St. Bernardine Medical Center

2022 Community Health Implementation Strategy

Adopted October 2022

Dignity Health.
St. Bernardine Medical Center

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At-a-Glance Summary

Community Served

The Dignity Health St. Bernardine Medical Center (SBMC) service area includes 31 ZIP Codes in 17 cities within San Bernardino County, including the City of San Bernardino. SBMC serves 1,208,298 racially diverse residents.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

- Access to health care
- Behavioral health (mental health and substance use)
- Chronic diseases, including overweight and obesity
- Housing and homelessness
- Preventive practices
- Safety and violence prevention

Strategies and Programs to Address Needs

The hospital intends to take several actions and dedicate resources to these needs, including:

Access to health care
Financial assistance
Community Health Navigator
Community health education
Baby & Family Center
Transitional Care Clinic
Community Health Improvement Grants Program
Graduate Medical Education Program

Behavioral health (substance use and mental health)
Behavioral Health Navigator Program
Cultural Trauma and Mental Health Resiliency Program
Community Health Navigator
Community health education
Community Health Improvement Grants Program
Family Focus Center

Chronic diseases, including overweight and obesity
Community health education
Baby & Family Center
Transitional Care Clinic
Support groups
Community Health Improvement Grants Program

	Housing and homelessness Accelerating Investments for Healthy Communities Initiative Community Health Navigator Community Health Improvement Grants Program *Preventive practices* Vaccines Personal protective equipment (PPE) Eye Clinic Community health education Community Health Improvement Grants Program *Safety and violence prevention* Family Focus Center Stepping Stones Program Cultural Trauma and Mental Health Resiliency Project Violence and Human Trafficking Prevention and Response Community Health Improvement Grants Program
Anticipated Impact 	The anticipated impact of these strategies and programs include: • Increased access to health care and reduced barriers to care. • Increased availability of behavioral health services in community settings. • Increased prevention and treatment of chronic diseases. • Increased access to community-based homeless services, including housing options. • Increased availability and access to preventive care services. • Reduced community violence. • Increased access to needed services and resources through collaboration with community partners.
Planned Collaboration 	Key community partners include (partial listing): • Community health centers • Faith-based organizations • Foundations • Housing and homeless service agencies • Mental health agencies • Organizations serving LGBTQ+ populations • Public safety agencies • Regional collaboratives • San Bernardino city agencies • San Bernardino County agencies, including public health • Schools and school districts • Senior centers and service agencies • Youth organizations

This document is publicly available online at the hospital's website. Written comments on this report can be submitted to the SBMC Community Health Office at 2101 North Waterman Avenue, San Bernardino, California 92404. To send comments or questions about this report, please email Christian Starks, Director of Community Health at christian.starks@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Bernardine Medical Center (SBMC) is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America. SBMC is located at 2101 North Waterman Avenue, San Bernardino, California 92404. It was founded in 1931 by the Sisters of Charity of the Incarnate Word and has served the greater San Bernardino area for over 90 years. The hospital facility is licensed for 342 beds and provides the latest technology and advanced services, from family care to cardiac surgery.

Our Mission

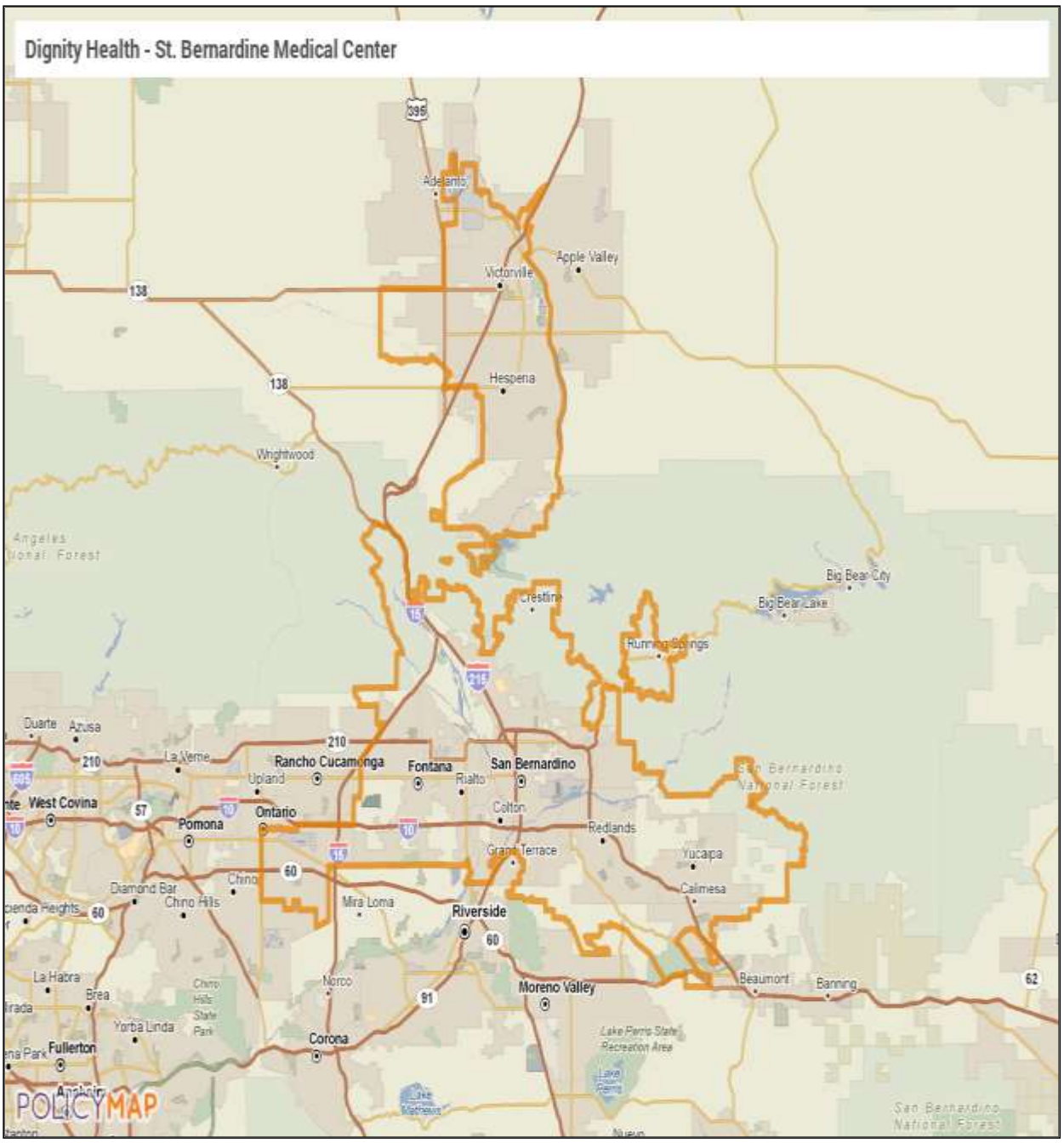
The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially 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 SBMC service area is 1,208,298. Children and youth, ages 0-17, make up 28% of the population, 61.8% are adults, ages 18-64, and 10.2% of the population are seniors, ages 65 and older. The largest portion of the population in the service area identifies as Hispanic/Latino (60.6%), 22.9% of the population identifies as White/Caucasian, 8.9% are Black/African American, and 4.9% are Asian. 2.2% of the population identifies as multiracial (two-or-more races), 0.2% as Native Hawaiian/Pacific Islander, and 0.2% as American Indian/Alaskan Native.

Among the residents in the service area, 17.3% are at or below 100% of the federal poverty level (FPL) and 40.3% are at 200% of FPL or below. Educational attainment is a key driver of health. In the hospital service area, 23.7% of adults, ages 25 and older, lack a high school diploma, which is higher than the state rate (16.7%). 17.7% of area adults have a Bachelor's or higher degree.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health Implementation Strategy and programs were identified in the most recent CHNA report, which was adopted in April 2022. The CHNA contains several key elements, including:

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

Additional details about the needs assessment process and findings 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 (page 4).

Significant Health Needs

The CHNA identified the significant community needs, which are briefly described in the table below. The table also indicates which needs the hospital intends to address in its Implementation Strategy. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to health care	Access to health care refers to the availability of primary care and specialty care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	X
Birth indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition.	
Chronic diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most	X

Significant Health Need	Description	Intend to Address?
	common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	
COVID-19[1]	The Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. In the U.S., over one million persons have died as a result of contracting COVID.	X
Dental care/oral health	Oral health refers to the health of the teeth, gums, and the entire oral-facial system. Some of the most common diseases that impact our oral health include cavities (tooth decay), gum (periodontal) disease, and oral cancer.	
Economic insecurity	Economic insecurity is correlated with poor health outcomes. Persons with low incomes are more likely to have difficulty accessing health care, have poor-quality health care, and seek health care less often.	
Food insecurity	The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially-acceptable ways.	
Housing and homelessness	Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing.	X
Mental health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	X
Overweight and obesity[2]	Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for heart disease and is linked to many other health problems, including type 2 diabetes and cancer.	X
Preventive practices	Preventive practices refer to health maintenance activities that help to prevent disease. For example, vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention are preventive practices.	X
Sexually transmitted infections	Sexually transmitted infections (STIs) usually pass from one person to another through sexual contact. Common STIs include syphilis, gonorrhea, and chlamydia.	

[1] COVID-19 will be addressed within the scope of the preventive practices need.
[2] Overweight and obesity will be addressed within the scope of the chronic diseases need.

Significant Health Need	Description	Intend to Address?
Substance use[3]	Substance use is the use of tobacco products, illegal drugs or prescription or over-the-counter drugs or alcohol. Excessive use of these substances, or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	X
Violence and injury	Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes.	X

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, SBMC will not directly address birth indicators, dental care, economic insecurity, food insecurity and sexually transmitted infections as priority health needs. Knowing that there are not sufficient resources to address all the community health needs, SBMC chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are currently addressed by others in the community.

[3] Substance use will be addressed within the scope of the behavioral health need

2022 Implementation Strategy

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 benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

The following criteria were used by the hospital to determine the significant health needs SBMC will address in the Implementation Strategy:

- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners 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: The hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

SBMC engaged hospital leaders in Community Health, Mission Integration and Executive Leadership, and the Community Benefit Initiative Committee to examine the identified health needs according to these criteria. The CHNA served as the resource document for the review of health needs as it provided statistical data on the severity of issues and also included community input on the health needs. As well, the community prioritization of the needs was taken into consideration. As a result of the review of needs and application of the above criteria, SBMC chose to focus on: access to care, behavioral health (mental health and substance use), chronic disease (including overweight and obesity), preventive practices, and safety and violence prevention. For each health need the hospital plans to address, the Implementation

Strategy describes: actions the hospital intends to take, including programs and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and other organizations. In most cases, the strategies identified to address the selected needs are based on existing programs that have evidence of success. For some strategies, SBMC is part of a larger collaborative initiative.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities address strategic aims while meeting locally-identified needs.

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Strategies and Program Activities by Health Need

 **Health Need: Access to Health Care**					
Anticipated Impact (Goal)	The hospital's initiatives to address access to care are anticipated to result in: increased access to health care for the medically underserved and reduced barriers to care.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Financial assistance for the uninsured or underinsured	Provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	X			
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to social service agencies.	X	X	X	
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.	X	X		
Baby & Family Center	Presents health care topics and local resources for new/expectant mothers and families including breast feeding support, child preparation classes and parenting classes.	X	X		
Transitional Care Clinic	Assists persons to identify and secure a medical home and provides connections to local social service agencies.	X	X	X	
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide			X	

Health Need: Access to Health Care					
	health care access programs and services.				
University of California, Riverside Graduate Medical Education (GME)	Expands and diversifies the physician workforce in Inland Southern California/City of San Bernardino. 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.	X	X	X	X
Planned Resources	The hospital will provide health care providers, enrollment counselors, health educators, Community Health Navigators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	Key partners include: University of California, Riverside, Lestonnac Free Clinic, CHAISR (Community Health Association Inland Southern Region), community-based organizations (Family Assistance Program, Mary's Mercy Center and others), schools and school districts, faith groups, public health and local cities.				

Health Need: Behavioral Health (Mental Health and Substance Use)					
Anticipated Impact (Goal)	The hospital's initiatives to address behavioral health are anticipated to result in: increased access to mental health and substance use services in the community, and improved screening and identification of mental health and substance use needs.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Behavioral Health Navigator Program (CA Bridge 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.	X	X	X	X
Cultural Trauma and Mental Health Resiliency Project	Joint effort of the six Dignity Health hospitals in Southern California working in partnership to increase the capacity of local community organizations, community members and hospitals to identify mental distress, address the impacts of trauma, and increase resiliency via delivery of mental health awareness education. The project focuses on children and youth of color living in underserved neighborhoods.	X	X	X	X
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to behavioral health service agencies.	X	X	X	
Community health education	Addresses a variety of behavioral health care topics.	X	X		

	**Health Need: Behavioral Health (Mental Health and Substance Use)**				
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide mental health and substance use programs and services.			X	
Planned Resources	The hospital will provide mental health care providers, Community Health Navigators, health educators, social workers, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
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.				

 **Health Need: Chronic Disease (including Overweight and Obesity)**					
Anticipated Impact (Goal)	The hospital's initiatives to address chronic diseases are anticipated to result in: increased identification and treatment of chronic diseases, increased compliance with disease prevention recommendations (screenings and life style and behavior changes) and improved health eating and active living.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
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.	X	X		X
Baby & Family Center	Offers educational classes for pregnant women and their families on breastfeeding, nutrition and prevention of disease and disability. The Sweet Success program focuses on gestational diabetes.	X	X		
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.	X	X	X	
Support groups	Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psychoeducation.		X		
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide chronic disease-focused programs and services.			X	

	**Health Need: Chronic Disease (including Overweight and Obesity)**
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, faith community, community clinics, community-based organizations, American Heart Association, maternal health collaboratives, American Cancer Society, and the American Diabetes Association.

 **Health Need: Housing and Homelessness**					
Anticipated Impact (Goal)	The hospital's initiatives to address housing and homelessness are anticipated to result in: increased access to community-based homeless services, including housing options, and improved health of persons experiencing homelessness.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Accelerating Investments for Healthy Communities Initiative	Advances affordable housing by investing capital, making grants and guarantees, convening local partners and leveraging skills and relationships to advocate for affordable housing policies and funding.	X	X	X	X
Community Health Navigator	Assists frequent users of the Emergency Department to find a medical home and provides connections to social service agencies.	X	X	X	
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.			X	
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,				

	**Health Need: Preventive Practices**				
Anticipated Impact (Goal)	The hospital's initiatives to address prevention are anticipated to result in: increased access to preventive care services in the community and increased compliance with preventive care recommendations (screenings, vaccines, and life style and behavior changes).				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Vaccines	Provides free vaccines in the community.		X		
Personal Protective Equipment (PPE)	Distributes PPE at local community events and to community partners.	X	X		
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.	X	X	X	
Community health education	Provides community education on a variety of preventive care topics.	X	X		
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide preventive care programs and services.			X	
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, Western University of Health Sciences and El Sol Neighborhood Educational Center.				

Health Need: Safety and Violence Prevention					
Anticipated Impact (Goal)	The hospital's initiative to address safety and violence prevention are anticipated to result in: increased access to programs in the community that focus on improved safety and reduced violence.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Family Focus Center	Provides services and programs for at-risk youth. Includes after school activities, career development, Late Night Hoops, Summer Camp, Drug & Violence Prevention and Health & Nutrition. The Values to Success program increases knowledge of healthy behaviors, helps build character and promotes a sense of self-worth and self-efficacy. The Bridges program supports young adults who have graduated high school but need assistance in navigating college, careers and housing.	X	X	X	X
Stepping Stones Program	Provides an opportunity for teens and young adults to gain valuable hospital workplace experience through volunteer and mentor activities. Allows participants to spend time volunteering in the hospital, provides focus on education attainment and career opportunities as a means to stability.	X	X	X	X
Cultural Trauma and Mental Health Resiliency Project	Increases the capacity of local community organizations, community members and hospitals to identify mental distress, address the impacts of trauma, and increase resiliency via delivery of mental health awareness education. The project focuses on children and youth of color living in underserved neighborhoods.	X	X	X	X

	**Health Need: Safety and Violence Prevention**				
Violence and Human Trafficking Prevention and Response Initiative	The Human Trafficking Response Task Force provides training to identify potential victims of sex and/or labor trafficking in the ED and other hospital units. Provides trauma-informed care and services to affected patients. Includes preventive education, intervention assistance, warm referrals to community agencies, and continued patient care and services.	X	X	X	X
Community Health Improvement Grants Program	Offers grants to nonprofit community organizations that provide safety and violence prevention programs and services.			X	
Planned Resources	The hospital will provide case managers, health care providers, health educators, social workers, philanthropic cash grants and outreach communications in support of this initiative.				
Planned Collaborators	Key partners include: public health, faith community, schools and school districts, youth organizations, community clinics, community-based organizations, County of San Bernardino, local law enforcement and regional collaboratives that seek to support community safety.				