Community Hospital of San Bernardino

2025 Community Health Implementation Strategy and Plan

Adopted November 2025



Dignity Health®
Community Hospital of San Bernardino

A member of CommonSpirit

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At-a-Glance Summary

Community Served	Dignity Health – Community Hospital of San Bernardino (CHSB) is located at 1805 Medical Center Drive, San Bernardino, California 92411. The hospital tracks ZIP Codes of origin for all patient admissions and includes all who received care without regard to insurance coverage or eligibility for financial assistance. For the purposes of this report, the hospital defines its primary service area to include 31 ZIP Codes in 17 cities within San Bernardino County.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs the hospitals intends to address with strategies and programs are: • Access to Health Care • Behavioral Health (Mental Health and Substance Use) • Chronic Diseases, including Overweight and Obesity • Housing and Homelessness • Preventive Practices
Strategies and Programs to Address Needs	The hospital intends to take several actions and dedicate resources to these needs, including: <u>Access to Health Care</u>: Financial assistance Para Su Salud - enrollment assistance Health Education Center Coordinated Community Network Community grants program <u>Behavioral Health (Substance Use and Mental Health)</u>: Cultural Trauma and Mental Health Resiliency Program Early Start Program Health Education Center Adult Behavioral Health Program Community grants program <u>Chronic Diseases, Including Overweight and Obesity</u>: Health Education Center Diabetes Wellness Center Support groups Community grants program <u>Housing and Homelessness</u>: Accelerating Investment for Healthy Communities Community Health Navigator

10th Decile Project
Community grants program

Preventive Practices:
Vaccines
Personal protective equipment (PPE)
Health Education Center
Community grants program

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

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

Our Hospital and the Community Served

About the Hospital

Community Hospital of San Bernardino is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Dignity Health's Community Hospital of San Bernardino is located at 1805 Medical Center Drive, San Bernardino, CA 92411. For the purposes of this report, the hospital defines its primary service area to include 31 ZIP Codes in 17 cities within San Bernardino County.

Since the day we opened our doors in 1910, Community Hospital of San Bernardino has been committed to making our local community a healthy one.

Community Hospital is a full-service, not-for-profit community hospital with 343 beds, providing exceptional healthcare to San Bernardino. The hospital is a Dignity Health Member, the fifth largest health system in the nation.

Our hospital offers a wide variety of programs and services for all your health care needs, most notably the Family Birth Center, Behavioral Health, Ear, Nose & Throat, Emergency Services, Health Education Center and Pediatrics.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

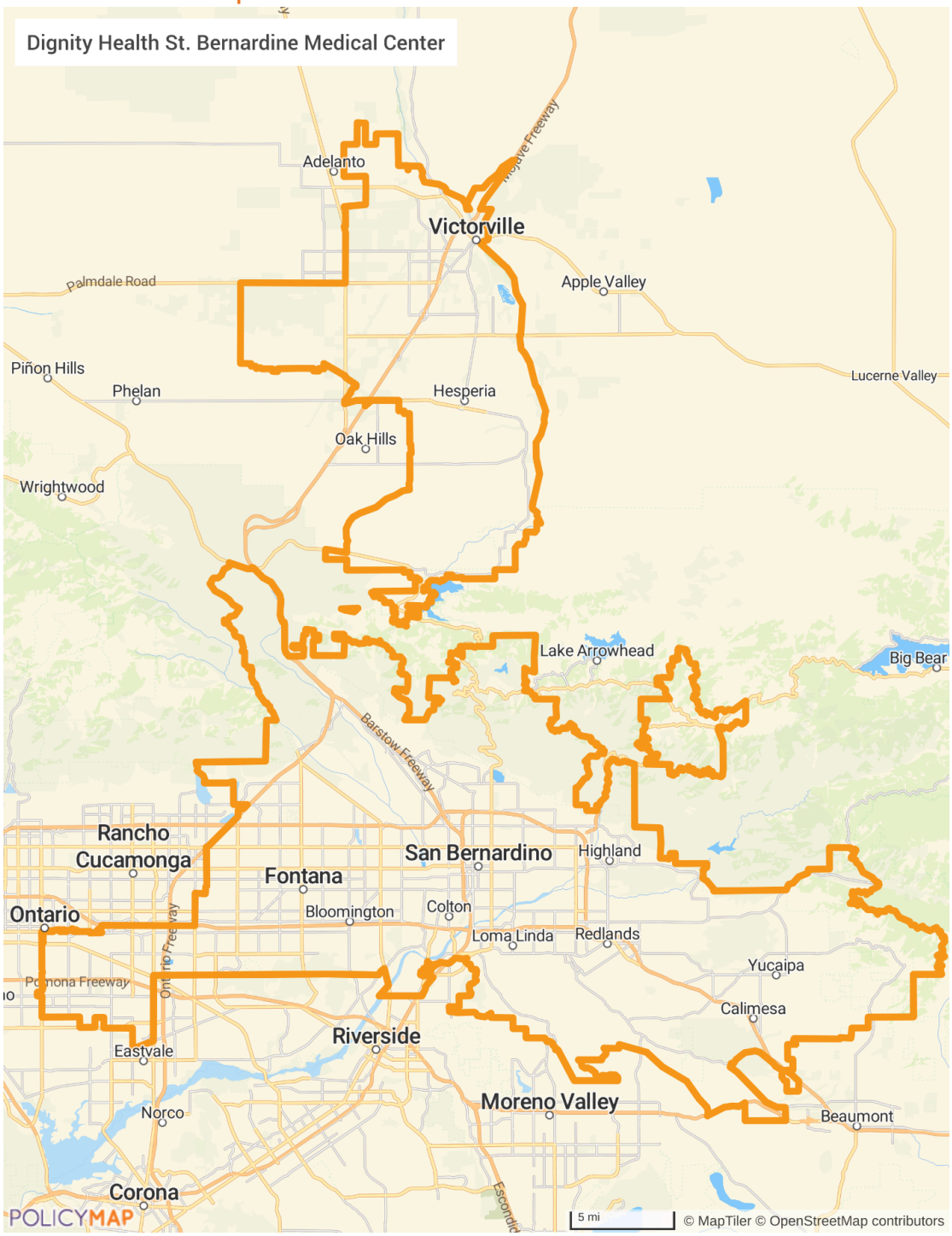
Description of the Community Served

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

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

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

Service Area Map



Community Assessment and Significant Needs

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

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

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

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Access to Health Care	90.6% of St. Bernardine Medical Center's (SBMC) service area's population has health insurance coverage which is lower than the Healthy People 2030 objective and lower than the County and State rates of insured. Certain communities in the service area are far below these insurance coverage rates, especially parts of Fontana and San Bernardino. When examined by race and ethnicity, Hispanic and other race adults are the least insured. Less patients are seeking care at local and regional FQHCs than previously. A third of adults do not have dental insurance.	X
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. The rate of low-birth-weight babies is higher in the hospital's service area than in the county and the state. And the rate of premature birth in the service area, occurring before the start of the 38th week of gestation is higher than the county rate and the state rate of premature birth. Additionally, the hospital service area's	

Significant Health Need	Description	Intend to Address?
	breastfeeding rates are lower than both the county and the state.	
Chronic Diseases	SBMC's service area has high rates of stroke deaths, cancer deaths for all cancers, and mortality due to diabetes, liver disease and kidney disease. More people in the service area are hospitalized for diabetes, heart failure and hypertension, compared to California. Asthma is more prevalent in adults in SBMC's service area than in the county and in California. More seniors in SBMC's service area are living with disability, compared to the county and California	X
Environmental Health	When people are exposed to hazards like polluted air and lead in their drinking water, they can develop serious conditions, such as asthma, heart disease, cancer and dementia. Most of the populated Census tracts in the service area belong to the highest-burdened level of environment hazards.	
Food Insecurity	The US Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods. Among children in San Bernardino County, 17.9% lived in households that experienced food insecurity. Feeding America estimates that 74% of those experiencing food insecurity in San Bernardino County, and 67% of county children experiencing food insecurity, are income-eligible for nutritional programs such as SNAP/CalFresh.	
Housing & Homelessness	40.7% of households in the service area spend 30% or more of their income on housing, which is designated as "cost burdened" by the U.S. Department of Housing and Urban Development. Over 70% of the 4,000+ unhoused individuals in San Bernardino County are unsheltered and over 50% are chronically homeless adults.	X
Mental Health	Adults in the hospital service area experience frequent mental distress more than in the county and in California. In San Bernardino County, more adults have been told they have a depressive disorder, compared to California. And more adults in San Bernardino sought help and did not receive treatment, compared to	X

Significant Health Need	Description	Intend to Address?
	California. San Bernardino County has less mental health providers per person, as compared to California.	
Overweight & Obesity	More teens in San Bernardino County are overweight, than in California. In San Bernardino County, 77.4% of Latino adults, 72.5% of non-Latino Black/African American, 67.7% of non-Latino multiracial, 64.5% of non-Latino White, and 41.9% of non-Latino Asian adults are overweight or obese, which are higher than state rates.	X
Preventative Practices	The Healthy People 2030 objective is for 70% of the population to receive a flu shot. 33.5% of San Bernardino County adults received a flu shot during the 2021 survey year. For mammograms, the Healthy People 2030 objective is for 80.3% of women, between the ages of 50 and 74, to have a mammogram in the past two years. In the service area, 75.7% of women had obtained mammograms in the prior two years. For colorectal cancer screenings, the Healthy People 2030 objective for adults, ages 50 to 75 years old, is for 68.3% to obtain a screening. 55% of service area residents, aged 50-75, met the colorectal cancer screening guidelines.	X
Sexually Transmitted Infections (e.g. HIV)	Common STIs include syphilis, gonorrhea, and chlamydia. STI cases and rates show a mostly downward trend. Rates for Chlamydia, Gonorrhea and Syphilis are highest for Black or African American residents. Also, the rate of new HIV cases in San Bernardino County was higher than the new case rate statewide.	
Substance Use & Misuse	Adults in San Bernardino County have higher alcohol use, compared to California, higher hospitalization rates for opioid overdose (excluding heroin), and higher opioid prescriptions per 1,000 people.	X

Significant Health Needs the Hospital Does Not Intend to Address

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

Birth outcomes such as low birth weight and infant mortality are important measures of community health. However, these needs are primarily addressed through county-level maternal and child health programs and local public health agencies that specialize in prenatal, perinatal, and early childhood care.

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

Food insecurity remains a challenge in San Bernardino County, impacting access to nutritious meals for many families. While CHSB supports health education related to nutrition and chronic disease prevention, direct food distribution is effectively managed by local food banks and community-based organizations.

Prevention and treatment of sexually transmitted infections are critical public health needs. These services are comprehensively managed by San Bernardino County Public Health and local community clinics that provide specialized outreach, screening, and treatment programs.

2025 Implementation Strategy and Plan

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

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



Creating the Implementation Strategy

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

The Implementation Strategy is created through a collaborative, multidisciplinary process involving hospital leaders, clinical staff, and community health representatives. The approach ensured that the plan is data-driven, community informed, and consistent with both the findings of the 2025 Community Health Needs Assessment (CHNA) and CHSB's commitment to addressing health equity and access.

Key participants in developing the Implementation Strategy included representatives from:

Mission Integration and Community Health
Nursing and Clinical Leadership
Finance and Strategy
Care Coordination / Social Services
Health Education Center
Communications & Philanthropy

Community input to this Implementation Strategy includes the prioritization process embedded in the 2025 CHNA. Stakeholder interview participants included a broad range of stakeholders concerned with health and wellbeing in San Bernardino County who spoke to issues and needs in the communities served by the hospital. Stakeholders included individuals who are leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies that have current data or other information relevant to the health needs of the community served by the hospital facility. In addition to interviews, stakeholders responded to an electronic survey, to rank each identified significant health needs. The results were used in prioritizing the Health Focus Areas for this Implementation Strategy.

Programs were prioritized according to the following criteria:

- Demonstrated effectiveness and evidence of success in improving health outcomes;
- Alignment with the hospital's core mission and areas of expertise;
- Availability of resources and potential for collaboration with community partners;
- Capacity to address disparities and promote health equity; and
- Potential for measurable outcomes and long-term community benefit.

Community Health Core Strategies

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

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

Vital Conditions and the Well-Being Portfolio

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

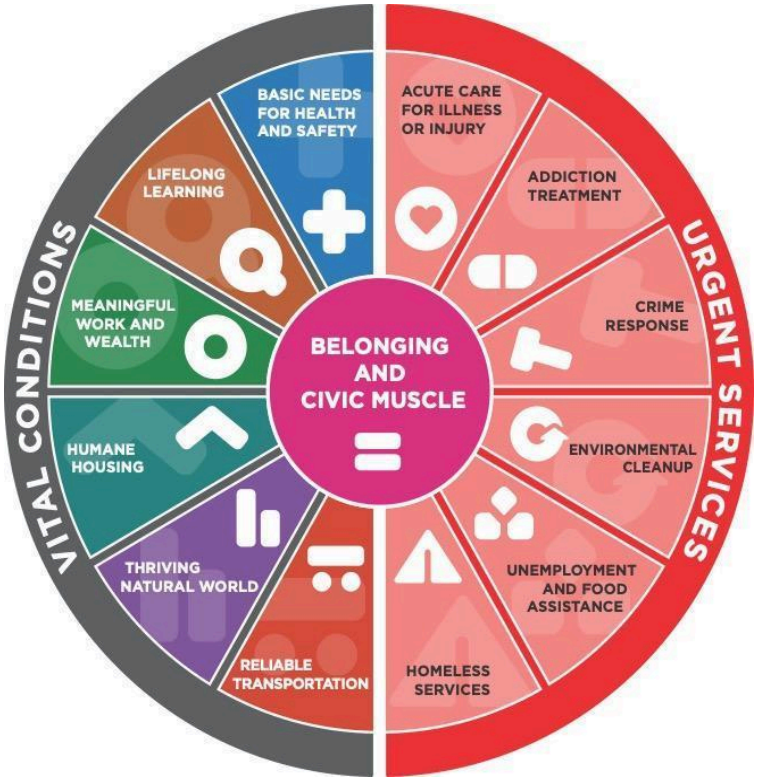
Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

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

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

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

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



Well-Being Portfolio in this Strategy and Plan

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

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

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

Strategies and Program Activities by Health Need

Health Need:	Access to Care				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Financial assistance for the uninsured or under-insured	Provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	●	●	●	VC
Para Su Salud – enrollment assistance program	Provides assistance to individuals and families to sign up for health insurance benefits. Assists persons with CalFresh and general relief benefits	●	●	●	VC
Coordinated Community Network (CCN)	Hospital care coordination and community partner agencies work together to identify the health and health-related social needs of vulnerable patients. The CCN electronically links clients to organizations that provided direct services.	●	●	●	VC
Health Education Center	Offers education to the community free of charge and addresses access to health care topics including: local resources for primary and preventive care, and navigating the health care system.	●	●	●	VC

Health Need:	Access to Care				
Community grants program	Offers grants to nonprofit community organizations that provide health care access programs and services.	•	•	•	VC
Planned Resources:	The hospital will provide health care providers, care coordinators, enrollment counselors, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: community clinics, faith groups, community-based organizations, public health and city agencies.				

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

Health Need:	Behavioral Health Services (Mental Health and Substance Use)				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Early Start Program	Provides early childhood education, health care and mental health services, parenting education, childcare, adult education, housing, legal, and financial assistance		●	●	VC
Adult Behavioral Health Program	Provides inpatient adult behavioral health program with 50 beds, Psychiatric Medical Program, and Involuntary Adult Inpatient Program.	●	●		US
Health Education Center	Addresses a variety of behavioral health care topics.	●	●	●	VC
Community grants program	Offers grants to nonprofit community organizations that provide mental health and substance use programs and services.	●	●	●	VC
Planned Resources:	The hospital will provide mental health care providers, 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, law enforcement, and regional collaboratives that seek to support individuals' mental health, substance use and case management needs.				

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

Health Need:	Chronic Diseases (including Overweight and Obesity)				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Health Education Center	Provides community education on chronic disease-related health care topics, including: Chronic Disease Self-Management, Healthy Eating Lifestyle Program and Diabetes Empowerment Education Program.	●	●	●	VC
Diabetes Wellness Center	Hosts the Sweet Success program, which focuses on gestational diabetes.	●	●	●	VC
Support groups	Assists persons with chronic diseases to improve their emotional well-being through mutual support, coping strategies, and psycho-education.	●	●		VC
Community grants program	Offers grants to nonprofit community organizations that provide chronic	●	●	●	VC

Health Need:	Chronic Diseases (including Overweight and Obesity)				
	disease-focused programs and services.				
Planned Resources:	The hospital will provide health care providers, patient navigators, health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include: public health, community clinics, community-based organizations, American Heart Association, maternal health organizations, American Cancer Society and American Diabetes Association.				

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

Health Need:	Housing Insecurity and Homelessness				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Accelerating Investment for Healthy Communities	Participates in a national initiative designed to increase investments in the social determinants of health with an emphasis on affordable housing.	●	●	●	VC
10th Decile Project	This grant-funded project connects the top 10%	●	●	●	VC

Health Need:	Housing Insecurity and Homelessness				
	of highest cost, highest need chronically homeless individuals seen at CHSB to intensive case management, supportive housing, and appropriate physical, mental, and behavioral health care services. diabetes.				
Community Health Navigator	Assists persons experiencing homelessness who seek care in the ER. Provides connections to social service agencies.	●	●		VC
Community grants program	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.	●	●	●	VC
Planned Resources:	The hospital will provide social workers, health care providers, case managers, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned Collaborators:	Key partners include: housing and homeless agencies, city agencies, funders, faith community, community clinics, and community-based organizations.				

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

Health Need:	Preventive Practices				
Population(s) of Focus:	Vulnerable Populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Vaccines	Provides free vaccines in the community.	●	●	●	VC
Personal Protective Equipment (PPE)	Distributes PPE at local community events and to community partners	●	●	●	VC
Health Education Center	Provides community education on a variety of preventive care topics.	●	●		VC
Community grants program	Offers grants to nonprofit community organi-zations that provide preventive care programs and services.	●	●	●	VC
Planned Resources:	The hospital will provide health care providers, health educators, philanthropic cash grants, outreach communications, and program management for this initiative.				
Planned Collaborators:	Key partners include: public health, faith community, community clinics, community-based organizations.				

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

Program Highlights

Over the next three years, Community Hospital of San Bernardino (CHSB) will continue to advance its mission of improving the health and well-being of the communities it serves through focused, collaborative, and sustainable initiatives. The hospital's programs are strategically designed to address the five prioritized health needs identified in the 2025 Community Health Needs Assessment: Access to Care, Behavioral Health, Chronic Diseases (including Overweight and Obesity), Housing and Homelessness, and Preventive Practices.

- Access to Care:
  CHSB will expand access to essential health services through programs such as Para Su Salud, the Enrollment Assistance Program, and the Coordinated Community Network (CCN). These initiatives will continue to strengthen linkages between hospital services and community-based providers, ensuring that vulnerable populations receive timely, affordable, and coordinated care.

- Behavioral Health:
  The hospital will enhance community mental health and substance use support through its Adult Behavioral Health Program, Early Start Program, and Health Education Center. Emphasis will be placed on early intervention, trauma-informed care, and partnerships with schools, community-based organizations, and local behavioral health agencies to improve access and continuity of care.

- Chronic Diseases:
  Through the Diabetes Wellness Center, Health Education Center, and community Support Groups, CHSB will promote chronic disease prevention and self-management education. Programs will focus on increasing community awareness of risk factors, encouraging healthy lifestyle practices, and reducing health disparities related to diabetes, cardiovascular disease, and obesity.

- Housing and Homelessness:
  CHSB will strengthen its commitment to supporting individuals experiencing housing instability through the 10th Decile Project, Community Health Navigator, and participation in the Accelerating Investment for Healthy Communities Initiative. These programs will connect high-risk and unhoused individuals to comprehensive care coordination, social services, and stable housing resources.

- Preventive Practices:
  Prevention remains central to CHSB's community benefit efforts. The hospital will continue to provide vaccination outreach, personal protective equipment (PPE) distribution, and health education through the Health Education Center and Community Grants Program. These initiatives will emphasize early detection, disease prevention, and empowerment through health literacy.

Through these strategic efforts, CHSB aims to strengthen partnerships, leverage data to measure impact, and foster long-term improvements in health equity and community well-being across San Bernardino County.