St. Bernard Hospital
and Health Care Center

Community Health Needs Assessment

Implementation Plan

February 17, 2025

Steering Committee Members:

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I. Executive Summary:

Hospital History and Services

Founded in 1904, St. Bernard Hospital is 174 licensed bed, 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 120 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 72,000 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, ophthalmology, emergency and intensive care services as well as inpatient/outpatient mental health services. We also treat acute and chronic conditions, such as heart disease and diabetes. St. Bernard offers a full range of diagnostic imaging services and a 24-hour Emergency Department. 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 3 story, 70,000 square foot, state-of-the-art outpatient facility on its campus. This facility expanded 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 and Family Practice Clinics, 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 that 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 2024. The process of creating the CHNA included asking 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 2024 CHNA was presented and approved by the Board of Trustees during the December 2024 meeting, while the Implementation Plan was approved by the Board of Directors during the February 2025 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 2024 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
- 60617 – Calument Heights, South Chicago, South Deering, Avalon 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

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 4 priorities that were identified are:

- Older Adult Health
- Heart Disease
- Respiratory Health
- Behavioral Health, Mental Health, and Substance Abuse

*Cross cutting health need: Access to Healthcare

III. Addressing Community Health Needs:

Health Need #1 – Older Adult Health

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	Recent launch of the Center for Better Aging – A clinic created to deliver comprehensive services designed around the specific needs of the older population	With the programming provided by this clinic, older adults should have a better overall quality of life, with access to specialists, nutritionists, and wrap around services including transportation. Reduce the barriers to care	Practitioners Administrator	Center for Better Aging Community groups and social service agencies that focus on seniors or supporting services Referring physicians Emergency Department
2	Re-launch of the Adult Health Mobile Unit	Reach adults who are not having regular interactions with a primary care doctor, provide basic screenings and refer them the appropriate clinic or provider in the Hospital	Fundraising clinician and other staff	Local faith-based organizations, community groups, senior living facilities
3	Continuation of monthly Senior Bingo	Combat isolation amongst seniors. Interaction with younger hospital staff in a relaxed setting	Hospital staff volunteers Gathering space refreshments	Senior living facilities adjacent to the Hospital campus
4	Provide support to seniors • Encourage family/ loved ones to attend appointments with the elderly patient	More seniors will keep appointments and better navigate the hospital systems (scheduling, appointments with other clinics in the Hospital)	Partner with local organizations that provide transportation and CHW's	Community based organizations Family members

5	Programming that emphasizes movement for seniors	Improving balance, circulation, coordination, cognition and improved socialization	PT staff	KKC (facility) Senior friendly organization Senior satellite center (on 63rd street)

Health Need #2 – 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 healthy habits like nutrition.	Education will help those living with the disease to better manage their condition and make informed decisions	Gather educational material from the American Heart Association	Providers in the Specialty and Immediate Care clinics. They will educate the patients on their visits.
2	Heart Health Awareness Day (National Wear Red Day, first Friday in Feb) Staff heart health day (also in Feb)	BP screenings in lobby of ACC and Hospital. Provide guidance to all participants based on the result of screening and information on heart health	Clinician Dietitian	
3	Create a support group, where participants are provided with a monitor to check and track their numbers, eating and exercise habits on a daily basis to identify trends that can be intercepted to better manage the condition. Possibly using free application that allow	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	Incorporate in discharge planning and post visit information
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

5	Focus on heart health in our Specialty Clinic through increased cardiac provider availability	Specialized approach will improve the overall health of patients with heart disease by providing regular and targeted interventions.	Medical supplies Clinic space practitioners	Physicians for referrals Partner with larger institutions that can address need for higher levels of care

Health Need #3 – 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 disease.	More awareness of triggers and issues that exacerbate the condition		Organization with CHW Faith based community
2	Lung Cancer screenings	Education and early detection for better long-term outcomes		American Lung Cancer Society Collaborative members
3	Continue to offer smoking cessation classes for patients and staff	Assist participants to quit smoking, which will directly improve their respiratory health	Certified counselor	American Respiratory Society
4	Education sessions about COPD	More educate the public and staff about the causes and long-term effects of certain activities like smoking. Increased awareness	Practitioners Refreshment for sessions Conference room space	Cardiologists Physician Assistants/ NP
5	Host vaccine clinics for senior in the fall, at congregate living facilities	Reduce the number of seniors that are susceptible to diseases like influenza, COVID, RSV.	Adult Health Mobile Units Vaccines Practitioner	Senior living facilities

Health Need #4 - Behavioral Health, Mental Health and Substance Abuse

	Actions intended to be taken	Anticipated impact of actions	Resources to be committed	Planned Collaborations
1	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
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.	
4	Create a resource kit for identifying resources that are available 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) Pediatric mental health providers
5	Implement a Narcan program (ER)	Safe resource for medication for substance use disorder patients	Narcan dispensing machines Medication	City of Chicago Pharmacy
6	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
7	Grief counseling for seniors	Provide tools for seniors to navigate crippling grief	Licensed providers	Senior living facilities Local faith groups

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 and Family Practice Clinics that allows patients to see a physician if they do not have PCP or if their PCP is unavailable. Reduce the practice of waiting until a health issue is critical to seek care in the ER.	ACC, staff and the various clinics housed within the building	Federally Qualified Health Centers Local physician offices Faith based organizations Community Based Organizations Staff that focus on enrolling patients in specific insurance plans to help them to cover the cost of healthcare, where possible
2	Partner with the local faith-based community to assist in educating and increasing awareness of locally available health services. Host health education events at local churches Provide toolkits for faith leaders to identify needs in their congregations	Educate the community residents on conditions that are prevalent in the community and the things that they should be doing to prevent or manage the conditions.	Marketing and educational material	Community faith based organizations Teamwork Englewood
3	Host the second Community Fit Fest	Create an environment and opportunity for the community to access health information and	Clinicians and staff to work the event.	Faith based community, media, outside vendors, sponsorships, farmers and entertainers

		screenings outside of the clinic setting on a large scale.	Cost of supplies and prizes Fundraising	
4	Host more Lunch and Learn events, to educated residents on the top health priorities identified by the CHNA	More education with help to inform the decisions the residents will make regarding the health of them and their family. This will awareness positively impact their overall health		Doctors of various specialties SSHCO CBA Community Based Organizations
5	Create a database of printed material that can be shared, as well as video clips regarding the top health conditions that can be shared for educational purposes.	Increase knowledge and awareness about the chronic conditions prevalent in the service area		
6	Transportation for patients	Reduce no show rates for clinic and follow up appointments		Ride share organizations Community organizations Center for Better Aging Clinic staff
7	Offer resources during Open enrollment	Health Insurance Resource Fair for the Community		Insurance companies

IV. Community Health Needs Not Addressed:

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

- Older Adult Health
- Respiratory Disease
- Heart Disease
- Behavioral Health, Mental Health and Substance Abuse

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 four health related issues identified during the 2024 CHNA process that St. Bernard has not addressing currently, they are:

- ***Community Safety***– As a safety-net hospital we do not have the resources to directly impact community safety. We do so, indirectly by collaborating with law enforcement to share information (safety alerts) where possible. We also try to ensure that our campus is as safe as possible for all who enter and seek services. We participate in community conversations about safety and support initiatives aimed at improving community safety
- ***Physical Environment*** – The Hospital in the past acquired vacant parcels of land and developed new for sale housing for first time home buyers and a 70,000 sf outpatient center. Currently the market is not conducive for new development. So, we maintain hospital owned vacant lots, with the hope to develop more properties in the near future.
- ***Income Security*** – We are the largest employer in the community, providing stable jobs for a fair wage to the residents.

V. Conclusion:

The St. Bernard Hospital board of trustees approved the 2024 CHNA on December 16, 2024. 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 Chief Hospital Support and Community Engagement Officer at 773-962-4100 or dsinclair@stbh.org.