Dignity Health.
St. Bernardine Medical Center

# St. Bernardine Medical Center

## Community Benefit 2018 Report and 2019 Plan

Dignity Health
St. Bernardine Medical Center

# A message from

Doug Kleam, president and CEO of St. Bernardine Medical Center, and Dr. Robert Carlson, Chair of the Dignity Health St. Bernardine Medical Center Community Board.

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

St. Bernardine Medical Center shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2018 (FY18), St. Bernardine Medical Center provided $28,249,371 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $22,625,607 in unreimbursed costs of caring for patients covered by Medicare.

St. Bernardine Medical Center's Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its October 3, 2018 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 909.475.5083.

Doug Kleam, President/CEO

Robert Carlson, PhD. Chairperson, Board of Directors

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## At-a-Glance Summary

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| **Community Served** | St. Bernardine Medical Center (SBMC) serves a broad and diverse population residing in multiple zip codes, as it serves as a regional referral facility for heart procedures. While a few of the zip code communities enjoy a higher standard of living, the majority of the communities served are high need. The majority of discharges come from twenty-two (22) zip codes concentrated in the following cities: Beaumont, Bloomington, Calimesa, Colton, Crestline, Fontana, Hesperia, Highland, Redlands, Rialto, San Bernardino, and Yucaipa. The total population of these communities is 1,027,971. |
| **Economic Value of Community Benefit** | $28,249,371 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits.<br><br>$22,625,607 in unreimbursed costs of caring for patients covered by Medicare. |
| **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). Those needs are:<br>• Access to Care<br>• Birth Indicators<br>• Chronic Disease<br>• Homelessness<br>• Overweight & Obesity<br>• Preventive Practices |
| **FY18 Actions to Address Needs** | In FY18, St. Bernardine Medical Center took numerous actions to help address identified needs. These included: programming at the Family Focus Center directed toward the youth of our community; the Bridges Program based at the Family Focus Center that focuses on young adults who have graduated high school but need assistance as they venture into adulthood; activities at the Baby & Family Center to promote healthy pregnancies and family lifestyles; a Community Health Navigator to work with the uninsured who visit our Emergency Department; a Community Grants program that awarded $217,480 to local non-profit agencies that address identified health needs; free flu shots for the community as well as community education, especially education focused on diabetes management and other chronic diseases. |
| **Planned Actions for FY19** | For FY19, St. Bernardine Medical Center plans to continue these programs. Additionally, the hospital will dedicate financial resources to support the opening of local Federally Qualified Health Centers (FQHCs) to provide access to primary care. |

This Community Benefit Report and Plan was first shared with members of the hospital board members, of whom many are community stakeholders. The complete Community Benefit 2018 Report and 2019 Plan can be accessed from the Dignity Health St. Bernardine Medical Center website at https://www.dignityhealth.org/socal/locations/stbernardinemedical/about-us/serving-the-community/community-health-needs-assessment-plan. Written comments on this report can be submitted to the St. Bernardine Medical Center Community Health Department at 2101 N. Waterman Avenue, San Bernardino, CA 92404 or by e-mail to Kathleen.McDonnell@DignityHealth.org.

# MISSION, VISION AND VALUES

St. Bernardine Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

## Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

## Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

## Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

***Dignity*** - Respecting the inherent value and worth of each person.

***Collaboration*** - Working together with people who support common values and vision to achieve shared goals.

***Justice*** - Advocating for social change and acting in ways that promote respect for all persons.

***Stewardship*** - Cultivating the resources entrusted to us to promote healing and wholeness.

***Excellence*** - Exceeding expectations through teamwork and innovation.

# OUR HOSPITAL AND THE COMMUNITY SERVED

## About St. Bernardine Medical Center

St. Bernardine Medical Center (SBMC) was founded in 1931 by the Sisters of Charity of the Incarnate Word. Today, St. Bernardine Medical Center is a member of Dignity Health and offers a myriad of health care services both locally and to the tertiary communities within the Inland Empire. Licensed for 342 beds with an average daily census of 184 during Fiscal Year 2018, St. Bernardine Medical Center employs 1,675 employees and maintains professional relationships with 425 local physicians and 92 Allied Health Professionals. As one of two hospitals in the city of San Bernardino, St. Bernardine Medical Center has a busy Emergency Department that received 78,567 visits in FY2018.

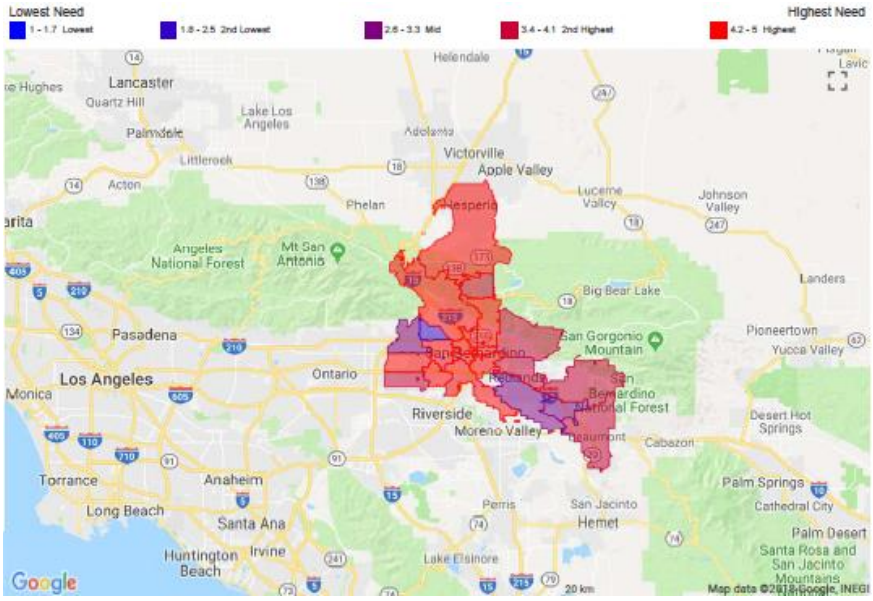
## Description of the Community Served

The Inland Empire is a diverse and struggling region. St. Bernardine Medical Center is an identified Disproportionate Share Hospital, thus making it a safety net for the many low-income, vulnerable populations and uninsured in the community. While the service area continues to improve from the depths of the Great Recession of 2008, currently, 8.5% to 46.6% of the population lives at or below 100% of the Federal Poverty Level. In 2018, San Bernardino County was ranked 41st (up from 45th last year) among counties in California for Health Outcomes by County Health Rankings & Roadmaps[1], still placing it in the bottom third of California counties for health outcomes. In FY18, the city acquired new city leadership, including a new City Manager, Assistant City Manager and other key positions. A new City Charter was adopted in 2016, streamlining various city policies and protocols in order to operate more efficiently and effectively. A summary description of the community is below, and additional details can be found in the CHNA report online.

- The following[2] reflects demographics for the service area:
  - Total Population: 1,027,971
  - Race/Ethnicity: 61.5% Hispanic or Latino; 22.5% White; 8.3% Black/African American; 5.2% Asian/Pacific Islander, 2.5% All Other
  - Median Income: $58,002
  - Uninsured: 9.8 %
  - Unemployment: 6.7%
  - No HS Diploma: 25.7%
  - CNI Score: 4.3
  - Medicaid Population: 35.4%
  - Other Area Hospitals: 6
  - Medically Underserved Areas or Populations: Yes

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

[1] A collaboration between the Robert Wood Johnson Foundation & the University of Wisconsin Population Health Institute
[2] Source: © 2018 The Claritas Company, © Copyright IBM Corporation 2018.




| | Zip Code | CNI Score | Population | City | County |
|---|---|---|---|---|---|
| | 92223 | 3.4 | 51,235 | Beaumont | Riverside |
| | 92316 | 4.2 | 33,100 | Bloomington | San Bernardino |
| | 92320 | 2.6 | 8,946 | Calimesa | Riverside |
| | 92324 | 4.4 | 59,288 | Colton | San Bernardino |
| | 92325 | 3.4 | 9,003 | Crestline | San Bernardino |
| | 92335 | 4.6 | 98,653 | Fontana | San Bernardino |
| | 92336 | 3.0 | 99,389 | Fontana | San Bernardino |
| | 92337 | 3.4 | 38,638 | Fontana | San Bernardino |
| | 92345 | 4.4 | 85,866 | Hesperia | San Bernardino |
| | 92346 | 4.0 | 57,165 | Highland | San Bernardino |
| | 92373 | 3.2 | 34,081 | Redlands | San Bernardino |
| | 92374 | 4.0 | 42,781 | Redlands | San Bernardino |
| | 92376 | 4.6 | 83,537 | Rialto | San Bernardino |
| | 92377 | 2.4 | 20,221 | Rialto | San Bernardino |
| | 92399 | 3.8 | 55,707 | Yucaipa | San Bernardino |
| | 92401 | 5.0 | 2,124 | San Bernardino | San Bernardino |
| | 92404 | 5.0 | 59,884 | San Bernardino | San Bernardino |
| | 92405 | 5.0 | 29,701 | San Bernardino | San Bernardino |
| | 92407 | 4.4 | 64,553 | San Bernardino | San Bernardino |
| | 92408 | 4.8 | 15,195 | San Bernardino | San Bernardino |
| | 92410 | 5.0 | 52,171 | San Bernardino | San Bernardino |
| | 92411 | 5.0 | 26,733 | San Bernardino | San Bernardino |

# COMMUNITY ASSESSMENT AND PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Community Benefit Initiative Committee (CBIC) and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

## Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in June, 2017.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

## CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

- **Access to Care**: Health insurance coverage is considered a key component to accessing health care including regular primary care, specialty care and other health services that contributes to one's health status. In the hospital service area, 78.5% of residents are insured.
- **Birth indicators**: Teen birth rates represent 10.6% of total births, much higher than the state rate of 7%; 17.3% of pregnant women enter prenatal care late or not at all, higher than the state rate of 16.2%; the service area also has a higher rate of low birth weight babies (7.3%) than the state (6.7%).
- **Chronic diseases**: Hospitalization rates for Prevention Quality Indicators for leading chronic diseases (diabetes, heart disease and asthma) greatly exceed that of the state – diabetes by 38.6%; heart disease by 36.7%; asthma by 20.3%.
- **Community safety/violence prevention**: Community input placed community safety/violence prevention in the top 10 concerns by participants in both the key stakeholder interviews (3rd place) and focus groups (5th place). Specifically mentioned were gang activity, poverty, early release of prisoners, mistrust in police and the December 2015 terrorist attack.

- **Homelessness**: Among the homeless subpopulations in San Bernardino County, 37% are chronically homeless; 31% have chronic health conditions; 27% are persons recently released from jail/prisons; and 26% have substance abuse issues.
- **Mental health**: Much of the data available is self-reported from the California Health Interview Survey (CHIS), but community input placed mental health at 2nd place (focus groups) and 4th place (key stakeholder interviews). A lack of providers was cited multiple times, which is confirmed by the 550:1 ratio of mental health providers in San Bernardino County to the 360:1 ratio achieved by the National Top Performer.
- **Overweight and obesity**: In San Bernardino County, 38% of the adult population is reported being overweight and 34% are obese. Just as alarming is the 26.3% of teens and children reported to be overweight and 11.1% of teens who are obese. When tracked over time, adult obesity levels in San Bernardino County show a gradual increase – from 26.2% in 2007 to 34.0% in 2014.
- **Preventive practices**: Due to state law, most children have high rates of compliance with childhood immunizations upon entry into kindergarten; the county does not do as well in the areas of flu vaccines or mammograms. Community input mentioned the lack of primary care physicians as a root cause, including transportation issues and long wait time for appointments. San Bernardino County has a shortage of primary care physicians – ratio of population to primary care physicians is 1,740:1 versus 1,040:1 ratio achieved by the National Top Performer.
- **Sexually transmitted infections**: While the rate of chlamydia in San Bernardino County is higher than the state rate, rates of gonorrhea, primary and secondary syphilis as well as early latent syphilis are lower. The number of persons living with a diagnosis of HIV is also lower than the state.
- **Substance abuse**: Much of the data available is self-reported from the California Health Interview Survey (CHIS), but input from the community included concerns regarding substance abuse across all segments of the population, including the homeless. It was noted that there is prevalence of liquor stores in lower-income areas and that "drugs are easier to find than kale".

Significant health needs identified in the CHNA that will not be addressed are mental health, sexually transmitted infections, and substance abuse and community safety/violence prevention 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 substance abuse and community safety/violence prevention are targeted to youth. Overweight and obesity will be included in the programming for chronic diseases. Preventive practices will be addressed through the hospital's efforts to increase access, especially to primary care. The CBIC identified that the hospital has limited resources. Therefore, where possible, collaboration with community partners will play a vital role in addressing homelessness and mental health and may be addressed through the Dignity Health Community Grants Program.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available on the hospital website at (https://www.dignityhealth.org/socal/locations/stbernardinemedical/about-us/serving-the-community/community-health-needs-assessment-plan or upon request at the hospital's Community Health office.

## Creating the Community Benefit Plan

Rooted in Dignity Health's mission, vision and values, St. Bernardine Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and Community Benefit Initiative Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

SBMC staff provided CBIC members with information regarding current programs already addressing identified health needs as well as evidence of success. CBIC community stakeholder members provided valuable insight and connectivity to additional resources in the community. Hospital sponsored programs continue to be impacted by growing need, and it was determined these programs are valuable tools in improving community health. Discussion also focused on programs in the community and the importance of collaborating with local non-profits through the Dignity Health Community Grants Program. These programs and strategies are highlighted on page 13-14.

# 2018 REPORT AND 2019 PLAN

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

## Report and Plan Summary

| **Health Need**: **Access to Health Care/Preventive Practices** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Financial Assistance | To ensure that lack of financial capacity does not prevent someone from seeking or receiving care, financial assistance is offered in accordance with Dignity Health's Financial Assistance Policy. See Appendix C. | ☒ | ☒ |
| FQHC Support | To provide more access to primary care, financial assistance is provided to aid in the opening of Federally Qualified Health Centers in the community. | ☒ | ☒ |
| Community Grants Program | Partner with local non-profit agencies that share common values and work together to improve access to care for our community. | ☒ | ☒ |
| Community Education | Offered free of charge to community members, classes address a variety of health issues. | ☒ | ☒ |
| Community Health Navigator | Navigator contacts uninsured individuals who are high utilizers of the Emergency Department in an effort to find a more suitable medical home as well as connections to other social services agencies providing basic needs. | ☒ | ☒ |
| Health Professionals Education | • Cardiac Symposium brings latest research to clinicians.<br>• Diabetes Symposium brings best practices to clinicians. | ☒ | ☒ |
| Free Flu Shots | Free flu shots will be offered to the community through a variety of flu shot clinics in the community. | ☒ | ☒ |
| Residents Training Program | Partnership with University of California Riverside School of Medicine to address the shortage of physicians in the Inland Empire | ☒ | ☒ |
| **Anticipated Impact**: The hospital's initiatives to address access to health care/preventive practices are anticipated to result in: increased access to basic health information in both culturally appropriate and understandable terms; gains in public or private health care coverage; increased knowledge about how to access and navigate the health care system; access to agencies providing basic needs, thereby providing a critical safety net; increased primary care "medical homes"; and an increase in primary care physicians (long term strategy). | | | |

| **Health Need: Birth Indicators** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Baby & Family Center | • Provides dedicated support of breast feeding<br>• Free bilirubin checks to all new babies within 48 hours of delivery | ☒ | ☒ |
| Sweet Success Program | Provides monitoring and education to gestational diabetic women. | ☒ | ☒ |
| Support Group | A support group for expectant and young moms, with a special outreach to pregnant and parenting teens to ensure a healthy pregnancy and support new moms. | ☐ | ☒ |
| **Anticipated Impact**: The hospital's initiatives to address birth indicators are anticipated to result in increased breast feeding among new mothers; a healthy birth for gestational diabetic women; better health for the gestational diabetic mother post-partum; better support for teen mothers before birth and post-partum. | | | |

| **Health Need**: **Chronic Diseases** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Chronic Disease Self-Management Program | Classes for chronic disease will be offered in English and Spanish to community members free of charge. | ☒ | ☒ |
| Diabetes Empowerment Education Program (DEEP) | Classes for diabetes specific will be offered in English and Spanish to community members free of charge. | ☒ | ☒ |
| Heart Care Clinic | Provides free services to referred patients diagnosed with heart disease as well as drop-ins from the community. | ☒ | ☐ |
| Sweet Success Program | Provides monitoring and education to gestational diabetic women. | ☒ | ☒ |
| Support Groups | Support groups for chronic health conditions include obesity, breast cancer (groups in both English and Spanish), and a bereavement support group meets twice a month with a hospital chaplain. | ☒ | ☒ |
| **Anticipated Impact**: The hospital's initiatives to address chronic diseases are anticipated to result in a better understanding of an individual's chronic condition, including measures to control or improve the medical condition; a healthy birth for gestational diabetic women; better health for the gestational diabetic mother post-partum; an improved sense of self through the support groups. | | | |

| **Health Need**: **Homelessness** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Financial Assistance | The hospital provides discounted and free health care to qualified individuals, following Dignity Health's Financial Assistance Policy. | ☒ | ☒ |
| Community Grants Program | Partner with local non-profit agencies that share common values and work together provide housing for the homeless as they are discharged from the hospital. | ☒ | ☒ |
| Community Health Navigator | Navigator contacts all uninsured individuals seen but not admitted in the Emergency Department in an effort to find a more suitable medical home as well as connections to other social services agencies providing basic needs. | ☒ | ☒ |
| **Anticipated Impact**: The hospital's initiatives to address homelessness are anticipated to result in early identification of the homeless and faster connections to appropriate agencies for basic needs; appropriate housing for homeless patients upon discharge; and increased primary care "medical homes" and access to health insurance among those reached by navigator. | | | |

| **Health Need**: **Youth Development/Community Safety & Violence Prevention** | | | |
|---|---|---|---|
| **Strategy or Activity** | **Summary Description** | **Active FY18** | **Planned FY19** |
| Family Focus Center | Provides after school services to at-risk youth in the community. Programs include:<br>• Late Night Hoops<br>• Drug & Violence Prevention Education<br>• Health & Nutrition<br>• Values to Success<br>• Bridges Program | ☒ | ☒ |
| Stepping Stones Program | Stepping Stones Program provides an opportunity to teens and young adults to gain valuable hospital workplace experience through volunteer and mentor activities. | ☒ | ☒ |
| **Anticipated Impact**: The hospital's initiatives to address youth development/community safety & violence prevention are anticipated to result in youth more focused on school with a plan for continued education and career path; tobacco, alcohol and drug avoidance; healthier lifestyles; and a support system to help them achieve their goals. | | | |

## Community Grants Program

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

In FY18, the hospital awarded five (5) grants totaling $217,480. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report. You will note that the total grant amount awarded exceeds $217,480. SBMC collaborates with Community Hospital of San Bernardino in order to better serve the vulnerable population, thus resulting in higher total awards.

| Grant Recipient | Project Name | Amount |
|---|---|---|
| Family Assistance Program Collaborative | Supporting Victims in the Emergency Dept. | $80,000 |
| Legal Aid of San Bernardino Collaborative | From At-Risk to Resiliency Via Access | $75,000 |
| Lestonnac Free Clinic Collaborative | Community Health & Education | $100,000 |
| Lutheran Social Services Collaborative | Comprehensive Homeless Intervention | $80,000 |
| Mary's Mercy Center Collaborative | Better Health Through Partnership | $30,000 |

## Anticipated Impact

The anticipated impacts of the hospital's activities on significant health needs are summarized above, and for select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

## Planned Collaboration

While the hospital partners with many non-profit community and government agencies, our strongest partners are often those we collaborate with through the Community Grants Program. In FY18 this included: Family Assistance Program, Legal Aid of San Bernardino, Lestonnac Free Clinic, Lutheran Social Services and Mary's Mercy Center. Staff from St. Bernardine Medical Center also serves on a county-wide collaborative called *Community Vital Signs. Community Vital Signs* is a community health improvement framework jointly developed by San Bernardino County residents, organizations and government. It builds upon the Countywide Vision by setting evidence-based goals and priorities for action that encompass policy, education, environment, and systems change in addition to quality, affordable and accessible health care and prevention services.

## Financial Assistance for Medically Necessary Care

St. Bernardine Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;

- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

## Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

| Dignity Health Community Grants Program | |
|---|---|
| **Significant Health Needs Addressed** | ☒ Access to Care/Preventive Practice<br>☐ Birth Indicators<br>☒ Chronic Diseases<br>☒ Homelessness<br>☐ Youth Development/Community Safety & Violence Prevention |
| **Core Principles Addressed** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>☒ Build Community Capacity<br>☒ Demonstrate Collaboration |
| **Program Description** | Award funds to local non-profit organizations to be used to effect collective impact, addressing the health priorities established by the hospital (based on the most recent Community Health Needs Assessment). Awards will be given to agencies with a formal collaboration and a link to the hospital. |
| **Community Benefit Category** | E1a – Cash Donation |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Focused attention on high utilizers in the hospital will provide connections to needed medical care and social services, thereby providing more appropriate care to the individual and reducing unnecessary financial burden to the hospital. |
| **Measurable Objective(s) with Indicator(s)** | Funding will be provided to implement programs that support hospital priorities and demonstrate strong collaboration with the hospital. 100% of funded programs will report objectives as a result of SBMC Community Grants on a semi-annual basis. |
| **Intervention Actions for Achieving Goal** | All awarded agencies will work with Director of Community Health to ensure programs are meeting the objectives stated in their grant proposals. |
| **Planned Collaboration** | Not only will awarded agencies collaborate with the partners stated on their grant proposal, but they will also continue to work with the Director of Community Health to ensure hospital collaboration. Case Management and Community Health Navigators will have vital roles in collaboration. |
| **Program Performance / Outcome** | 5 collaborative proposals, representing 17 local non-profit agencies, were awarded. Grants ranged from $30,000 to $100,000 addressing access to care, chronic disease and homelessness. |
| **Hospital's Contribution / Program Expense** | $217,480 |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Focused attention on high utilizers in the hospital will provide connections to needed medical care and social services, thereby providing more appropriate care to the individual and reducing unnecessary financial burden to the hospital. |
| **Measurable Objective(s) with Indicator(s)** | Funding will be provided to implement programs that support hospital priorities and demonstrate strong collaboration with the hospital. 100% of funded programs will report objectives as a result of SBMC Community Grants on a semi-annual basis. |
| **Intervention Actions for Achieving Goal** | All awarded agencies will work with Director of Community Health to ensure programs are meeting the objectives stated in their grant proposals. |
| **Planned Collaboration** | Continued collaboration with agencies receiving funding in FY18 include: Family Assistance Program, Legal Aid of San Bernardino, Lestonnac Free Clinic, Lutheran Social Services and Mary's Mercy Center. Future collaboration may include additional agencies awarded funding in FY19. |

| Baby & Family Center | |
|---|---|
| **Significant Health Needs Addressed** | ☒ Access to Care/Preventive Practice<br>☒ Birth Indicators<br>☒ Chronic Diseases<br>☐ Homelessness<br>☐ Youth Development/Community Safety & Violence Prevention |
| **Core Principles Addressed** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>☒ Build Community Capacity<br>☒ Demonstrate Collaboration |
| **Program Description** | The Baby & Family Center (BFC) is an education site providing a multitude of services targeted to pregnant women and their families. In addition to breastfeeding support and education, the site provides health educators who lead a variety of support groups. Vulnerable populations are of highest priority. The Sweet Success program is housed at the BFC to focus on gestational diabetes. Incorporating Sweet Success in the BFC enhances the continuum of care effort to make families aware of all of the services of the BFC and encourages healthy lifestyles post-partum. |
| **Community Benefit Category** | A1a – Community Education |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Improve the health of pregnant mothers and their families through education with an emphasis on breastfeeding and diabetes education. Participants in the program will understand that breastfeeding is best for baby and results in reduced obesity rates. |
| **Measurable Objective(s) with Indicator(s)** | Increase in-hospital breastfeeding (any and exclusive) rates by 2%. *Sweet Success* participants will deliver full-term infants and experience zero fetal demise. Hospital will maintain its *Baby Friendly* designation. |
| **Intervention Actions for Achieving Goal** | Encourage breastfeeding for inpatient and community members; conduct breastfeeding support groups; offer Sweet Success counseling to women with gestational diabetes. |
| **Planned Collaboration** | Staff collaborates with Inland Empire Breastfeeding Coalition to ensure adherence to most up-to-date practices and techniques. |
| **Program Performance / Outcome** | Exclusive breastfeeding declined slightly from 45.8% to 45.0%. Any breastfeeding is at 78.0%. The Sweet Success Program educated 206 women with gestational diabetes, and clients experienced zero pre-term labor, and zero fetal demise. |
| **Hospital's Contribution / Program Expense** | $57,344 |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Improve the health of pregnant mothers and their families through education with an emphasis on breastfeeding and diabetes education. Participants in the program will understand that breastfeeding is best for baby. |
| **Measurable Objective(s) with Indicator(s)** | Increase in-hospital breastfeeding (any and exclusive) rates by 2%. Sweet Success participants will deliver full-term infants and experience zero fetal demise. Hospital will maintain its Baby Friendly designation. |
| **Intervention Actions for Achieving Goal** | Encourage breastfeeding for inpatient and community members; lactation consultants will see every mom who delivers; offer Sweet Success counseling to women with gestational diabetes. |
| **Planned Collaboration** | Continued collaboration with Inland Empire Breastfeeding Coalition. |

| Community Health Navigator | |
|---|---|
| **Significant Health Needs Addressed** | ☒ Access to Care/Preventive Practice<br>☐ Birth Indicators<br>☐ Chronic Diseases<br>☒ Homelessness<br>☐ Youth Development/Community Safety & Violence Prevention |
| **Core Principles Addressed** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>☒ Build Community Capacity<br>☒ Demonstrate Collaboration |
| **Program Description** | The Community Health Navigator follows up by phone to patients who are high utilizers of the ED who are seen for diagnoses that could be addressed in an outpatient setting. Patients are provided with community resources (English and Spanish), including the sites offering specialty care. Assistance is provided for enrolling in government sponsored plans as well as arranging referrals for needed services from local non-profit agencies. |
| **Community Benefit Category** | A3 – Healthcare Support Services Information & Referral |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Assist the frequent users of the ED with conditions better treated as an outpatient in finding a medical home instead of using the ED as regular source of health care. Connection to social service agencies will be provided as appropriate. |
| **Measurable Objective(s) with Indicator(s)** | 10% of those contacted by the Navigator will receive a referral to a free clinic. |
| **Intervention Actions for Achieving Goal** | Navigator will continue to follow up by phone to high utilizers of the ED, primarily the uninsured. ED Admitting staff also provides Navigator information to patients. |
| **Planned Collaboration** | Community Health Navigator works closely with Director of Community Health and Care Coordination Team from the hospital, as well as several local non-profit social services agencies. |
| **Program Performance / Outcome** | In FY2018 3,718 uninsured patients were seen in ED and not admitted. High utilizers are defined as those seen in the ED multiple times over the previous six month period. Of the 1,327 contacted by the Navigator, 201 (15.15%) received a referral to Lestonnac Free Clinic. |
| **Hospital's Contribution / Program Expense** | $34,195 (this position was vacant for eight months during FY18) |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Assist the frequent users of the ED with conditions better treated as an outpatient in finding a medical home instead of using the ED as regular source of health care. Connection to social service agencies will be provided as appropriate. |
| **Measurable Objective(s) with Indicator(s)** | 10% of those contacted by the Navigator will receive a referral to a free clinic. |
| **Intervention Actions for Achieving Goal** | Navigator will continue to follow up on the high utilizers of the ED. ED Admitting staff also provides Navigator information to patients. |
| **Planned Collaboration** | Community Health Navigator works closely with Director of Community Health and Care Coordination Team from the hospital, as well as several local non-profit social services agencies. |

| Family Focus Center | |
|---|---|
| **Significant Health Needs Addressed** | ☒ Access to Care/Preventive Practice<br>☒ Birth Indicators<br>☐ Chronic Diseases<br>☐ Homelessness<br>☒ Youth Development/Community Safety & Violence Prevention |
| **Core Principles Addressed** | ☒ Focus on Disproportionate Unmet Health-Related Needs<br>☒ Emphasize Prevention<br>☒ Contribute to a Seamless Continuum of Care<br>☒ Build Community Capacity<br>☒ Demonstrate Collaboration |
| **Program Description** | A program geared to at-risk youth in the community. The Family Focus Center is located across the street from San Bernardino High School. Services provided by the hospital at the center include: after school activities, career development, Late Night Hoops, Summer Camp (summer months only), Drug & Violence Prevention and Health & Nutrition. *Values to Success* increases participants overall knowledge of healthy behaviors, helps build character and promotes a sense of self-worth and self-efficacy. *Bridges* supports young adults who have graduated high school but need assistance in navigating college, career and housing. |
| **Community Benefit Category** | A4 – Social and Environmental Improvement Activities |
| **FY 2018 Report** | |
| **Program Goal / Anticipated Impact** | Improve the lives of those attending Family Focus Center. |
| **Measurable Objective(s) with Indicator(s)** | Increase the percentage of youth completing the Values to Success Program. |
| **Intervention Actions for Achieving Goal** | Components of the program include workshops, presentations, and activities striving to increase participants overall knowledge of healthy behaviors, help build character, and promote a sense of self-worth and self-efficacy. |
| **Planned Collaboration** | The Family Focus Center collaborates with several community agencies, bringing in a variety of experts in multiple fields to engage with the at-risk population we serve. |
| **Program Performance / Outcome** | FY2017: 157 enrolled with 68 completing the program (43.3%).<br>FY2018: 94 enrolled with 69 completing the program (73.4%). |
| **Hospital's Contribution / Program Expense** | $14,362 for Values to Success Program<br>$385,815 for all programs at Family Focus Center |
| **FY 2019 Plan** | |
| **Program Goal / Anticipated Impact** | Improve the lives of those attending Family Focus Center. |
| **Measurable Objective(s) with Indicator(s)** | Increase the number of youth enrolled in the Bridges Program who complete their individualized Success Plans. |
| **Intervention Actions for Achieving Goal** | Each person enrolled in the Bridges Program works with staff to set personal goals. Goals may include obtaining legal documents, education goals, career goals, housing and/or personal growth and development. |
| **Planned Collaboration** | The Family Focus Center collaborates with several community agencies, bringing in a variety of experts in multiple fields to engage with the at-risk population we serve. |

## ECONOMIC VALUE OF COMMUNITY BENEFIT

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

**For period from 7/1/2017 through 6/30/2018**

| | Persons Served | Net Benefit | % of Org. Expenses |
|---|---|---|---|
| **Benefits for Living in Poverty** | | | |
| **Financial Assistance** | **463** | **3,703,152** | **0.9** |
| **Medicaid**[3] | **116,510** | **17,765,569** | **4.2** |
| **Community Services** | | | |
| A - Community Health Improvement Services | 6,342 | 657,667 | 0.2 |
| E - Cash and In-Kind Contributions | 68 | 2,177,162 | 0.5 |
| F - Community Building Activities | 0 | 86 | 0.0 |
| G - Community Benefit Operations | 0 | 310,426 | 0.1 |
| **Totals for Community Services** | **6,410** | **3,145,341** | **0.7** |
| **Totals for Living in Poverty** | **123,383** | **24,614,062** | **5.8** |
| **Benefits for Broader Community** | | | |
| **Community Services** | | | |
| A - Community Health Improvement Services | 2,812 | 158,736 | 0.0 |
| B - Health Professions Education | 135 | 3,313,275 | 0.8 |
| E - Cash and In-Kind Contributions | 3,948 | 46,105 | 0.0 |
| F - Community Building Activities | 636 | 117,193 | 0.0 |
| **Totals for Community Services** | **7,531** | **3,635,309** | **0.9** |
| **Totals for Broader Community** | **7,531** | **3,635,309** | **0.9** |
| **Totals - Community Benefit** | **130,914** | **28,249,371** | **6.7** |
| **Medicare** | **29,782** | **22,625,607** | **5.3** |
| **Totals with Medicare** | **160,696** | **50,874,978** | **12.0** |

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

[3] The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $31,393,904.

# APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

## HOSPITAL COMMUNITY ADVISORY BOARD ROSTER FY2018

Toni Callicott, Board Chair
Retired, President
American Red Cross Inland Empire

Robert Carlson, PhD, Vice-Chair
Retired, Educator
California State University San Bernardino

Samuel Cherny, MD
Internal Medicine

June Collison, President
Community Hospital of San Bernardino

Osvaldo Garcia, DDS
Osvaldo R. Garcia & Associates

Jean-Claude Hage, M.D.
Family Practice Medical Group of San Bernardino

Sr. Deenan Hubbard, CCVI
Sponsoring Order
Sisters of Charity of the Incarnate Word

Sr. Nancy Jurecki, OP
Providence Health and Services

Wilfrid Lemann
Fullerton, Lemann, Schaefer & Dominick, LLP

Ashis Mukherjee, MD
Cardiovascular Disease

Vellore Muraligopal, MD
Neonatology Medical Group

Ron Rezek
Rezek Logistics

Michael Salazar, Vice President
UBS Financial Services

Connie Threlkel, President/Owner
Goodfaith Medical Transportation Company

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Ex Officio Members

Douglas Kleam, President
St. Bernardine Medical Center

Ruben Osorio, MD
Chief of Staff (January 1, 2017-December 31, 2017)

Fariborz Lalezarzadeh, DO
Chief of Staff (effective January 1, 2018)

## COMMUNITY BENEFIT INITIATIVE COMMITTEE ROSTER FY2018

Fr. Michael Barry, SS.CC.
Mary's Mercy Center

Tarrisyna Bartley, LCSW
IESA[4] Care Coordination Manager

Claudia Davis, PhD
Associate Professor & Faculty Fellow
California State University San Bernardino
Board Member of Community Hospital of San Bernardino

Deborah Davis
Chief Administrator
Legal Aid of San Bernardino

Sr. Deenan Hubbard, CCVI
Board Member & Sponsoring Order
St. Bernardine Medical Center

Vicki Lee
Homeless Liaison, SBCUSD
Family Resource Center
Board Member of Community Hospital of San Bernardino

Christopher Lopez
San Bernardino Mayor's Chief of Staff

Linda McDonald
Southern California Vice President
Mission Integration
Dignity Health

Kathleen McDonnell
IESA Director, Mission Integration

Dan Murphy
IESA Vice President Foundation

Rev. Tom Rennard
First Presbyterian Church of San Bernardino

Jordan Wright, Policy Advisor
Board of Supervisors
Josie Gonzales, Supervisor 5th District

Sr. Margo Young, MD
IESA Director, Community Health

[4] IESA – Inland Empire Service Area (includes Community Hospital of San Bernardino and St. Bernardine Medical Center)

## APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

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

- Since its launch in 2011, San Bernardino County *Community Vital Signs* has attracted both local and national attention spotlighting the county's efforts for rich collaboration by exemplifying the idea that all sectors are interrelated and must work in concert for collective action. The Community Transformation Plan serves as a guide to transform San Bernardino County into a healthier place to live, work, learn and play. Community Health and Outreach staff have served on the Steering Committee of Community Vital Signs to ensure integration of the health component in the program planning.

- Inland Caregiver Resource Center (ICRC) has been a partner with Dignity Health for 10 years. This nonprofit organization provides an array of supportive services to family caregivers of adults with brain-impaired conditions, such as Alzheimer's disease, stroke, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and traumatic brain injury. ICRC provides these services at no cost to residents of the counties of Riverside, San Bernardino, Inyo and Mono. Dignity Health's current **$150,000 line of credit** approved in 2017 for another two years is enabling ICRC to manage cash flow while it waits for reimbursement from county contracts.

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

- Dignity Health established a system-wide initiative to address the issue of Human Trafficking. St. Bernardine Medical Center has embraced this cause, understanding that this crime against the most vulnerable in our society is in direct opposition to our values of dignity and justice. In addition to training staff to recognize the red flags of human trafficking, presentations have been made to community organizations to raise awareness, and collaboration with agencies supporting victims and survivors of human trafficking is underway to build strong, multi-agency resource networks. Dignity Health advocates for laws and policies that prevent exploitation as well as those that protect victims and vulnerable populations, and St. Bernardine Medical Center's community partners have responded to our requests to express their support of these laws to their legislative representatives.

- Dignity Health again partnered with Kids for Peace to sponsor The Great Kindness Challenge, a global program that aims to inspire people to make a lifelong commitment to service and kindness. The Great Kindness Challenge School Edition is an anti-bullying initiative dedicated to creating a culture of kindness in elementary, middle, and high schools worldwide. St. Bernardine Medical Center partnered with Lincoln Elementary and Howard Inghram Elementary schools in the San Bernardino City Unified School District to encourage the students

to perform acts of kindness. The hospital also collaborated with the Holy Rosary Academy of the Diocese of San Bernardino Catholic to promote the challenge at our local Catholic elementary school.

- As part of our commitment to building healthier communities, SBMC seeks ways to be an example of a responsible employer by reducing our own environmental hazards and waste as well as partnering with others to advance ecological initiatives. Practice Greenhealth recognized St. Bernardine Medical Center's recycling and stewardship innovations with their Partner Recognition Award in 2018. This year, plastic straws have been eliminated in the cafeteria.

- In addition to collaboration with local agencies, St. Bernardine Medical Center continues to engage in the annual California Statewide Medical and Health Exercise (SWMHE), a realistic exercise meant to aid healthcare entities and their partners in developing operational plans in the event of a community emergency. This exercise is sponsored by the California Department of Public Health and the Emergency Medical Services Authority with representatives from multiple additional agencies. The FY18 California Statewide Medical and Health Exercise was held on November 16, 2017.

# APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

### Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

### Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

**Traducción disponible**: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area at 2101 N. Waterman Avenue, San Bernardino, CA 92404 and can be reached at the telephone number listed below for your hospital.

**Financial Counseling** 909.883.8711 ext. 4408 | **Patient Financial Services** 909.881.4418
www.dignityhealth.org/stbernardinemedical/paymenthelp