Dignity Health.
St. Bernardine Medical Center

St. Bernardine Medical Center
2014 Community Health Needs Assessment & Implementation Strategy

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St. Bernardine Medical Center

2014 Community Health Needs Assessment Summary

St. Bernardine Medical Center (SBMC) is a 463-bed, nonprofit hospital that serves San Bernardino County, California. The hospital is a member of Dignity Health, the fifth largest hospital provider in the nation and the largest hospital system in California. We have a culture based on a strong set of core values, driven by a mission of service, and expressed through compassion and care of body, mind and spirit.

St. Bernardine Medical Center has undertaken a Community Health Needs Assessment as required by California law. As well, the passage of the Patient Protection and Affordable Care Act requires tax exempt hospitals to conduct Community Health Needs Assessments and develop Implementation Strategies every three years.

The Community Health Needs Assessment is a tool used by SBMC to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other community services to address unmet community health needs. The assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the service area.

The complete Community Health Needs Assessment can be accessed from the hospital website: www.SBMCOutreach.org.

Description of Community Served by the Hospital

St. Bernardine Medical Center serves a broad and diverse population in multiple zip codes. The service area encompasses 27 zip codes representing 15 cities.

Banning	92220	Redlands	92373
Beaumont	92223	Redlands	92374
Bloomington	92316	Rialto	92376
Colton	92324	Rialto	92377
Crestline	92325	San Bernardino	92401
Fontana	92335	San Bernardino	92404
Fontana	92336	San Bernardino	92405
Fontana	92337	San Bernardino	92407
Hemet	92543	San Bernardino	92408
Hemet	92544	San Bernardino	92410
Hemet	92545	San Bernardino	92411
Hesperia	92345	Victorville	92392
Highland	92346	Yucaipa	92399
Rancho Cucamonga	91730		

The following reflect demographics for the primary service area:

- Population: 1,231,262 (*U.S. 2010 Census)*
- Diversity: Hispanic (53.1%), White (30.5%), Black or African American (9.1%), Asian/Pacific Islander (4.6%), all others (2.7%) (*U.S. 2010 Census)*
- Average Household Income: $51,844 (*U.S. Bureau of the Census, 2000 Census and 2008-2012 ACS 5-year average)*
- Uninsured Adults: 25.7% (*California Health Interview Survey, 2011-2012)*
- Unemployment: 12.7% (*California Employment Development Department, Labor Market Information Division)*
- No High School Diploma: 24.8% (*U.S. Bureau of the Census, 2008-2012 ACS 5-year average)*
- Renters: 34.2% *(U.S. Census, 2000 and 2010)*
- CNI Average Score: 4.3 *(Dignity Health)*
- Medi-Cal Patients (ages 0-17): 43.5% (*California Health Interview Survey, 2011-2012)*

The Community Need Index (CNI) is a tool developed by Dignity Health to measure community need in a specific geography through analyzing the degree to which a community has the following health care access barriers: 1) Income Barriers, 2) Educational Barriers, 3) Language and Cultural Barriers, 4) Insurance Barriers and 5) Housing Barriers. Communities with scores of "5" are more than twice as likely to utilize inpatient care for preventable conditions as communities with a score of "1". The average CNI score of the hospital's service area is **4.3** with six (6) of the zip code communities scoring a "5". Many of the neighborhoods served have been federally designated as a Medically Underserved Area (MUA).

Poverty rates paint an important picture of the population within the SBMC Service Area. The data indicate that within the SBMC Service Area, from 7.5% to 48.5% of the population live at or below 100% of the Federal Poverty Level. Many of the neighborhoods served by SBMC have more than half of the residents living at or below 200% of the Federal Poverty Level. In San Bernardino 92401, 88.5% of the population is at this level of poverty, followed by San Bernardino 92411 (72.5%), San Bernardino 92410 (71.0%), and Hemet 92543 (65.7%). Almost a third (30.7%) of all families in the county that have a female Head of Household, live in poverty.

Education is a key determinant of health. Of the population age 25 and over, 24.8% have less than a high school diploma. For 27% of area adults, high school graduation was their highest level of educational attainment.

Who was Involved in Assessment

In FY14 St. Bernardine Medical Center (SBMC), in collaboration with Community Hospital of San Bernardino (CHSB), conducted a Community Health Needs Assessment. Melissa Biel of Biel Consulting, Inc. conducted the Community Health Needs Assessment. She was joined by Deborah Silver, MS. Biel Consulting, Inc. is an independent consulting firm that works with hospitals, clinics and community-based nonprofit organizations. Dr. Biel and Ms. Silver have extensive experience conducting hospital Community Health Needs Assessments and working with hospitals on developing, implementing, and evaluating community benefit programs.

How the Assessment was Conducted

The assessment incorporated:

Primary Data Collection

- Twenty targeted interviews were conducted to gather information and opinions from persons who represent the broad interests of the community served by the hospital. Interview participants included leaders and representatives of medically underserved, low-income, and minority populations, as well as the local health department that has "current data or information relevant to the health needs of the community served by the hospital facility," per IRS requirements. The interviews took into account input from a broad range of persons located in or serving its community including: health care consumers, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers. A list of the stakeholder interview respondents, including their titles and organizations can be found in Appendix 1.
- Six focus groups (four in English and two in Spanish) were conducted with 54 area residents who represent medically underserved, low-income and minority populations in the service area. A list of the focus groups can be found in Appendix 2.

Secondary Data

- Data were obtained from a variety of local, county, and state sources to present a community profile, birth indicators, leading causes of death, access to care, chronic disease, communicable disease, health behaviors, social issues, and school and student characteristics.
- When available, data were provided by zip code, county and state to frame the scope of the issues as related to the broader community.
- Benchmark data compared SBMC community data findings with Healthy People 2020 objectives.

Overview of Key Findings and Community Needs

This overview summarizes significant findings drawn from an analysis of the data from each section of the Community Health Needs Assessment report. Complete data descriptions, findings, and data sources are available in the full report, which can be found at www.SBMCOutreach.org.

Community Profile

The population in the SBMC service area was 1,231,262 at the time of the 2010 Census.

Population by Age

Children and youth, ages 0-19, make up one-third (33.7%) of the population; 34.5% are 20-44 years of age; 22% are 45-64; and 9.7% of the population are seniors, 65 years of age and older.

Population by Race and Ethnicity

Over half the population in the SBMC service area (53.1%) is Hispanic or Latino, and 30.5% of the population is White. Blacks or African Americans make up 9.1% of the population in the SBMC service area, while Asians/Pacific Islanders are 4.6% of the population. In the SBMC service area there is a higher percentage of Hispanics/Latinos and a lower percentage of Whites and Asians/Pacific Islanders than found in the county and the state. The percentage of the population that is Black/African American is higher than for the county as a whole, but lower than the state.

Unemployment

Within the service area unemployment had risen to 16.2% in 2010; by 2012 it had dropped to 12.7%. Areas with the highest unemployment were San Bernardino (16.0%) and Bloomington (15.9%). Redlands (8.8%) and Rancho Cucamonga (7.8%) had the lowest unemployment rates.

Poverty

Many of the neighborhoods served by SBMC have more than half of the residents living at or below 200% of the Federal Poverty Level. In San Bernardino 92401, 88.5% of the population is at this level of poverty, followed by San Bernardino 92411 (72.5%), San Bernardino 92410 (71.0%), and Hemet 92543 (65.7%).

Households and Household Income

There are more than 360,000 households in the SBMC service area. From 2000 to 2010 the number of households increased 10.3%. Average household income for the area was $38,609 in 2000, increasing to $51,844 in 2010 for a 34.3% increase in household income; however, these numbers are not adjusted for inflation, and do not mean an increase of 34.3% in household purchasing power. The

service area lags behind the county in median household income.

Education

Of the population age 25 and over, 24.8% have less than a high school diploma; this is a higher incompletion rate than the county (22.0%) or state (19.0%). For 27% of area adults, high school graduation was their highest level of educational attainment.

Language

In the SBMC service area, English and Spanish are the two most frequently spoken languages. Fontana 92335 (69.9%), Bloomington (64.3%), and San Bernardino 92410 (60.7%) have high percentages of Spanish speakers. In San Bernardino 92408, 11.2% of the population speaks an Asian language in their homes.

Homelessness

72% of the 2,321 homeless individuals counted in San Bernardino County in 2013 were found to be in the SBMC Service Area, with most (908 homeless) located in San Bernardino City.

Crime

Crime, including violent crime, has been on a decline in San Bernardino County as well as California. In 2010, there were 31 crimes per 1,000 residents in San Bernardino County, down from 36 per 1,000 in 2006. Since 2007, however, the rate of crime has been higher in the county than the state, and the rate of violent crime has also been slightly higher.

Birth Characteristics

In 2011, there were 19,547 births in the area. The rate of births has decreased by approximately 13.2% since 2007. The majority of births (62.6%) were to mothers who are Hispanic or Latino; 21.4% of births were to Whites, and 9.2% of births were to Blacks/African Americans.

Teen Births

Teen birth rates occurred at a three-year average rate of 121.6 per 1,000 births (or 12.2% of total births). This rate is higher than the teen birth rate found in the state.

Birth Indicators

The birth indicators within the SBMC service area compare favorably to the Healthy People 2020 objectives:

- Among pregnant women, 81.6% obtain prenatal care as recommended in the first trimester.
- Low birth weight babies (less than 2500 g) are 7.1% of live births.
- In the service area, the infant death rate is 6.7 per 1,000 live births.
- 86.1% of new mothers giving birth at SBMC breastfeed their infants.

Leading Causes of Death

The three leading causes of death are heart disease, cancer and lung disease. The heart disease and stroke death rates in the SBMC service area exceed the Healthy People 2020 objective.

Access to Health Care

Health Insurance

Among the adult population, ages 18-64, 74.3% have health insurance and 97.7% of children, ages 0-17, are insured. Among the residents of San Bernardino County, 84.2% indicate they have a usual source of care.

Delayed Medical Care

Overall, 11.2% of the population of San Bernardino County delayed or did not get needed medical care. When examined by age group, adults, ages 18-64, delay care at much higher rates than children or seniors. This may be a result of higher rates of health insurance for children and seniors. Poverty level residents also have higher rates of delaying access to medical care.

Dental Care

Among children 3-11, and 2-year-olds with teeth, 12.3% had never been to a dentist, and the main reason that all 2-11 year olds had not seen a dentist in the past year was due to affordability and lack of insurance. These were both higher than the state rates. San Bernardino County teens, 12-19, were seeing the dentist at a higher rate than their California counterparts, and when they hadn't seen a dentist in the past year it was less likely to have been primarily due to cost.

Chronic Disease

The residents of San Bernardino County have higher rates of diabetes and hypertension than found in the state. Almost one-third of adults (32.2%) have hypertension; of these, 67.8% take medication for their hypertension.

13.8% of adults in San Bernardino County have been diagnosed with asthma. Of these, 88.9% had symptoms related to asthma in the past 12 months and 18.6% accessed an ER or Urgent Care because of asthma symptoms. Among children 0-17 in San Bernardino County, 21.4% were reported to have been diagnosed with asthma, which is an increase from previous years, and higher than the state level.

Among adults in San Bernardino County, 10.6% of the population has been diagnosed with diabetes; this is higher than the state rate of 8.4%. Of those with diabetes, 10.9% have Type I diabetes and 83% have Type II diabetes. Among Latinos, 14% have been diagnosed with diabetes, the highest of all ethnic groups in the area, and higher than

Latinos in California in general.

Cancer

The cancer incidence rate in San Bernardino County is 425.8 cases per 100,000 persons; this is lower than the state rate of 435.4 per 100,000 persons. When compared to state cancer incidence rates, San Bernardino County has higher rates of prostate, lung and bronchus cancer, colorectal cancer, cervical cancer and esophageal cancer.

Communicable Disease

Tuberculosis

The rates of TB have risen slightly in San Bernardino County from 2011 to 2012. The rates in the county are lower than the rate of TB in the state.

HIV/AIDS

San Bernardino County has 1,620 total cases of HIV, making it the 7th among counties in the State based on number of diagnosed HIV cases. It is 9th in the State among Counties with 4,359 diagnosed AIDS cases.

Sexually Transmitted Diseases

San Bernardino County has higher rates of Chlamydia and Gonorrhea than compared to the state. Females have the highest rates of Chlamydia and Gonorrhea. Young adults, ages 20-24, and Blacks/African Americans have the highest rates of sexually transmitted infections.

Health Behaviors

Preventive Practices

In San Bernardino County, 62.8% of seniors have obtained a flu shot; 23.8% of adults, age 50 and over, have been screened for colorectal cancer. Among adult women, 90.8% received a Pap smear in the last three years, and 78.3% of women, 40 years and over, received a mammogram in the last two years. The rate of engaging in these health prevention activities is at a rate below Healthy People 2020 objectives.

Overweight and Obesity

In San Bernardino County, 35.9% of adults are overweight and 33.2% are obese. These percentages equate to over two-thirds of the adult population (69.1%) being overweight or obese. Youth in San Bernardino also have high rates of obesity, although they are lower than statewide levels – 15.6% are considered overweight or obese (Body Mass Index in the top 5th percentile), with an additional 13.1% considered 'at risk of overweight', with Body Mass Indexes in the 85th – 95th percentiles.

In addition, 15.6% of children 0 to 11 are considered overweight for their age (a measurement which does not factor in height). This is higher than at the state level, and has been trending up dramatically

over the past 7 years.

Smoking

Smoking continues to be a leading cause of preventable death in the United States. Among adults in San Bernardino County, 14.5% are current smokers and 21.2% are former smokers. The rate of smoking indicates that 35.1% of adults smoke 6-10 cigarettes a day and 22.7% smoke 20 or more a day.

Social Issues

In San Bernardino County, 39% of children consumed fast food twice or more in a week; 48.5% of adults consumed fast food two or more times a week. Over one-quarter of teens (29.5%) consume two or more sodas or sweetened drinks a day; 57.8% of children and 15.7% of teens consume five or more fruits and vegetables a day.

Mental Health

Among adults, 7.5% experienced some type of psychological distress in the past year; 13.9% needed help for a mental health problem; 11.9% of adults saw a health care provider for mental health or drug/alcohol related issues, 11.5% have taken medicine for more than two weeks for mental health issues. A large percentage of adults (42.9%) who needed help for an emotional or mental health problem did not receive treatment.

Alcohol Use

In the county, 30.7% of teens had consumed alcohol; and 29.6% of adults had engaged in binge drinking in the past year. Binge drinking is measured as consuming a certain amount of alcohol in a designated period of time. For males this is five or more drinks per occasion and for females four or more drinks per occasion.

Student and School Characteristics

The number of students eligible for the free and reduced price meal program is one indicator of the socioeconomic status of a school district's student population. The majority of students in the San Bernardino City Unified School District (SBCU) were eligible for the free or reduced price lunch program (91.5%), indicating a high level of low income families. Testing for student proficiency indicates that 41.5% of students in all grades tested are proficient in language arts, and almost half (49.5%) in math. The high school graduation rate is 73.5 and 17.2% of graduates are UC/CSU ready.

Community Stakeholder Interview Findings

The biggest issues and concerns in the community were identified as:

- The economy, including high rates of unemployment, underemployment, lack of jobs, low median income and large number of low-wage jobs.

- High rates of poverty and related issues, such as lack of access to health care and limited access to other services, poor education levels, lack of affordable housing, focus on meeting basic needs (e.g., food, shelter, clothing), inability to purchase healthier food or gym memberships for exercise, poor life skills, and chronic stress.
- Poor health outcomes, including high rates of cardiovascular disease, diabetes and obesity. Reasons given for poor health status included high poverty rates, shortage of affordable health care resources for primary care, safety concerns that prevent outdoor exercise, lack of access to healthy and affordable food (i.e., a food desert), air quality, smoking rates, chronic stress, lack of understanding of how to navigate the system and access available resources, large numbers of poor and undocumented people in the area who do not qualify for health coverage, under-resourced health department and distance to Arrowhead Regional Medical Center in Rialto.
- High crime rates and lack of public safety, including thefts and violent crime, resulting in fear among residents.
- Poor education levels and limited educational opportunities.
- Lack of affordable housing.
- Unsettled city government (i.e., City Council and Mayor) that is struggling to address current needs and issues.
- Perceived lack of voice/empowerment among Latino population to organize, to advocate for their issues and concerns, and to effect policy change.
- Lack of funding to the community from local and statewide foundations.

Problems in Obtaining Health Care and Other Health/Social Services

Interview respondents were asked about the problems and challenges children and families face in accessing health care and mental health services. Several interviewees expressed uncertainty about how implementation of the ACA will ultimately impact access and whether it will improve access over time. The most frequently identified challenges in obtaining primary care were identified as:

- Transportation to services for people without cars or who lack appropriate transportation, including cost of the bus system, needing multiple bus lines to get to services, families covered under different insurance plans requiring them to go to multiple providers, and distance to services for people living in the High Desert or for people who need specialty care services outside San Bernardino.
- Cultural and immigration issues, including language barriers, fear of accessing services associated with lack of documentation, ineligibility for Medi-Cal coverage due to being undocumented, people not being treated with respect and lack of cultural competency among health care professionals.
- Shortage of low-cost, affordable primary care providers and

community clinics to meet the needs of the population. It was noted that San Bernardino has been designated a Medically Underserved Area; i.e., there is an insufficient number of health care providers to meet the demand of the population.

- Lack of insurance or ability to pay for insurance.
- Challenges in navigating the health care system, understanding coverage (who, what, where) or knowing how to access care and use coverage.

Additional challenges included:

- Family members on multiple plans, creating hardships for families needing to go to different providers in different locations with different paperwork requirements.
- Lack of education or understanding about the importance of prevention, resulting in people not accessing care until health problems are emergent, and then only accessing the emergency room.
- Continued use of the emergency room for primary care and non-emergent health needs. Lack of education about the appropriate place to access care depending on the health problem.
- Lack of priority on health care for families struggling to meet basic needs.
- Lack of hospitals that offer specialized services in San Bernardino, requiring people to travel outside the area for some specialty care.
- Long wait times for appointments at Arrowhead Regional Medical Center.
- Limited clinic hours, with most open when people are at work or kids are at school.
- Needs among veterans in the area that are not being adequately met.

The primary difficulty identified to access mental health services was the shortage of mental health providers and facilities for counseling, treatment and medication. A particular need was identified for counseling services, as the County's Behavioral Health Department is more focused on people with serious mental illness or who are suicidal. It was noted that, "lower level counseling services are pretty much unavailable… there's a huge, gaping hole in these services" and that, "most families don't need psychiatric services, but could use basic counseling services related to stress and to help prevent domestic violence, child abuse, etc." Several mental health service providers have closed down due to lack of funding.

Other barriers to accessing mental health services were identified as:

- Transportation.
- Cultural/immigration issues, including the stigma associated with needing or accessing mental health services among the Latino population and the need for bilingual and bicultural providers.
- Restrictions to the mental health services covered under Medi-Cal

and other private insurance and that attempting to use these benefits is cumbersome.

- People are unaware they have a mental health condition that could benefit from services as they do not have a regular primary care provider who could make the diagnosis and refer for further treatment and care provided in the emergency room does not look to identify other needs among patients beyond the presenting problem.

Barriers to Accessing Healthy Foods and Improving Healthy Eating Habits

Interview participants were asked to share the barriers that people face in accessing healthy foods and improving healthy eating habits. The primary barriers were identified as:

- Lack of grocery stores in the western part of the city of San Bernardino (i.e., a food desert), creating transportation barriers for people without cars. People need to either carry groceries on the bus, or walk, or not buy food at grocery stores.
- Prevalence of fast food outlets, liquor stores and convenience stores, where it is difficult to find and purchase affordable fresh, healthy food.
- Fresh produce and organic foods are expensive as well as not easy to locate in lower-income neighborhoods. There are few if any stores geared towards providing healthier foods at affordable prices (e.g., Trader Joe's, Sprouts, Fresh 'n Easy).
- Fast food is more convenient and affordable for those trying to stretch food stamps or limited dollars to feed a whole family and who are working multiple jobs with limited time to shop and prepare healthy meals, or who are living in hectic and chaotic households.
    - One interviewee characterized the appeal of fast food establishments as follows: "The kids get a toy and get to play and are happy, the family spends less money than if they bought and prepared food, the place has air conditioning, everyone eats and gets full, and there are no dishes to wash."
    - Another interviewee said that parents "Take the simple route and don't take time to plan and prepare healthy meals. They want the quick fix and offer what is quick and easy, such as potato chips, sugary cereals, candy, pizza, fast food, hot dogs, macaroni & cheese, etc."

Community and School Safety Issues

Interview participants were asked to share the community and school safety issues that people in the community are facing. One interviewee said there is a "culture of violent crime in the area" and that much of the crime goes unreported, as people are "afraid of retaliation." Several participants indicated that the generally high crime rate in the area,

including significant gang and drug involvement, is related to the high rates of unemployment and poverty, leaving people with too much idle and time and creating desperation for income. Several interviewees commented on the fact that kids living in the more impoverished areas are being exposed to and witnessing considerable violence in their homes and on the streets, and that in some cases parents are using alcohol or drugs or are gang members themselves, leaving kids to basically raise themselves. It was additionally noted that many kids are left home alone, as child care is very expensive. The most frequently identified community and school safety issues were identified to include:

- Gang involvement.
- Drug use and trafficking.
- Bullying.
- Prostitution and human trafficking.
- Lack of sidewalks and lighting that compromises pedestrian safety for kids walking to school, or for people walking in their neighborhood.
- Inability for children to play or walk outside due to fear of violence. Sometimes kids have to cross gang territories to get to school, putting them at risk.
- Weapons on school grounds.
- Large number of registered sex offenders living in the county.
- Ex-felons being released into the area with nowhere to live and without resources to assist them in their re-entry process, putting them at higher risk for recidivism.
- Graffiti and trash.
- Lack of confidence in the police due to extremely slow response times; often, there are so many burglaries that they are unable to respond in a timely way.
- Sexting and negative use of social media.
- Increases in elder abuse by their own families.
- Fear associated with random acts of violence that happen frequently in the city.

Community Focus Group Findings

The community issues most frequently identified were:

- Poverty and joblessness, including overall downturn in economy, unemployment, loss of jobs and homes, lack of jobs for the unemployed, mostly part-time work without insurance benefits, homelessness and low-wage jobs (i.e., “wages not sufficient to survive”).
- Concerns about education, including dropouts, a poor school system, and lack of understanding about the importance of education.
- Cultural and immigration issues expressed by participants in the Spanish-language groups, including losing ties to culture, discrimination against Latinos, deportations, and people without

papers/lack of documentation.
- Family stress, including kids raising kids because parents are on drugs and a disproportionate burden on women.
- Crime and drug issues, such as gang activity, car theft, public drug abuse and sales, prostitution, violence and graffiti.
- Lack of activities for youth.
- Lack of awareness of available community resources.
- Infrastructure concerns, such as potholes that cause flooding when it rains, uneven sidewalks, and lack of sidewalks.
- Lack of support for ex-felons who get dumped into the streets, and so are likely to act out again.
- Transportation.

The biggest health concerns for people and their families were identified:

- Chronic diseases, such as asthma, cancer, diabetes, obesity among children and adults, high blood pressure and high cholesterol.
- Depression and stress.
- Hunger.
- Dental problems and difficulty accessing dental care.
- Alcoholism and drug dependency.
- Presence of liquor stores on every corner and a lot of alcohol advertisements.
- Lack of health insurance.
- Homeless who are required to leave the shelter during daytime hours and fend for themselves on the street, sometimes in extreme temperatures.
- Lack of money to buy medications or pay for medication co-pays.
- Long waits for specialty care services.

Access to Care

Focus group participants were also asked about the problems or challenges they face obtaining needed health care and mental health services. Their responses included:

- Long wait times at clinics, in emergency rooms, and at the Department of Behavioral Health.
- Cost issues, including:
    - High cost of health care services and medications.
    - Income too much to qualify for Medi-Cal, but cost of care too expensive.
    - Hospitals overcharge for services.
    - Co-pays and deductibles for services and medications are too high.
- Immigration issues, including:
    - Fear among undocumented workers of accessing services.
    - Inability to access insurance due to immigration status.

- Limited access issues, including:
    - Inability to access dental services under Medi-Cal over age 18.
    - Insurance coverage is often limited and excludes some medications.
    - Veterans have limited access to their doctors due to overextended caseloads, and are only able to see their primary care physician once every six months. Veterans are also required to access VA services at Loma Linda, and will not be seen at local hospitals.
- Poor treatment by health professionals, including:
    - Rude workers and being "treated terribly."
    - Doctors and nurses are impersonal and have poor relationships with patients.
    - Lack of cultural proficiency among health professionals.
    - Stereotyping and profiling reported by the homeless participants, including (a) getting less service than other people; (b) only getting generic medications; and (c) assumption that they are all addicts.
- Transportation issues, including:
    - Distance of walk to bus stop can be prohibitive depending on weather or physical condition of person.
    - Cost of using the bus can be prohibitive (some participants said they can only use the bus if they have a voucher).
    - Referrals from Arrowhead Regional Medical Center to multiple places for tests and services.
- Poor quality services at Behavioral Health clinic.
- See different doctors at each visit and so providers do not know the patients.
- Lack of knowledge about available services and how to access them.
- More transitional services from sober living arrangements.

Healthy Eating

Barriers faced in staying healthy were identified by focus groups to include:

- Lack of knowledge and education
    - Parents not educated about how to eat healthy and do not feed their children healthy food. No nutrition classes in schools for children.
    - Culture/expectation of "cleaning your plate."
- Change is difficult
    - Children resist change and will often throw away fruits and vegetables provided to them at school.
    - Difficult to cut back on sweets and to control portion sizes.
- Cost/Affordability
    - Healthy food and organic food is too expensive.

- Difficult to find healthy food that is inexpensive/affordable.
- Fast food is everywhere, cheap, filling and feeds more people than healthy food for the dollar.
- Homeless participants living in the shelter said they are required to eat what is provided at the shelter and cannot bring food into the shelter unless there is enough to share with all residents or they have a doctor's note.

- Barriers to exercising included:
  - Takes time to exercise and too tired after getting home from work (gone from 6am – 8pm and use public transportation to get to/from work).
  - Too dangerous to walk outside at night.
  - Physical disabilities (knee pain, hip problems).

Community and School Safety

Participants were asked about community and school violence they have witnessed or experienced or that they are aware of in their neighborhoods. Participants in all groups reported a high degree of violence in their neighborhoods, and shared that much of this occurs openly on the street as well as in schools, in parking lots, in parks, by bus stops, and by liquor stores. The only places were participants reported feeling safe are at home (primarily), at the agency sites where the focus groups were held (e.g., El Sol, Catholic Charities, Salvation Army), at church, the library, or at work.

Significant Health Needs

Based on the results of the primary and secondary data collection, significant health needs were identified. Each health need was confirmed by more than one indicator or data source (i.e., the health need was suggested by more than one source of secondary or primary data). In addition, the health needs were based on the size of the problem (relative portion of population afflicted by the problem) or the seriousness of the problem (impact at individual, family, and community levels). To determine size or seriousness of a problem, the health need indicators identified in the secondary data were measured against benchmark data, specifically county or state rates or Healthy People 2020 objectives. Indicators related to the health needs that performed poorly against these benchmarks were considered to have met the size or seriousness criteria. Additionally, primary data sources were asked to identify community and health issues based on the perceived size or seriousness of a problem.

The identified significant health needs included:

- Access to care
- Alcohol/drugs/tobacco
- Chronic diseases (asthma, cancer, heart disease, diabetes)
- Community growth and enrichment (safety, homelessness, education, economic development)
- Dental health
- Mental health
- Overweight/obesity (healthy eating and physical activity)
- Preventive health care (screenings, immunizations)

Potential Measures and Resources to Address Significant Needs

A description of the potential measures and resources identified through the CHNA to address the significant health needs can be found in Appendix 3.

Priority Health Needs

The results of the Community Health Needs Assessment were presented in oral and written forms to the hospital's Community Benefit Initiative Committee for review and feedback as well as for establishing health priorities. The following criteria were used to prioritize the significant health needs:

- Size of the problem – the relative portion of population afflicted by the problem.
- Existing infrastructure – hospital has programs, systems, staff and support resources in place to address the issue.
- Ongoing investment - existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus area – hospital has acknowledged competencies and expertise to address the issue and the issue fits with the

organizational mission.

Application of the criteria resulted in the following prioritization of the significant health needs:

1. Chronic diseases (asthma, cancer, heart disease, diabetes)
2. Access to care
3. Mental health
4. Overweight/Obesity
5. Preventive health care
6. Community growth and enrichment (safety, homelessness, education, economic development)
7. Alcohol/drugs/tobacco
8. Dental health

Implementation Strategy

In FY14, St. Bernardine Medical Center (SBMC) in partnership with Community Hospital of San Bernardino (CHSB) conducted a Community Health Needs Assessment (CHNA) to comply with California state and federal regulations guiding nonprofit hospitals. The Community Health Needs Assessment incorporated existing demographic and health data for the community served by SBMC. It included collection and analysis of input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of public health. This report summarizes the plans to address the prioritized needs from the 2014 Community Health Needs Assessment (CHNA).

Process for Prioritizing Health Needs

The health needs were identified from issues supported by the primary and secondary data sources gathered for the Community Health Needs Assessment. The needs were indicated by stakeholder interviews, focus groups, and secondary data sources. The needs were confirmed by more than one indicator or data source. In addition, the health needs were based on the size of the problem or the seriousness of the problem (impact at individual, family, and community levels).

On April 9, 2014 the Community Benefit Initiative Committee convened to review the significant health needs identified in the Community Health Needs Assessment and to establish the process and criteria to prioritize the health needs. The following criteria were used to prioritize the significant health needs:

- Size of the problem – the relative portion of population afflicted by the problem.
- Existing infrastructure – hospital has programs, systems, staff and support resources in place to address the issue.
- Ongoing investment - existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus area – hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

The health needs that will be addressed in the Implementation Strategy are:

1. **Access to care** with a focus on:
    a. Health care resources, including preventive health care.
    b. Dental care resources.
    c. Mental health resources.
2. **Chronic health conditions** with a focus on:
    a. Diabetes, including risk factors of obesity, lack of physical activity, and unhealthy eating.
    b. Heart disease.
    c. Cancer.
    d. Asthma.

e. Chronic Obstructive Pulmonary Disease (COPD).

3. **Youth development** with a focus on:
   a. Healthy lifestyle alternatives, including alcohol, drugs and tobacco avoidance.
   b. Teen pregnancy avoidance.
   c. Education promotion.
   d. Career development.

Description of What SBMC will do to Address the Priority Health Needs

The priority health needs are identified and goals established that indicate the expected changes in the health needs as a result of the programs and strategies that will be implemented. Data sources will be tracked to measure program impact. This information is outlined in the priority health need tables below.

Planned collaboration

Collaboration is one of the five core values adopted by Dignity Health hospitals. Our stated value is: **Collaboration –** Working together with people who support common values and vision to achieve shared goals.

SBMC will work together with its sister Dignity Health hospital, Community Hospital of San Bernardino and other facilities and organizations in our service area to address the priority health needs. A listing of potential partners can be found in Appendix 3.

Evaluation of Impact

SBMC will evaluate the impact of the programs/strategies. The evaluation plan includes a structured reporting system where program managers submit impact measure data on an annual basis. As well, community grant recipients are required to submit annual Accountability Reports that track and report impact measures and data sources. The data are analyzed as they address the impact on the goals. Findings will be reported to the CBIC. Changes in programs will be recommended based on data results.

Priority Health Need: Access to Care		
Goal	**Programs/Strategies to Address Health Need**	**Impact Measure Data Sources**
Increase access to primary health care, mental health and dental health for underserved and uninsured residents in the service area.	Emergency Department Navigator; Individuals without a regular source of care will be assisted to find a medical home. Connection with local social services will be provided.	# of individuals assisted; type of assistance provided; # and type of referrals made; # of individuals referred from the ED who are connected with a source of primary care.
	Financial assistance.	# of individuals assisted.
	Enrollment assistance for no cost/low cost insurance plans.	# of individuals assisted; # of individuals enrolled in health insurance coverage.
	Community education: • Baby & Family Center	# of classes or encounters; types of classes; # of attendees; increase knowledge as a result of education.
	Flu shot clinics.	# served; # and type of shots.
	Dignity Health Community Grants Program to support increased access to primary health care, dental care and	# of grants; dollar amount of grants provided; # of individuals reached; services provided.

	mental health care. Grants are provided through an annual competitive process and funds are provided to local community clinics and social service agencies. Funding is provided for programs that support hospital priorities and: 1) focus on disproportionate unmet health needs; 2) emphasize primary prevention and address underlying causes of health problems; 3) contribute to a seamless continuum of care; 4) build community capacity; and 5) emphasize collaborative governance.	Accountability reports from agencies who receive grants will track process and outcome measures.
Priority Health Need: Chronic Health Conditions		
Goal	**Programs/Strategies to Address Health Need**	**Impact Measure Data Sources**
Reduce the impact of chronic disease on health.	Community health education. Stanford University Chronic Disease Self-Management offered in English and Spanish, with a focus on diabetes and heart disease. Sweet Success Program is offered to expectant mothers with diabetes.	# of classes; types of classes; # of attendees; reduced admissions to the hospital or ED for the 90 days following participation in chronic disease programs.
	The Heart Care Center.	# of encounters; # and type of services offered; increased knowledge as a result of education.
	Support groups.	# and type of support groups; # of individuals reached.
	Dignity Health Community Grants Program to support increased access to primary health care, dental care and mental health care. Grants are provided through an annual competitive process and funds are provided to local community clinics and social service agencies. Funding is provided for programs that support hospital priorities and: 1) focus on disproportionate unmet health needs; 2) emphasize primary prevention and address underlying causes of health problems; 3) contribute to a seamless continuum of care; 4) build community capacity; and 5) emphasize collaborative governance.	# of grants; dollar amount of grants provided; # of individuals reached; services provided. Accountability reports from agencies who receive grants will track process and outcome measures.
Priority Health Need: Youth Development		
Goal	**Programs/Strategies to Address Health Need**	**Impact Measure Data Sources**
Improve the health of teens and young adults and provide them with pathways to livable wage jobs.	Family Focus Center: provides the opportunity to educate the community's at-risk youth in the areas of health, drug and gang avoidance, and education promotion to improve high school graduation rates. Programs include after school activities, a summer camp and collaboration with various local agencies	# of classes; types of classes; # of attendees; increased knowledge as a result of education.

	to bring information and resources to this vulnerable population.	
	Teen Choices: a program aimed to provide expert information and advice for pregnant and parenting teens who want to make the best decisions for their babies and themselves.	# of classes; types of classes; # of attendees; increased knowledge as a result of education.
	Stepping Stones: provides community youth with hospital-based internship, mentoring and career development opportunities to increase exposure to and employment in the health care field. Stepping Stones participants receive a stipend and learn about job search and interviewing skills, résumé writing techniques, and successful personal presentation strategies.	# of youth provided with mentoring and job development and training; # of Stepping Stones sessions annually; increased knowledge as a result of education.
	Dignity Health Community Grants Program to support increased access to primary health care, dental care and mental health care. Grants are provided through an annual competitive process and funds are provided to local community clinics and social service agencies. Funding is provided for programs that support hospital priorities and: 1) focus on disproportionate unmet health needs; 2) emphasize primary prevention and address underlying causes of health problems; 3) contribute to a seamless continuum of care; 4) build community capacity; and 5) emphasize collaborative governance.	# of grants; dollar amount of grants provided; # of individuals reached; services provided. Accountability reports from agencies who receive grants will track process and outcome measures.

Health Needs Not Addressed by the Implementation Strategy

Significant health needs identified in the CHNA that are not addressed in the Implementation Strategy are community growth and enrichment (safety, homelessness, education, economic development) specific to adult populations. We are strongly committed to breaking the cycle of phenomena (i.e. education, poverty, and employment) that impact the social determinants of health. Therefore our efforts at community growth and enrichment are targeted to youth. While recognizing that there are other valid concerns that impact the health of the community, the CBIC identified the hospital has limited resources. Therefore, the committee elected to focus on this issue specific to at-risk youth populations as there are existing programs in place through the facility or with community partners.

Approval

Each year the St. Bernardine Medical Center Community Benefit Initiative Committee, which includes representatives of the surrounding community, reviews the prior fiscal year's Community Benefit Report and approves the Community Benefit Implementation Strategy for addressing priorities identified in the most recent Community Health Needs Assessment and other plans for community benefit. The report is approved by the governing Community Board.

This report was prepared for the June 4, 2014 meeting of the Governing Board.

St. Bernardine Medical Center Approval:

Name and Title

June 4, 2014

Date

Appendix 1. Key Stakeholder Interviewees

Contact	Title	Organization
Leslie Bramson, Dr.PH	Assistant Professor	Department of Pediatrics, Loma Linda University Medical Center
Aviana Cerezo	Mayor's Office Legislative Aide/Healthy San Bernardino Coalition Co-Chair	City of San Bernardino
Ellen Daroszewski, NP	Executive Director	H Street Clinic
Deborah Davis	Executive Director	Legal Aid Society of San Bernardino
Alexander Fajardo	Executive Director	El Sol Neighborhood Educational Center
Alton Garrett, Jr.	President of Board of Directors	African American Health Institute of San Bernardino County
Eric Goddard	Director of Administration	California State University San Bernardino, Re-Entry Initiative (CSRI)
Salvador Gutierrez	Program Manager	Latino Health Collaborative
Tom Hernandez	Homeless Services Manager	Office of Homeless Services, Department of Behavioral Health
Angela Jones, RN	Health Services Coordinator	San Bernardino City Unified School District
Matthew Keane	Executive Director	Community Clinic Association of San Bernardino County
Chuck Leming	Staff Analyst II	San Bernardino County Department of Public Health, Healthy Communities Program
David Nagler	Pastor/CEO	Central City Lutheran Mission
Faye Pointer	Board Member	St. Bernardine Medical Center
Fr. Stephen Porter	Pastor	St. Catherine of Siena Catholic Church
Terry Roberts	Area Director	American Lung Association of California
Ken Sawa	CEO	Catholic Charities San Bernardino & Riverside Counties
Candy Stallings	Executive Director	San Bernardino Sexual Assault Services
Monique Stensrud	Business Development Director, Inland Empire Division Office	American Heart Association
Michael Wright	Community Services Supervisor	City of Fontana, Community Services Department

Appendix 2. Focus Group Participants

Group	Total Participants	Number of Males	Number of Females	Population
El Sol Neighborhood Center	6	0	6	Spanish-Speaking Promotoras
Mary's Mercy Center	7	0	7	Spanish-Speaking Women
Al-Shifa Clinic	8	2	6	Clinic Patients and Staff
Salvation Army – Transitional Living Program	12	3	9	Homeless Adults
Goodwill Industries	9	1	8	Employees
Catholic Charities	12	4	8	Program Participants, Ages 18-24
TOTAL	**54**	**10**	**44**	

Appendix 3. Potential Measures and Community Resources to Address Significant Health Needs

Significant Health Needs	Potential Measures	Community Resources
Access to Health Care	• Population with health insurance coverage. • Population with a usual source of primary care. • Reduced use of ER for routine care. • Reduced barriers to accessing care or delaying access to care.	Community Hospital of San Bernardino, Arrowhead Regional Medical Center, Kaiser Permanente Fontana, Loma Linda University Medical Center, County Public Health Clinics, H Street Clinic, SACH Clinics, La Salle, El Sol Neighborhood Educational Center, Al-Shifa Clinic, Whitney Young Family Health Clinic, Buddhist Tzu Chi Free Medical Clinic, Latino Health Collaborative, Healthy San Bernardino, Community Clinic Association of San Bernardino County, VA, Inland Family Community Health Center D Street Clinic, WIC, Metropolitan Family Medical Clinics
Alcohol/Drugs/Tobacco	• Smoking incidence. • Binge drinking incidence. • Drug use incidence. • Chronic disease incidence. • Death rates.	County Department of Public Health, American Lung Association, American Heart Association, Arrowhead Regional Medical Center, VA, County Department of Behavioral Health, Salvation Army, Catholic Charities
Chronic Disease (Asthma, Cancer, Cardiovascular Disease, Diabetes)	• Incidence rates. • Hospitalization rates. • Use of the ER. • Death rates.	Inland Empire Heart & Vascular Institute at St. Bernardine Medical Center, Community Hospital of San Bernardino, Arrowhead Regional Medical Center, Kaiser Permanente Fontana, Loma Linda University Medical Center, County Public Health Clinics, H Street Clinic, El Sol, SACH Clinics, American Heart Association, American Diabetes Association, Al-Shifa Clinic, Whitney Young Family Health Clinic, Buddhist Tzu Chi Free Medical Clinic, Inland Empire Asthma Coalition, Inland Family Community Health Center D Street Clinic, American Lung Association
Community Growth and Enrichment (Safety, Homelessness, Education, Economic Development)	• Unemployment rates. • High school graduation rates. • Rates of homelessness. • Crime rates. • Perceptions of safety among area residents.	School districts, police departments, CSRI, Boys & Girls Club, Boy Scouts, Girl Scouts, Rim Family Services, Young Visionaries, Department of Public Health, San Bernardino Guns and Drugs Task Force, Healthy San Bernardino,

	• Access to affordable housing.	Time for Change Foundation, Mil Mujeres, Catholic Charities, Rialto Community Center, Red Cross, Salvation Army, Goodwill Industries, Mary's Mercy Center, Option House, Office of Homeless Services Department of Behavioral Health, U.S. Veterans Initiative, Restoration House of Refuge, Operation Grace, Turrill Transitional Assistance Program
Dental Health	• Population with insurance coverage. • Reduced barriers to accessing dental care.	Loma Linda University School of Dentistry, Inland Family Community Health Center D Street Clinic, Dr. Earl R. Crane Children's Dental Center, Whitney Young Family Health Clinic, SAC Clinics (Norton, Arrowhead, Frazee), New Hope Free Clinic
Mental Health	• Population with insurance coverage. • Reduced barriers to accessing mental health care.	County Department of Behavioral Health, Salvation Army, Catholic Charities, San Bernardino Sexual Assault Services, Native American Resource Center, VA, Inland Family Community Health Center D Street Clinic, Phoenix Clinic, Arrowhead Regional Medical Center
Overweight and Obesity Healthy Eating Physical Activity	• Access to healthy foods. • Body Mass Index (BMI). • Access to open spaces and safe places for exercise. • Increase in physical activity among residents.	El Sol Promotoras, Latino Health Collaborative, Catholic Charities, St. Catherine of Siena Catholic Church, H Street Clinic, Al-Shifa Clinic, American Heart Association, WIC, Partners for Health, Healthy San Bernardino, Nutrition Network, El Sol Neighborhood Center, Credible Edible Community Garden, YMCA, Arrowhead Regional Medical Center
Preventive Health Care	• Population with insurance coverage. • Compliance with recommended prevention screenings, vaccines.	Community Hospital of San Bernardino, Arrowhead Regional Medical Center, Kaiser Permanente Fontana, Loma Linda University Medical Center, County Public Health Clinics, H Street Clinic, La Salle, El Sol Neighborhood Educational Center, Department of Public Health, SACH Clinics, Al-Shifa Clinic, Inland Family Community Health Center D Street Clinic