St. Bernard Hospital
and Health Care Center

Community Health Needs Assessment

Implementation Plan

April 12, 2022

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I. Executive Summary:

Hospital History and Services

Founded in 1904, St. Bernard Hospital is a 174 licensed beds, Catholic community safety-net hospital operating under the sponsorship of Catholic Health International. Our mission calls for us to care for the sick and promote the health of residents of Chicago's South Side, while sustaining values of respect, dignity, caring and compassion for all persons. For over 117 years, St. Bernard has operated within the Englewood Community and developed a reputation for quality, compassionate care, and great clinical outcomes.

St. Bernard Hospital is accredited by the Joint Commission, providing high quality health inpatient and outpatient care services to about 80,000 patients, annually. The emergency room serves about 40,000 patients each year. The hospital provides comprehensive inpatient and outpatient care, offering a wide range of specialties, including dentistry, gastroenterology, nephrology, emergency and intensive care services as well as inpatient/outpatient mental health services. The hospital is technologically advanced, having electronic medical records, computerized physician order entry, and bar code medication administration in place to ensure quality and patient safety. Each year, the hospital donates millions of dollars in charity care ensuring that community residents have access to the health care services they need regardless of their ability to pay.

In 2016 the Hospital opened its Ambulatory Care Center (ACC), a newly-built 3 story, 70,000 square foot, state-of-the-art outpatient facility on campus. This expands on the established clinical practices and wellness programs offered by the Hospital. Services offered at the ACC include comprehensive women's health in the Women's Wellness Clinic, specialty care services in the Specialty Clinics, primary care services in the Immediate Care Clinic, adult, pediatric and special-needs dentistry in the Dental Center, state of the art diagnostic imaging services; as well as spacious physician offices. Onsite laboratory and pharmacy make it easy for patients to get tests and prescriptions. This one stop shop facility allows the residents of Englewood to get the care they need close to home. Other outpatient services include significant outpatient and day long behavioral health programs and an Adult Mobile Health Unit. St. Bernard also operates a Pediatric Mobile Health Unit, providing free immunization, physicals, testing and education to thousands of children at schools, daycares, and local events.

How the Implementation Strategy was developed:

The Community Health Needs Assessment (CHNA) was completed in September of 2021. The process of creating the CHNA included asking the participants in a number of virtual meetings for suggestions of how St. Bernard Hospital could positively impact the identified health priorities. We then held subsequent meetings with the hospital's Patient Family Advisory Council and representatives of the senior citizen community who gave more insight and confirmation that the directive received from the prior meetings were accurate. The 2021 CHNA was presented and approved by the Board of Directors during the November 2021 meeting, while the Implementation Plan was approved by the Board of Directors during the April 2022 meeting. Please refer to the CHNA hosted on our website (www.stbh.org) for the full report. The implementation strategy was developed by members of the Hospital staff, the CHNA Advisory Committee and the Hospital's Patient Family Advisory Council.

Specific strategies were developed to address each of the top 5 health needs identified by the CHNA.

II. Identified Community Health Needs:

St. Bernard Hospital contracted with the Sinai Urban Health Institute (SUHI) to conduct the 2021 CHNA. The community health needs were identified using a process that included gathering quantitative and qualitative data. The data that was collected focused on the Hospital's primary and secondary service areas.

St. Bernard's service area, located on Chicago's Southside included the following zip codes:

- 60609 – Back of the Yards, Fuller Park, McKinley Park, Bridgeport
- 60615 – Kenwood, Hyde Park
- 60619 – Burnside, Chatham, Avalon Park, Greater Grand Crossing
- 60620 – Auburn Gresham, Beverly, Washington Heights
- 60621 – Englewood
- 60628 – Roseland, Pullman, West Pullman, Riverside
- 60629 – West Lawn, Chicago Lawn, West Elsdon, Gage Park
- 60636 – West Englewood
- 60637 – Woodlawn, Washington Park

- 60649 – South Shore
- 60653 – Oakland, Grand Boulevard

Through the gathering of secondary data and conversations with health practitioners, community residents and leaders, a number of priorities were identified. Once identified, the CHNA Advisory Committee ranked the top priorities by going through a process that scored them based on an established criterion. See the complete CHNA Report, hosted on the Hospital's website for details on the methodology utilized.

The top 5 priorities that were identified are:

- Behavioral Health, Mental Health, and Substance Abuse
- Diabetes
- Heart Disease
- Obesity
- Respiratory Disease

*Cross cutting theme Healthcare Access

III. Addressing Community Health Needs:

Health Need #1 Behavioral Health, Mental Health and Substance Abuse

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Integrate a Trauma informed approach to serving everyone at St. Bernard Hospital (co-workers, visitors and patients). The impact of the high rates of trauma that occur in Englewood and the surrounding communities affects not just the parties involved in the traumatic incident but the families and the community at large. A trauma informed approach will help our staff to be more understanding and have additional skills to deal with how trauma presents on a daily basis in people's behavior.	• Reduce the tension and conflicts that occur on a daily basis while interacting with the public that we serve • Create a more pleasant working environment • Create a healing environment for patients from the moment that they enter the campus.	Grant funds to underwrite the cost of organization wide training. Hospital covering the cost of non-productive hours while employees are participating in training sessions.	
2	Make behavioral health and substance abuse screening tools a part of our standard screening toolkit at all community health fairs, outreach activities and the hospital clinics. Deliberately using language that is simple and welcoming to combat the stigma associated with behavioral and mental health in minority communities.	Proactively identify those individuals that may be reluctant to seek treatment in a welcoming and supportive environment and offer them support and services that they may not be aware of or conscious of their own need.	Behavioral health director will create the screening tool and train other parties in the use.	
3	Create opportunities to educate the community on the resources available to address behavioral health, mental health and substance abuse related issues:	Increase awareness of resources available to support residents in addressing the issues that may be present in their homes or the community.		Faith leaders Community partners Other organizations that have mental health as their focus
4	Create a resource kit for the community for the pediatric population in need of mental health and substance abuse support.	Pediatric patients will be directed to the appropriate institution to receive the treatment that they need.		other CBO's (to be named)

Health #1 – Behavioral Health (cont'd)

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
5	Create social events for the senior citizens (like bingo and exercise) to help minimize the feeling of isolation.	A feeling of connection to others in the community	Meeting space Prizes MA for basic screening	Senior facilities

Health Need #2 - Diabetes

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Create a pre-diabetes education program.	Help patients to understand the signs, symptoms and long-term implication of the disease. Help patients understand the importance of diet and lifestyle to successfully manage the condition.	Underwrite a portion of the cost of an AmeriCorps volunteer to create a program at St. Bernard Hospital	Other existing programs on the south side of Chicago
2	Create a screening tool that can be used in the Emergency Room and the clinics to identify patients that would be good candidates for the Pre-Diabetes Clinic	Identify potential candidates for the education program and increasing the reach of the program		Hospital clinics Physician offices ER staff
3	Engage the registered dietitian to teach participants healthy options for preparing popular dishes and how to prepare certain food that will aid in disease management	Provide participants with practical skills to manage their health condition	Time of the dietitian	Community groups including churches and food pantries.
4	Adult Mobile Health Unit will continue hosting educational sessions with seniors and screening for Diabetes	Increased awareness of their status and tools to manage the disease	AMHU	Senior facilities and neighborhood churches

5	Create informational packet that can be shared with members of the class and community members that speaks about the symptoms, risks, information on risk factors, ways to prevent onset of the disease and steps to manage diabetes	Knowledge of the disease Direction for more information Local resources	Create material to be displayed in the hospital waiting room, at health fairs and other community events. Business development and outreach teams can utilize the material to help increase awareness	Neighborhood Churches Health Fairs Community Groups

Health Need #3 – Heart Disease

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Provide patients information on ways to manage their disease. This would include the signs, risks, factors that exacerbate the disease and ways to manage.	Education will help those living with the disease to better manage their condition	Gather educational material from the American Heart Association	Nurse Practitioners in the specialty clinics. They will educate the patients on their weekly visits.
2	Creation of a Hypertension clinic	Patients would be treated by a physician that would provide education, suggest lifestyle changes and tools to monitor and improve the base line condition		ER physicians Specialty clinics Discharge planning team
3	Create a support group, where participants are provided with a monitor to check and track their numbers on a daily basis to identify trends that can be intercepted to better manage the condition.	Increased awareness of the factors that impact the number and better management of the disease. Have people with the same issue to talk to	Grant funding to provide equipment to patients	
4	Referrals from department and clinics	Identify patients that have poor test results and encourage them to participate in one of the programs		All hospital clinics and inpatient departments

Health Need #4 – Obesity

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Educational series teaching residents how to prepare a variety of fresh vegetables and healthier versions of popular dishes. • Provide ingredients so participants can replicate the dishes at home.	Encourage healthy eating through easy to follow actions They will try the recipes at home and continue with the healthier version	Dietitian Donations of groceries Groceries for the classes	Food pantries and local churches. Partner with local farms and grocery stores
2	Recruit participants to the future walking club. Participants would be required to have baseline measurements taken and progress checked every 4 weeks.	Get participants to be more active in a safe environment	Staff time	Local schools (for space)

Health Need #5 – Respiratory Disease

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Educate community residents on the signs, symptoms, adverse effects of the disease and other illnesses that are a result of respiratory complications.			
2	Develop a list of resources and connections where patients can be referred to for a higher level of care			South Side Health Care Collaborative members
3	Resume smoking cessation classes for patients and staff	Assist participants to quit smoking, which will directly improve their respiratory health	Certified counselor	American Respiratory Society

Cross cutting theme – Healthcare Access

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Ambulatory Care Center (ACC) is the outpatient center where patients can see a primary care physician, have specialty services and imaging, and other tests conducted. There is also a lab and pharmacy on site. This allows patients in the Englewood community the ability to address many issues in a single location close to where they live. Increase Medicaid and Medicare enrollment opportunities for those who are eligible but not previously enrolled	Minimize the distance and time spent traveling to access services by residents of the community. Increasing the availability of specialty services to the Englewood and surrounding community. Increase the access to primary care services through the Immediate Care Clinic that allows patients to see a physician if they do not have PCP or if their PCP is unavailable. Reduce the practice of seeking emergency care when the problem becomes critical and instead, encourage preventative care. Reduce financial implication of treating non- emergency issues in the Emergency Room	ACC, staff and the various clinics housed within	Federally Qualified Health Centers Local physician offices Faith based organizations
3	Partner with the local faith-based community to assist in educating and increasing awareness of locally available health services.	Ensure that more community members are informed of the many services available in the community.	Marketing and educational material	Community faith based organizations Teamwork Englewood

IV. Community Health Needs Not Addressed:

As stated previously, the top five health needs that were identified during the CHNA process were:

- Behavioral Health, Mental Health and Substance Abuse
- Diabetes
- Heart Disease
- Obesity
- Respiratory Disease

Though not one of the top five health needs, the COVID-19 pandemic that has impacted every aspect of life for the last two years and must be mentioned. St. Bernard Hospital has been at the forefront of tackling COVID -19 and its impact on the community. Efforts to address this disease include:

- Making modifications to inpatient rooms and the emergency department to minimize the transmission and circulations of the virus
- Converting all inpatient units (except Obstetrics) into COVID units to meet increased demand for inpatient COVID beds
- Utilizing electronic devises to minimize isolation and allow patients to communicate with loved ones that could not enter the hospital
- Provide testing clinics on the Hospital campus and via the Mobile Health Units to identified positive patients
- Conducted contact tracing, to identified persons that may have been exposed to try to minimize the spread of the virus
- Purchased ultra-cold freezers to be able to receive vaccines once approved by the FDA
- Opened a vaccination clinic to make vaccines available
- Conducted vaccine clinics off-site and provided services to home bound patients, to bring equity to the vaccine distribution
- Opened a call center so that patients that had limited or no access to the internet could make vaccine reservations
- Started providing vaccinations to children (once approved by the FDA) at the schools, so that parents did not have to take time away from work to get them vaccinated.
- Hosted COVID-19 virtual education sessions for the public.
- Created multiple educational opportunities for our staff., to address concerns regarding becoming vaccinated

As a community safety net hospital there are limitations to the resources that are available to us. Many of the chronic conditions identified requires the service of specialists that are not on staff at St. Bernard so we have to collaborate with other institutions. There are three health issues identified during the 2021 CHNA process that St. Bernard has not addressing currently, they are:

- ***Cancer*** – As a safety-net hospital we do not have the specialist and supporting resources to adequately treat cancer patients. If there a suspicion of or a confirmation of a cancer diagnosis, the patient is referred to a tertiary institution with the capability to treat the condition.
- ***Maternal and Infant Health*** – Due to the increased cost of operations and declining number of patients, in November 2020, the hospital stopped providing inpatient obstetrical services. All mothers who are ready to deliver are referred to a number of hospitals. We also have an established agreement with tertiary institutions so that mothers who come to the Emergency Room in active delivery many be transferred to them to deliver and provide the best care available to mother and child.
- ***Sexual Health*** – As a Catholic institution, we can treat and educate the community about sexually transmitted diseases. However, there are services that we are prohibited from providing (like birth control) due to the Ethical and Religious Directives of Catholic Health Care. In such cases we refer the patient to another provider.

V. Conclusion:

The St. Bernard Hospital board of directors approved the 2021 CHNA on November 15, 2021. A complete copy of the report can be viewed at www.stbh.org

A link to the Implementation Plan can be found at www.stbh.org.

If you have any questions regarding the CHNA, the Implementation Plan or to get a copy or either please contact Diahann Sinclair V.P. Organizational and Community Development at 773-962-4100 or dsinclair@stbh.org.