St. Bernardine Medical Center

2025 Community Health Implementation Strategy and Plan

Adopted October 2025

Dignity Health.
A member of CommonSpirit

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At-a-Glance Summary

Community Served 	Dignity Health – St. Bernardine Medical Center is located at 2101 N Waterman Ave, San Bernardino, CA 92404. 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.
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 the hospital intends to address with 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
Strategies and Programs to Address Needs 	The hospital intends to take several actions and dedicate resources to these needs, including: <u>Access to Health Care</u> Baby & Family Center Family Focus Center Community Health Education Community Health Navigator Emergency Department Syphilis/HIV/HCV Screening Program (EDSP) Financial assistance Graduate Medical Education Community Health Improvement Grants Program Substance Use Navigator Program Transitional Care Clinic <u>Behavioral Health (Mental Health and Substance Use)</u> Community Health Navigator Community Health Improvement Grants Program Substance Use Navigator Program <u>Chronic Diseases, including Overweight and Obesity</u> Community Health Education Community Health Improvement Grants Program Emergency Department Syphilis/HIV/HCV Screening Program (EDSP)

Replate Program
Transitional Care Clinic
Support groups

Housing and Homelessness
Community Health Navigator
Community Health Improvement Grants Program
Financial Assistance (Transportation/ vouchers for the unhoused)

Preventive Practices
Community health education
Community Health Improvement Grants Program
Emergency Department Syphilis/HIV/HCV Screening Program (EDSP)
Eye Clinic
Family Focus Center
Substance Use Navigator Program
Transitional Care Clinic
Vaccines

Safety and Violence Prevention
Community Health Improvement Grants Program
Family Focus Center
Violence and Human Trafficking Prevention and Response

Sexually Transmitted Infections (e.g. HIV)
Community Health Education
Emergency Department Syphilis/HIV/HCV Screening Program (EDSP)
Transitional Care Clinic

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the “Strategies and Program Activities by Health Need” section of the document.

This document is publicly available online at the hospital’s website. Written comments on this strategy and plan can be submitted by e-mail to Christian.Starks@CommonSpirit.org.

Our Hospital and the Community Served

About the Hospital

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.

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Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

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.

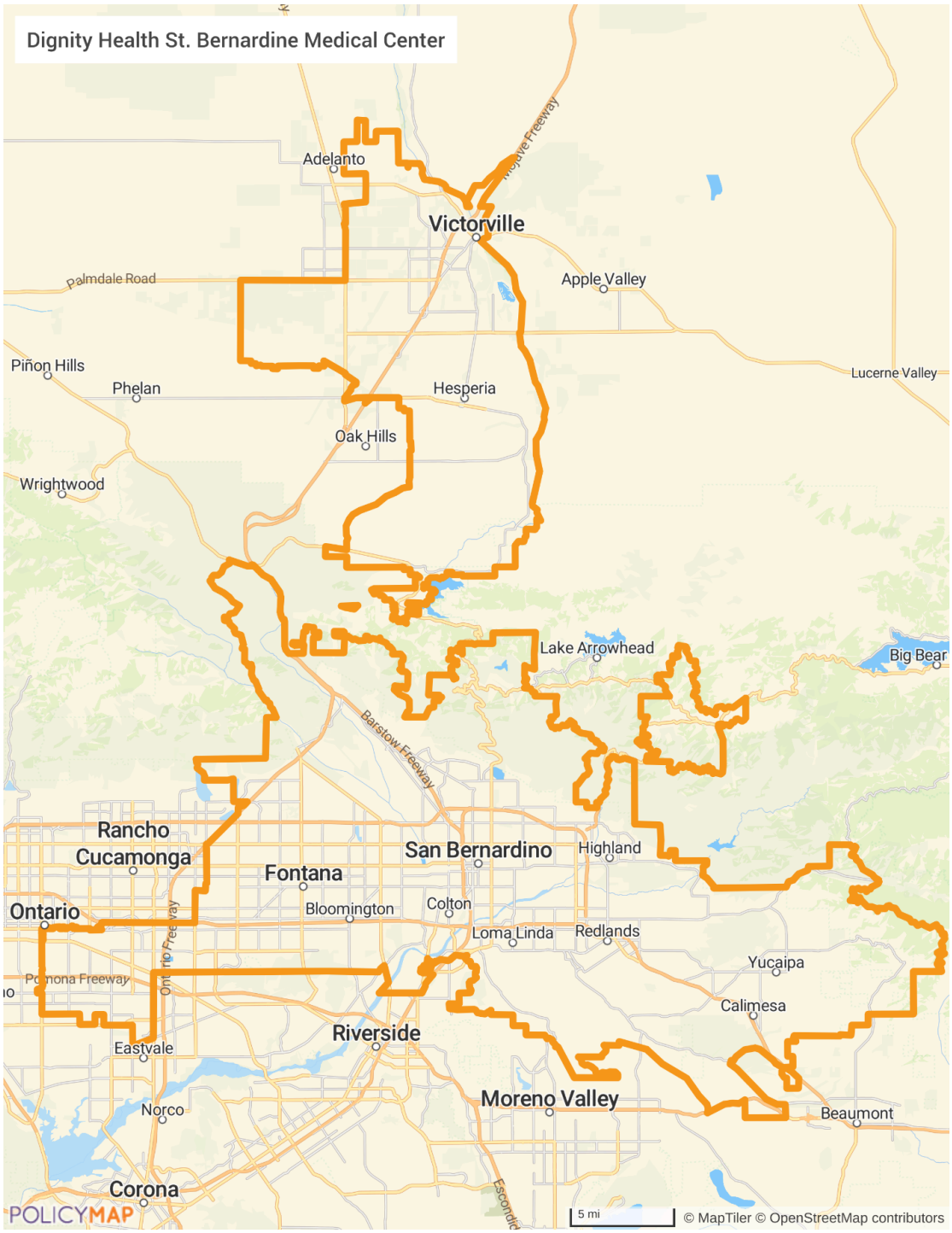
Description of the Community Served

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.

Hospital Service Area Map



Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in June of 2025. The CHNA contains several key elements, including:

- Description of the community assessed consistent with the hospital's service area;
- Description of the assessment process and methods;
- Data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

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 or health care services, and also health-related social and community 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 (SBMC) service area's population has health insurance coverage which is lower than the Healthy People 2030 objective and lower than the County and State rates of insured. Certain communities in the service area are far below these insurance coverage rates, especially parts of Fontana and San Bernardino. When examined by race and ethnicity, Hispanic and other race adults are the least insured. Less patients are seeking care at local and regional FQHCs than previously. A third of adults do not have dental insurance.	X
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. The rate of low-birth-weight babies is higher in the hospital's service area than in the county and the state. And the rate of premature birth in the service area, occurring before the start of the 38th week of gestation is higher than the county rate and the state rate of premature birth. Additionally, the hospital service area's	X

Significant Health Need	Description	Intend to Address?
	breastfeeding rates are lower than both the county and the state.	
Chronic Diseases	SBMC's service area has high rates of stroke deaths, cancer deaths for all cancers, and mortality due to diabetes, liver disease and kidney disease. More people in the service area are hospitalized for diabetes, heart failure and hypertension, compared to California. Asthma is more prevalent in adults in SBMC's service area than in the county and in California. More seniors in SBMC's service area are living with disability, compared to the county and California	X
Environmental Health	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. Most of the populated Census tracts in the service area belong to the highest-burdened level of environment hazards.	
Food Insecurity	The US Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods. 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
Housing & Homelessness	40.7% of 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. Over 70% of the 4,000+ unhoused individuals in San Bernardino County 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. 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	X

Significant Health Need	Description	Intend to Address?
	California. San Bernardino County has less mental health providers per person, as compared to California.	
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, which are higher than state rates.	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. 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. 55% of service area residents, aged 50-75, met the colorectal cancer screening guidelines.	X
Sexually Transmitted Infections (e.g. HIV)	Common STIs include syphilis, gonorrhea, and chlamydia. STI cases and rates show a mostly downward trend. Rates for Chlamydia, Gonorrhea and Syphilis are highest for Black or African American residents. Also, the rate of new HIV cases in San Bernardino County was higher than the new case rate statewide.	X
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 people.	X

Significant Health 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 Health 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.

Environmental factors, including air quality, water safety, and exposure to pollutants, significantly influence community well-being. Addressing these issues requires policy-level interventions and environmental management efforts that extend beyond the hospital's core mission and capacity.

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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 Implementation Strategy

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

Existing programs, systems, staff and support resources were assessed by the hospital to determine the significant health needs SBMC will address in the Implementation Strategy. Key participants in developing the Implementation Strategy included representatives from:

Community Health
Nurses
Mission Services
Quality
Clinicians
Health Equity
Social Work
Care Coordination

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.

Programs were prioritized according to the following criteria:

- Established Relationships: The hospital has long-standing established relationships in the community to address the issue.
- Ongoing Investment: Resources are committed to this issue and show long-term impact in the community.
- Institutional Priority: The hospital has acknowledged competencies and expertise to address the issue; and the issue is aligned with the hospital's mission.

Community Health Core Strategies

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

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs.

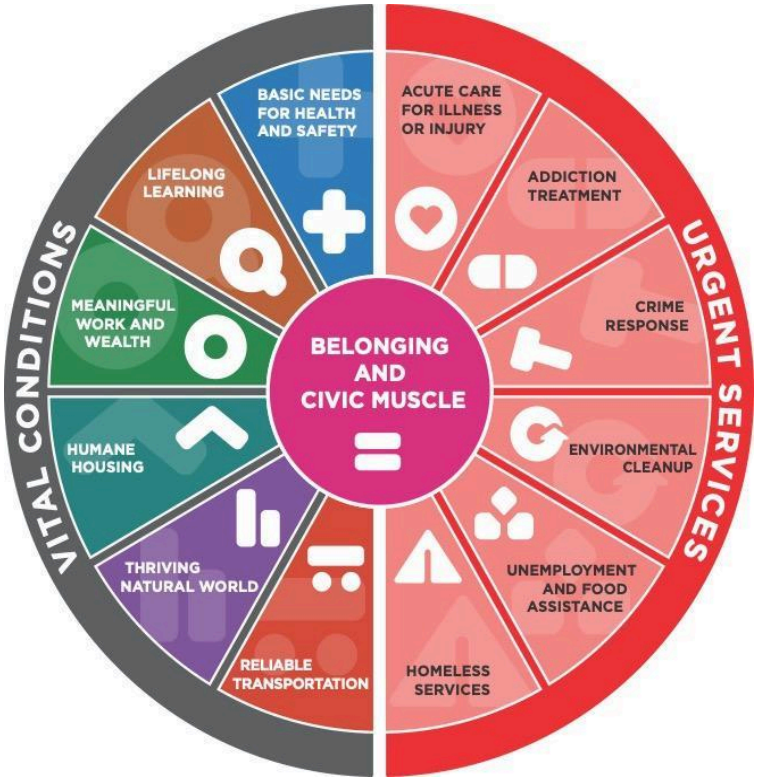
Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.



Well-Being Portfolio in this Strategy and Plan

The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

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 Program	Offers grants to nonprofit community organizations that provide health care access programs and services.	●		●	VC: Basic Needs for Health and 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

Health Need:	Access to Care				
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 home and provides connections to local social service agencies.	●	●	●	VC: Basic Needs for 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				

Health Need:	Access to Care
	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 Program	Offers grants to nonprofit community organizations that provide mental health and substance use programs and services.	●	●	●	VC
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to behavioral health	●	●	●	VC

Health Need:	Behavioral Health Services (Mental Health and Substance Use)				
	service agencies.				
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 psychoeducation.	●	●		VC
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	●	●		VC

Health Need:	Chronic Diseases (including Overweight and Obesity)				
	secure a medical home and provides connections to local social service agencies.				
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)**
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	Offers grants to nonprofit community		●	●	VC

Health Need:	Housing and Homelessness				
Improvement Grants Program	organizations that provide housing and homelessness programs and services.				
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 navigators to identify patients who would benefit from initiating medication for addiction treatment (MAT) or mental health services.	●	●		VC

Health Need:	Preventive Practices				
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	Vulnerable Populations and Broader Community

Health Need:	Safety and Violence				
Focus:					
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

Program Highlights

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

Baby and Family Center	
Significant Health Needs Addressed	• Access to Care • Preventive Practice • 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 FY25.
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 related programming expenses in FY25.
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.

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.

Family Focus Center	
Significant Health Needs Addressed	• Access to Care • Preventative Practice • Safety and Violence
Program Description	The Family Focus Center (FFC) functions as a drop-in after-school program, directly addressing the needs of at-risk youth and young adults in our community. Situated within walking distance of San Bernardino High School and Arrowview Middle School, the FFC offers a diverse range of services, from violence prevention and career development to fundamental character-building activities. Beyond cultivating essential life skills, all attending youth are provided with a warm meal, underscoring the hospital's approach to community well-being.
Population Served	At-risk youth and young adults in the city of San Bernardino.
Program Goal / Anticipated Impact	Specific Indicators: • 100% of participating FFC youth will be offered a nutritious meal daily, contributing to a measurable reduction in food insecurity within the served population. (Addressing Food Insecurity) • By the end of FY25, at least 80% of FFC participants will self-report improved feelings of safety, social connection, and engagement in healthy activities. (Addressing Behavioral Health, Preventative Practices, Access to Care) • By the end of FY25, participation in structured recreational activities, such as Late Night Hoop sessions, will increase by at least 15%, demonstrating enhanced engagement in positive youth development and preventative practices. (Addressing Preventative Practices, Behavioral Health)
FY 2025 Report	
Activities Summary	Principal program activities conducted in FY25 included:

	• Operating the Family Focus Center as a daily after-school and community hub, offering a variety of skill-building workshops and engaging activities. • Providing a nutritious meal daily to all youth attending the center. • Hosting structured evening recreational programs, specifically the Late Night Hoop sessions.
Performance / Impact	A total of 4,654 unduplicated youth attended Family Focus Center. That is a 134% increase in attendance compared to previous fiscal year. All 4,654 participating youth were provided with a nutritious meal, directly addressing food insecurity and supporting their overall well-being. A total of 93 youth attended the Late Night Hoop sessions offering safe and supervised evening recreational opportunities. These programs together foster a supportive environment, promoting physical activity, safety, mental well-being, and community engagement for youth and young adults.
Hospital's Contribution / Program Expense	$624,237 was expended in program-related costs, including dedicated facility space, staffing, and direct expenses for activities and resources benefitting FFC participants.
FY 2026 Plan	
Program Goal / Anticipated Impact	To empower at-risk youth and young adults by fostering resilience, promoting well-being, and equipping them with essential life skills, career awareness, and access to supportive resources within a safe, nurturing after-school and community environment. • Improve mental health support and increased access to vital services for at-risk youth and young adults. ○ The Mental Health Resource Specialist will facilitate a minimum of 15 unique mental health referrals for at-risk youth and young adults in FY26.

	● Increase awareness and viable pathways into healthcare careers for at-risk youth and young adults. ○ Host one healthcare career fair in FY26 with attendance of a minimum of 50 attendees. ● Empower at-risk youth and young adults with reduced vulnerability to substance abuse and strengthened coping mechanisms. ○ Substance Use Navigator will host 5 workshops and 50% of participants will demonstrate increased knowledge of substance abuse impacts and positive coping skills. ● The Family Focus Center will maintain an average daily attendance of 40 at-risk youth/young adults. ● Late Night Hoop sessions will engage 25 unique participants per session, ● 100% of attending youth will be offered a nutritious meal daily.
Planned Activities	Principal program activities planned for FY26 include: ● Mental Health Resource Specialist LCSW will assist with mental health referrals. (Addressing Behavioral Health and Access to Care) ● Conducting a career resource fair at our Hospital facility to explore healthcare careers. (Addressing workforce development) ● Host youth wellness workshops aimed to educate on the negative impacts of alcohol and drug use and help develop life skills for positive coping with stress and trauma. (Addressing Substance Use & Mental Health) Note: We will also continue to operate the Family Focus Center as a daily after-school and community hub, provide a nutritious meal daily to all youth attending the center, and host structured evening recreational programs, specifically the Late Night Hoop sessions.