setting. Patients are provided with community resources and assistance is provided for enrolling in government sponsored plans and finding a medical home. The navigator may also assist with housing, food and employment needs
Population Served	Vulnerable populations
Program Goal / Anticipated Impact	Assist the frequent users of the Emergency Department (ED) and San Bernardino County residents in locating medical and social services as appropriate.
FY 2025 Report	
Activities Summary	Navigator followed up by phone and appointment to high utilizers of the ED, primarily the uninsured.
Performance / Impact	Improved individual health outcomes and strengthened patient provider relationships ultimately leading to reduced healthcare costs.
Hospital's Contribution / Program Expense	$31, 512.67 was expended in staffing and related programming expenses in FY25.
FY 2026 Plan	
Program Goal / Anticipated Impact	Assist the frequent users of the Emergency Department (ED) and San Bernardino County residents in locating medical and social services as appropriate.
Planned Activities	Navigator will continue to follow up by phone and in person with San Bernardino County residents and high utilizers of the ED. SBMC's Transitional Care Clinic will be an option for those who need more immediate follow up care. Lestonnac Free Clinic will continue to be a medical home option for those without insurance, primarily our immigrant population.

	Navigator will also assist with enrollment in government sponsored programs.

Baby and Family Center	
Significant Health Needs Addressed	• Access to Care • Preventive Practice • Chronic Diseases, including Overweight and Obesity • Birth Indicators
Program Description	The St. Berardine Medical Center Baby and Family Center is a walk-in clinic providing prenatal and postpartum wellness education and support to new and expecting parents.
Population Served	Vulnerable populations
Program Goal / Anticipated Impact	Assist new and expectant parents with prenatal and postpartum education, resources, and support and decrease infant and maternal health morbidity and mortality rates.
FY 2025 Report	
Activities Summary	Educational classes for pregnant women and their families on breastfeeding, nutrition and prevention of disease and disability
Performance / Impact	A total of 902 persons were directly served through the Baby and Family Center program.
Hospital's Contribution / Program Expense	$67, 193 was expended in staffing and related programming expenses in FY24.
FY 2026 Plan	
Program Goal / Anticipated Impact	Assist new and expectant parents with prenatal and postpartum education, resources, and support and decrease infant and maternal health morbidity and mortality rates.
Planned Activities	Staff will continue to provide educational classes for pregnant women and their families on breastfeeding, nutrition and prevention of disease and disability. Community activities such as car seat safety checks and diaper distributions will continue quarterly.

Replate	
Significant Health Needs Addressed	• Chronic Diseases, including Overweight and Obesity
Program Description	The St. Berardine Medical Center Replate program provides surplus food to communities in need, addresses hunger, and promotes environmental sustainability.
Population Served	Vulnerable populations
Program Goal / Anticipated Impact	Provides surplus food to communities in need, addresses hunger, and promotes environmental sustainability.
FY 2025 Report	
Activities Summary	The project will send surplus food from the St. Bernardine Medical Center cafeteria to vulnerable communities to combat hunger and food insecurity.
Performance / Impact	A total of 13 food donations were provided to community-based organizations serving people experiencing food insecurity.
Hospital's Contribution / Program Expense	$1, 765 was expended in staffing and related programming expenses in FY24.
FY 2026 Plan	
Program Goal / Anticipated Impact	The St. Bernardine Medical Center Replate program will continue to provide surplus food to communities in need, address hunger, and promote environmental sustainability.
Planned Activities	Staff will continue to utilize the Replate technology to donate St. Bernardine Medical Center surplus food to local community-based organizations serving people experiencing food insecurity.

Other Community Health and Community Building Programs

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

First Step Staffing, Inc. (FSS)
First Step Staffing was incorporated in Atlanta, Georgia, in 2006 as a nonprofit organization for the purpose of providing companies with a socially responsible alternative to typical staffing agencies, while offering meaningful employment opportunities for men and women who are in transition. In November, 2019, CommonSpirit Health approved a 5-year $1,500,000 loan to FSSLA as gap financing for the acquisition of customer accounts and assets of OS4L in Paramount, Irwindale and Corona, helping very-low-income and homeless individuals find temporary and permanent employment opportunities.

Mary Erickson Community Housing
In September 2020, CommonSpirit Health approved a 7-year, $1,200,000 line of credit to Mary Erickson Community Housing with loan proceeds used for developing 11 single family manufactured homes for low income families seeking first-time homeownership opportunities in San Bernardino. MECH is a nonprofit organization supporting homeownership opportunities for working families through the preservation and increase in the supply of affordable housing.

National Community Renaissance of California (NCRC)
In June 2018 Dignity Health approved a 7-year $1,200,000 loan to NCRC, one of the largest nonprofit affordable housing developers in the U.S., who is partnering with the County of San Bernardino on the redevelopment of Waterman Gardens into Arrowhead Grove—a mixed income housing development together with attractive neighborhood facilities, shopping and recreational facilities.

Neighborhood Partnership Housing Services, Inc. (NPHS)
In September 2020, CommonSpirit Health approved a 5-year, $1,000,000 line of credit to NPHS with loan proceeds used to develop 10 scattered single-family factory-built homes for low-income families. The average home will feature 3 bedrooms and 2 baths and will be approximately 1,600 square feet. The development will be on scattered, underutilized land in the City of San Bernardino. Founded in 1991, Neighborhood Partnership Housing Services, Inc. (NPHS) has become one of the most respected and innovative nonprofit housing organizations serving three Southern California counties which include Riverside, East Los Angeles, and San Bernardino.

Community Vital Signs
Since its launch in 2011, San Bernardino County Community Vital Signs has attracted both local and national attention spotlighting the county's efforts for rich

collaboration by exemplifying the idea that all sectors must work together for collective impact. The Community Transformation Plan serves as a guide to transform San Bernardino County into a healthier place to live, work, learn and play. Community Health staff from St. Bernardine Medical Center has served on the Steering Committee since its inception to ensure integration of the health component in program planning.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Medicare reported here excludes Medicare reported as a part of Graduate Medical Education.

Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Financial Assistance and Means-Tested Government Programs	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$7,554,721		$7,554,721
Medi-Cal	$42,288,587		$42,288,587
Other Means-Tested Government (Indigent Care)	$0		$0
Sum Financial Assistance and Means-Tested Government Programs	**$49,843,308**		**$49,843,308**
Other Benefits			
Community Health Improvement Services	$644,471	$87,801	$732,272
Community Benefit Operations	$153,745	$13,200	$166,945
Health Professions Education	$0	$13,747,036	$13,747,036
Subsidized Health Services	$0	$0	$0
Research	$0	$0	$0
Cash and In-Kind Contributions for Community Benefit	$1,513,316	$38,841	$1,552,157
Other Community Benefits	$0	$0	$0
Total Other Benefits	**$2,311,532**	**$13,886,878**	**$16,198,410**
Community Benefits Spending			
Total Community Benefits	**$52,154,840**	**$13,886,878**	**$66,041,718**
Medicare	$3,210,157		$3,210,157
Total Community Benefits with Medicare	**$55,364,997**	**$13,886,878**	**$69,251,875**

Hospital Board and Committee Rosters

First Name	Last Name	Board Title	Occupation
Jill	Welton	Ex Officio - Market President	Market President, Southern California
Douglas	Kleam	Ex Officio - Hospital President	President, St. Bernardine Medical Center
June	Collison	Ex Officio - Hospital President	President, Community Hospital of San Bernardino
Betty	Daniels, MD	Ex Officio - Chief of Staff	Chief of Staff, Community Hospital of San Bernardino
Samir	Kubba, MD	Ex Officio - Chief of Staff	Chief of Staff, Community Hospital of St. Bernardine Medical Center
Tony	Myrell	Chair	Owner, Premier Medical Transportation
Dan	Munoz	Vice Chair	Deputy Executive Director, Inland Counties Emergency Medical Agency
Julie	Bearie	Secretary	Vice President, SoCal Emergency Medicine Urgent Care Centers
Andrew	Cutler	Member	Accounting Partner
Claudia	Davis, PhD	Member	Professor, California State University, San Bernardino
Johnny	Negusse, MD	Member	Physician, Community Hospital of San Bernardino

Wilfrid (Bill)	Lemann	Member	Chair, Fullerton, Lemann, Schaefer & Dominick LLP
Craig	Nelson	Member	Retired, Ethicist Kaiser Permanente