SAN ANTONIO
REGIONAL HOSPITAL

San Antonio Regional Hospital Community Benefit Implementation Strategy

2020 – 2022

SAN ANTONIO
REGIONAL HOSPITAL

Dear Community Member:

Welcome to San Antonio Regional Hospital's 2020 – 2022 Community Benefit Implementation Strategy. The document that follows is the culmination the 2019 Community Health Needs Assessment and our hospital's planning effort that resulted in a strategy designed to address some of the most pressing health needs in the communities we serve.

Like many industries, healthcare is continually evolving. There is ongoing innovation to create new technologies and methods to treat illness and injury, but over the last several years, there has been a growing movement toward population health management. Population health goes beyond measuring the health of a population, and healthcare goes beyond treating illness and injury. Hospitals are engaging with their communities to improve population health by increasing health awareness and providing education and resources to prevent disease.

San Antonio Regional Hospital's mission is to "improve the health and well-being of the people we serve." Our vision is to "be a leader in creating healthy futures through excellence and compassion." We believe the best way to achieve our vision of the future is by working together with our community. We hope you share our belief in the power of community engagement and collaboration, and you will join us in our journey to improve population health – working together, we will improve the overall health of our region.

Sincerely,

John T. Chapman

John T. Chapman
President and Chief Executive Officer - Interim

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EXECUTIVE SUMMARY

San Antonio Regional Hospital collaborated with the Hospital Association of Southern California to plan and execute the 2019 Inland Empire Regional Community Health Needs Assessment (CHNA). This assessment incorporated extensive research and analysis derived from public health, population, and demographic data available from a variety of public and private data sources. In addition, primary research data in the form of online surveys, key informant interviews, and focus groups were collected, aggregated, and analyzed. The findings from this body of work were used to identify the following regional priorities for collective impact:

- Mental Health
- Chronic Diseases
- Access to Healthcare

Following the completion of the regional CHNA, San Antonio finalized its 2019 CHNA and embarked on a methodical prioritization process to identify the most significant health needs to be addressed over next three years. The results were similar to the regional prioritization, with the following areas of need identified:

- Mental Health
- Chronic Diseases
- Access to Health
- Prevention and Wellness

The next step was a review of the 2017 – 2019 Implementation Strategy and the outcomes achieved. With this evaluation as context, and the CHNA findings serving as a compass, strategic planning was initiated to create overall goals and objectives within each priority area, as well as the specific initiatives to be undertaken during the three-year implementation period. For each initiative selected for implementation, the planning team identified specific objectives, baseline measurements, performance targets, indicators, and data sources. This planning effort led to the creation of San Antonio Regional Hospital's 2020 – 2022 Community Benefit Implementation Strategy.

The document that follows includes the detailed 2020 – 2022 Implementation Strategy, as well as a summary of the 2019 CHNA. The hospital's evaluation methodology is also provided, along with the evaluation of the 2017 – 2019 Implementation Strategy.

Questions and comments regarding the CHNA and the Implementation Strategy are encouraged. Please let us know if you interested in collaborating with us to improve the health and wellness of the people in our region by contacting Angelica Baltazar, Executive Director, Lewis-San Antonio Healthy Communities Institute at abaltazar@sarh.org.

INLAND EMPIRE REGIONAL CHNA

The Hospital Association of Southern California worked with eleven hospitals on the 2016 inaugural regional community health needs assessment (CHNA) for the Inland Empire. The 2019 CHNA was a commitment to continue this crosscutting work, share resources, collaborate for collective impact, and build upon the existing body of work through expanded data collection from important voices in our community. The 2019 assessment also reaffirmed a commitment to serving the needs of the most vulnerable members of our communities.

Hospitals participating in the 2019 Inland Empire Regional Community Health Needs Assessment included:

- Desert Regional Medical Center
- Hi-Desert Medical Center
- Inland Valley Medical Center
- JFK Memorial Hospital
- Mountains Community Hospital
- Rancho Springs Medical Center
- Redlands Community Hospital
- San Antonio Regional Hospital

CHNA Methodology

Primary and secondary data sources were included in the CHNA. From November 12, 2018 to January 18, 2019, multiple focus groups, key informant interviews, and online surveys were administered. A total of 228 people were surveyed to obtain input from the community in the form of 11 focus groups (with a total of 97 focus group participants), 32 key informant interviews, and 99 online surveys (including a Spanish option). The main objective in engaging the community was to understand the greatest areas of need and to discover strategies in which participating hospitals could collaborate to better serve communities and elevate the health status of our region.

Secondary Data

Secondary sources included publicly available state and nationally recognized data sources available at the zip code, county and state level. Health indicators for social and economic factors, health system, public health and prevention, and physical environment were included. The top leading causes of death as well as conditions of morbidity that illustrate the communicable and chronic disease burden across San Bernardino and Riverside counties were also included. A significant portion of the data for the assessment was collected through a custom report generated through Community Common's Engagement Network CHNA (https://engagementnetwork.org/assessment/). Other sources included California Department of Public Health, County Health Rankings & Roadmaps, and California Environmental Protection Agency's Office of Environmental Health Hazard Assessment. When feasible, health metrics were further compared to estimates for the state or national benchmarks, such as the Healthy People 2020 objectives.

Inpatient hospitalization discharge data for 2017 was derived from the California Office of Statewide Health Planning and Development (OSHPD) hospital dataset utilizing the SpeedTrack analytics platform.

Hospitalization discharge data was stratified by gender, race/ethnicity, and age. Data containing an n-value of 10 or less were not included.

Primary Data

The hospitals participating in the two-county assessment worked to identify relevant key informants and topical focus groups to gather more insightful data and to aid in describing the community. To determine focus groups and key informants, members of the Inland Empire Regional CHNA Taskforce individually created interview lists. Taskforce members considered a variety of sectors to be represented, including community-based organizations, local businesses, foundation/funders, school boards/districts, city councils, public health departments, law enforcement, legal, faith-based organizations, and hospital leaders. In addition, the following populations were contemplated for the focus groups: those dealing with mental health issues or substance abuse, minorities, low income, medically underserved/uninsured/underinsured, and youth. In their review of potential candidates, taskforce members reviewed the following criteria:

- Does this person represent a vulnerable population?
- Does this person represent the uninsured/underinsured population?
- Does this person's role transcend over more than one county?
- Does this person's role cross sectors?
- Do we have representation from all sectors?
- Does the proposed list meet the requirement of community health needs assessments?

Finally, the taskforce was encouraged to send survey links to any partner organizations that did not make the key informant or focus group lists.

Community Voices

An online survey in English and Spanish was created and distributed for greater community input. It should be noted that the survey results were not based on a stratified random sample of residents throughout Riverside and San Bernardino counties. The perspectives captured in this data simply represent the community members who agreed to participate and have an interest in healthcare. In addition, the assessment relied on several national and state entities with publicly available data. All limitations inherent in these sources were present for the assessment.

Participants in the focus groups were end-users of programs and services as well as volunteers and/or auxiliary board members provided by the hospitals participating in this CHNA. Populations represented by focus group members included low-income populations, homeless, seniors, women's cancer, single mothers/maternal health, and Spanish-speaking promotoras.

Key informant interviews consisted of key leaders in our community from an array of agencies, including those that serve children, homeless populations, veterans, seniors, and Spanish-speaking populations. Other organizations represented included public health agencies, law enforcement, healthcare organizations, funders, and school districts. Most of the key informants had titles such as Director or Executive Director, President or Vice President, or were a part of the medical staff of their organizations.

Seven respondents mentioned working for nonprofit organizations. Community hospitals, public and/or population health, workforce development, affordable housing, and fire protection services were most frequently stated as services provided.

Approach

To better understand the needs, the focus groups and key informant interviews concentrated on these themes:

- Visions of a Healthy Community
- Health Needs
- Existing Resources
- Barriers to Accessing Resources and Addressing Needs
- Methods of Hospital Improvement
- Additional Feedback

Key informants and respondents to the survey were asked about the health problems and health needs of the community, including what is healthy in the community, what is not healthy in the community, and what the community needs to be healthy. They were also asked about the greatest health and social needs of children, services that could improve health in the community, barriers for clients from an organizational perspective, and for any additional feedback.

CHNA Findings

The focus groups, key informants, and surveys contained questions about the most significant health need in the community. Based on those responses, prioritization was given to the issues most frequently mentioned in all three data sources. The overarching themes included mental health and alcohol/drug substance abuse, transportation especially for the senior population, poverty and food insecurity, affordable housing and homelessness, education and awareness, chronic diseases, access to healthcare, and preventative healthcare. The top five identified in the table below are a combination of all three data sources based on the frequency of response.

Most Frequently Mentioned Issues by Data Source (rank order)

	Focus Groups	Key Informants	Surveys
1	Mental health (including substance abuse)	Social determinants/issues (i.e., education, housing, nutrition, jobs)	High rates of chronic diseases (i.e., diabetes, obesity, asthma, cancer)
2	Social issues (i.e., housing, transportation, nutrition, poverty)	Mental health (including substance abuse)	Lack of affordable housing options
3	Chronic disease (i.e., diabetes, obesity, cancer)	Access to healthcare (i.e., insurance, provider shortage)	Lack of access to pediatric care
4	Access to healthcare (i.e., provider shortage, overcrowding)	Chronic disease (i.e., diabetes, obesity, cancer)	Lack of access to mental health services (including substance abuse)
5	Lack of preventative care; senior health issues	Preventative healthcare	High need for help navigating assistance programs

Prioritization Process and Identified Health Needs

On April 19, 2019, HC2 Strategies, Inc. facilitated a strategy meeting with the members of the Inland Empire Regional CHNA Taskforce to review the results of the CHNA and to determine the top three priority needs that the hospitals will address over the next three years. To aid in determining the priority needs, the taskforce members considered the following criteria:

- Addresses disparities of subgroups
- Available evidence or practice-based approaches
- Existing resources/programs to address problems
- Feasibility of intervention
- Identified community need
- Importance to community
- Magnitude
- Mission alignment and resources of hospital
- Opportunity for partnership
- Opportunity to intervene at population level
- Severity
- Solution could impact multiple problems

The voting members in attendance were:

- Brian Connors, Inland Valley Medical Center and Rancho Springs Medical Center
- Linda Evans, Desert Regional Medical Center, Hi-Desert Medical Center, and JFK Memorial Hospital
- Keven Porter, Hospital Association of Southern California
- Cathy Rebman, San Antonio Regional Hospital
- Deanna Stover, representing Redlands Community Hospital

Following evaluation and discussion, the top three community health needs were identified as:

- Mental Health
- Chronic Diseases
- Access to Healthcare

The table below shows the prioritized health needs for 2019 CHNA compared to 2016.

Year	Health Outcomes	Social Determinants	Clinical Care	Built Environment

2019	• Mental Health and Alcohol/Drug Substance Abuse
	• Chronic Diseases:
	  • Asthma
	  • Cancer
	  • Diabetes
	  • Heart Disease
	  • Obesity
			• Access to Health Care
			• Provider shortage
			• Insurance	

2016	• Diabetes (higher rates among Hispanics)
	• Behavioral Health
	• Heart disease and stroke
	• Chronic Obstructive Pulmonary Disease
	• Cancer
	  • Colorectal
	  • Lung
	• Obesity
		• High rates of poverty; lower median incomes
		• Lower educational attainment
			• Poor access to primary care and behavioral health providers
			• Lack of preventive screenings for cancer
			• Inadequate prenatal care
				• Housing shortages
				• Lack of access to healthy foods

SAN ANTONIO REGIONAL HOSPITAL IMPLEMENTATION STRATEGY

Background

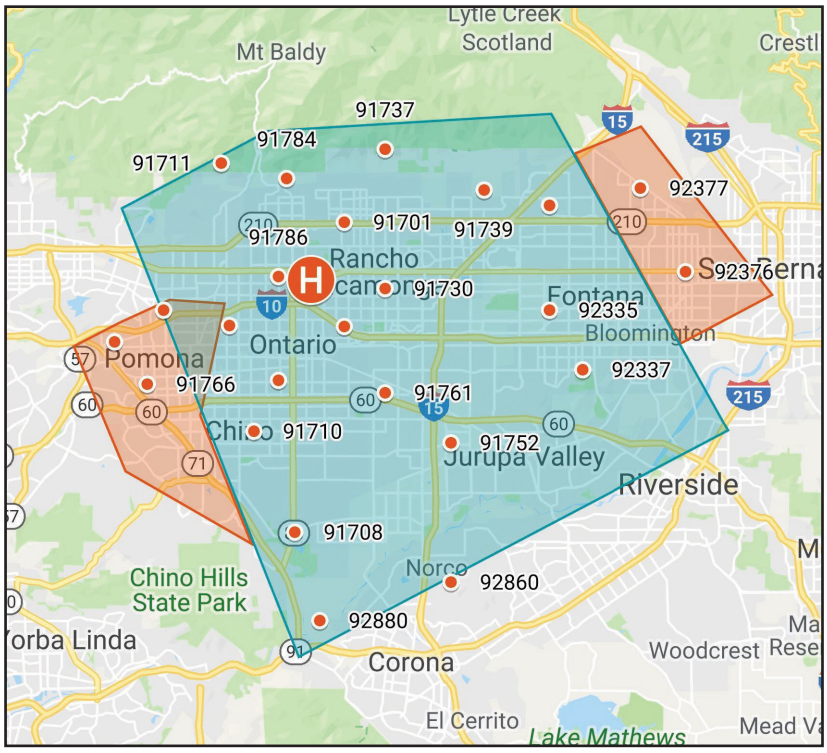
San Antonio Regional Hospital has an unwavering commitment to the hospital's mission, vision, values, and strategic plan, which focus on improving the region's overall health by providing quality patient care in a compassionate and caring environment. To this end, the hospital's 2019 Community Health Needs Assessment (CHNA) was conducted in collaboration with the Inland Empire's regional CHNA research team, consisting of the Hospital Association of Southern California's (HASC) Inland Empire Regional CHNA Task Force and HC2 Strategies. Following the collection and analysis of extensive secondary data, primary data was collected to validate the findings of the secondary data research. Throughout the primary research process, San Antonio engaged residents, stakeholders, agencies, organizations, and members of Healthy Cities to provide feedback about the most pressing health issues facing our community. Firsthand accounts from local residents were collected through focus groups, key informant interviews, and an online survey.

Community Profile

A community is seen as having both physical and geographic components, as well as socioeconomic and psychosocial factors that define a sense of community. Individuals can thus be part of multiple communities: geographic, virtual, and social. The current focus on community-based participatory research in public health has prompted an evaluation of what constitutes a community. For the purposes of the CHNA, a community is defined as the geographic area and the populations served by a specific hospital facility.

San Antonio Regional Hospital resides in the City of Upland, located in the "West End" of San Bernardino County. However, like many hospitals, San Antonio's "service area" is defined as the geographic area from which it receives the majority of its hospital admissions. The total service area is divided into "primary" and "secondary" areas, with the primary service area accounting for approximately 80% of the hospital's admissions and the majority of San Antonio's planning efforts

The hospital's primary service area includes the cities of Claremont, Chino, Eastvale, Fontana, Montclair, Ontario, Rancho Cucamonga, and Upland. The secondary service area extends to Pomona, Chino Hills, Corona, Norco, and Rialto.



San Antonio Regional Hospital Community

Primary Service Area

Secondary Service Area

Fulfilling our Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinants of health. Each component influences the next, and communities can collectively achieve improved health status by building upon demonstrated successes.

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and how we will engage partners to achieve positive change. More importantly though, we hope you can imagine a healthier region and will work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

The Community Benefit Implementation Strategy that follows marks the second phase in a collaborative effort to systematically investigate, identify, and prioritize our community's most pressing needs. After a thorough review of the health status in our community as delineated in the 2019 CHNA, we identified specific areas we can address using our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and to fulfill our mission "to improve the health and well-being of the people we serve."

Prioritization Process

The results of the CHNA guided the creation of San Antonio's Community Benefit Implementation Strategy by providing the framework for determining how we can improve the health of our community, and particularly, the most vulnerable among us. Using the CHNA as both context and the lens through which the community's needs were identified, San Antonio embarked on a formal prioritization process

that included input from community stakeholders. The prioritization team evaluated the health needs identified in the 2019 CHNA using the following criteria:

- Size, severity, and importance of the need to the community
- Alignment with the hospital's mission, scope, and strategic plan
- Resources required and available to address the community need
- Hospital's ability to impact the community need

The table that follows illustrates the scoring methodology the prioritization team used to rank each need.

Priority Level	Importance	Alignment	Resources	Impact
High Priority - 3	High	Consistent with mission, scope, and two or more San Antonio strategies	No additional resources needed, or services are currently in place	Can provide a service likely to measurably improve the community's health status
Moderate Priority - 2	Moderate	Consistent with mission, scope, and one of the San Antonio strategies	Minimal resources needed to initiate new or extend a current service	Can provide a service likely to measurably improve the community's health status; may involve collaboration with other community organizations
Lower Priority - 1	Low	Outside the scope/ not addressed in San Antonio strategies	Requires significant new resources	Inability to measurably improve this need; outside hospital scope

Common themes emerged during the prioritization process, and the following priority areas were adopted for community health investment for the next three years (2020-2022):

- Mental Health
- Chronic Diseases
- Access to Health Care
- Prevention and Wellness

Strategic Planning

Community health needs are complex, often difficult to define, and may affect diverse populations. Equally challenging is the task of creating interventions to address these needs in meaningful ways that are impactful and measurable. With the completion of the CHNA and the prioritization process, the next step was to develop and/or expand community benefit programs designed to improve community health status. During the strategic planning process, the community benefit team developed initiatives within each of the identified priority areas with defined goals, objectives, and evaluation metrics. Each initiative in San Antonio Regional Hospital's Implementation Strategy relates to one or more of the four priority areas, the specific needs identified in the 2019 CHNA, and input sought and provided by community stakeholders.

	Significant Health Needs			
Initiative	**Behavioral Health**	**Chronic Disease Management**	**Access to Healthcare**	**Prevention and Wellness**
Mental Health First Aid	X		X	X
CHIP Expansion		X	X	
KYN Expansion			X	X
BUILD Case Management Expansion		X	X	X
wHealth *(Workforce Development)*	X		X	X

Priority Need 1 – Mental Health

Mental health was one of the most frequently mentioned health needs in nearly every question by the focus groups, key informants, and survey respondents. Children and the aging population were noted as populations with mental health concerns. Issues mentioned included shortage of staff, addiction, lack of available services, trauma, isolation, and social factors such as transportation, all of which lead to continued unmet needs.

Goal:

Support local and regional mental health policy change and educational awareness initiatives.

Objective:

Increase knowledge and access to mental health resources

Short term Objective

Expand mental resiliency component across adolescent wellness program (wHealth)

1. Provide skills trainings for youth to understand stress and its effects
2. Increase understanding of available resources

Intermediate Objective

Increase knowledge of coping skills

1. Support mental health first aid certification (MHFA)
2. Integrate MHFA trainers into community programs targeting parents and seniors
3. Collaborate with school districts on development of mental health programming

Long-term Objective

Develop mental health resources

1. Implement mental health first aid trainings across service area
2. Collaborate with regional task force on policy development for mental health services and resources

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Expand mental resiliency training across wHealth program	• Average of 78% of students surveyed self-report that they have good coping strategies. • New participants on regional mental health task force	• Increase percentage of student self-reporting good coping skills to 88% over three years	• Number of positive surveys	• wHealth records • Survey results • Partner feedback • Meeting notes
Increase opportunities for community knowledge of coping skills	• Current coping skills education occurring only for parents	• Expand training and educational opportunities for general population in each community served	• Number of trainings • Number of participants	• Survey • Sign in sheets
Develop mental health resources	• No SARH staff or community partners trained in mental health first aid	• Certify 3 community members as MHFA trainers to provide training	• Number of trainers	• Training invoices • Sign-in sheets

Community Partners:

Chaffey Joint Union High School District
El Sol Neighborhood Center
Upland Unified School District

Priority Need 2 – Chronic Disease

(Community Health Improvement Program – CHIP)

The top three leading causes of death in San Bernardino and Riverside counties are cancer, heart disease, and chronic lower respiratory disease. Analysis of the Prevention Quality Indicators (PQI) reveal that San Bernardino County has the number of highest hospital admissions for diabetes short-term complications, diabetes long-term complications, hypertension, uncontrolled diabetes, and asthma in younger adults.

Goal:

Improve the health status of an at-risk population.

Short term Objective

Identify and enroll at-risk population

1. Screen frequent emergency department visitors
2. Conduct evaluation for program participation

Intermediate Objective

Reduce unnecessary emergency department visits and hospitalizations

1. Provide personalized health coaching and navigation
2. Provide site visits and/or telephonic follow-up
3. Collaborate with member physicians
4. Conduct weekly case reviews with care team and coaches

Long-term Objective

Overall improvement in health status of enrolled CHIP members

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Identify and enroll at-risk patients	• 238 patients identified as at risk	• Enroll an additional 45 members per year	• Number of coaches • Number of participants	• Patient log
Demonstrate increased reduction in unnecessary emergency department visits	• 81% of members have demonstrated improvement	• 84% of members have demonstrated improvement (3% increase)	• Number of members with reduced emergency department visits	• Monthly report • Manager report
Demonstrate increased reduction in unnecessary hospitalizations	• 83% have demonstrated reduction in unnecessary hospitalizations	• 85% have demonstrated reduction in unnecessary hospitalizations (2% increase)	• Number of members with reduced hospitalization	• Report card • Hospitalization
Demonstrate overall improvement in health status of enrolled CHIP members	• 87% have demonstrated an improved health status	• 92% have demonstrated an improved health status (5% increase)	• Members demonstrating improvement	• Report card

Community Partners:

Inland Empire Health Plan
Member Physicians

Priority Need 3 – Access to Healthcare

The Know Your Numbers (KYN) program provides health education and biometric screenings in community health hubs that serve low-income, uninsured, or underinsured populations. KYN utilizes a clinical community health worker (CCHW) model to engage the population.

Goal:

Increased access to health education and preventative services

Short term Objective

Increase number of people assessed among vulnerable populations

1. Ensure materials and resources are culturally and linguistically appropriate
2. Utilize CCHW model to educate community members about screenings

Intermediate Objective

Promote early cancer education

1. Provide community education opportunities in English and Spanish
2. Promote early detection cancer education and screening activities
3. Collaborate with partners to expand educational opportunities

Long-term Objective

Connect participants with a medical home

1. Participate in community Health Access workgroup

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Increase number of vulnerable population assessed	• 57% are returning participants	• Increase to 67%	• Number of participants and returning participants screened	• KYN data
Increase number of community members educated on early cancer detection	• Education activities have occurred in two communities reaching 110 residents	• Increase education to 500 residents	• Number of education and screening activities and participants	• Sign-in sheets
Connect community members to a medical home	• 141 members connected to a medical home	• Increase connected members by 20%	• Number of referrals provided	• KYN reports

Community Partners:

American Cancer Society
El Sol
County of San Bernardino Department of Public Health
Social Impact Artists

Priority Need 4 – Prevention and Wellness

The *Know Your Numbers* (KYN) program provides health education in community health hubs that serve low-income, uninsured, or underinsured populations. KYN utilizes a clinical community health worker (CCHW) model to engage the population.

Goal:

Improve the health and well-being of community residents

Short term Objective

Promote healthy lifestyles and activities of residents

1. Continue and enhance community partnerships to promote health
2. Provide in-kind support for community screenings
3. Utilize CCHWs to educate community about screenings

Intermediate Objective

Participate in ongoing education for CCHW for enhanced case management

1. Provide training opportunities for CCHW
2. Engage youth in leading health activities in the community

Long-term Objective

Improved health status of KYN participants

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Promote healthy lifestyles and activities among residents	• 500 residents have been screened	• Increase number of residents screened by 20%	• Number of members participating in screenings	• KYN data
Participate in ongoing education for CCHWs for enhanced case management	• One nutrition education offering has been provided; CCHWs have requested training on multiple topics to enhance their knowledge and support case management	• Support three training opportunities per year	• Number of educational opportunities	• KYN data • Sign-in sheets
Improved health status of KYN participants	• Based on individual numbers at initial screenings	• Members will improve overall numbers by 20%	• Improved biometric values/measurable improvements	• KYN data • Surveys

Community Partners:

American Cancer Society
El Sol
County of San Bernardino Department of Public Health
Social Impact Artists

Priority Need 4 – Prevention and Wellness

The wHealth (adolescent wellness and workforce development) program provides a three pronged approach including curriculum on fitness, nutrition, and mental resiliency. The program is offered in partnership with local universities and school districts.

Goal:

Improve the health and well-being of students

Short term Objective

Promote healthy lifestyles and activities in our youth

1. Enhance community partnerships to promote health
2. Expand wHealth (adolescent wellness) program

Intermediate Objective

Introduce youth to a variety of health careers

1. Promote health careers through career days, mentors, and presentations
2. Connect youth with health education opportunities

Long-term Objective

Retain local youth as part of health care workforce

1. Provide internships for local university students enrolled in health disciplines
2. Provide preceptors/supervision to meet practicum requirements

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Promote healthy lifestyles and activities of students	• Three high schools and four middle schools participate in wHealth program	• Six high schools and seven middle schools participate in wHealth program	• Number of students participating in wHealth program	• wHealth survey • School district reports
Educate and engage youth in future health careers	• 68 Students have been trained as health educators	• Increase number by 22 students	• Number of student trainers	• Trainer logs
Retain local youth as health workforce	• 42 Interns supervised through HCI internships	• Increase number of student interns by 20%	• Number of interns	• HCI data

Community Partners:

Chaffey Joint Union High School District
Farm at Fairplex
Upland High School District
Sprouts
Loma Linda University
Claremont Graduate University
California State University, San Bernardino

Evaluation and Continuous Improvement

We engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Are our interventions making a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Each year, and at the conclusion of the three-year Implementation Strategy, San Antonio Regional Hospital evaluates the effectiveness of its community benefit programs to determine the level of measurable community health impact.

Identified Need from CHNA Not Addressed

Taking existing hospital and community resources into consideration, San Antonio Regional Hospital will not directly address the remaining health needs identified in the CHNA including: transportation , poverty and food insecurity, and affordable housing and homelessness. The hospital cannot address all the health needs present in the community; therefore, it will concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. San Antonio Regional Hospital will look for partnership opportunities that address needs not selected where it can appropriately contribute to addressing those needs, or where those needs align with current strategies and priorities.

2017–2019 IMPLEMENTATION STRATEGY EVALUATION

San Antonio Regional Hospital developed and approved an Implementation Strategy to address significant health needs identified in the 2016 CHNA. This process included developing goals, objectives, and initiatives using the primary and secondary data collected during the CHNA as the framework to identify opportunities, realize potential challenges, provide insight into established programming, and create community partnerships for addressing the identified health needs. The following priority areas served as the pillars for the development of the Implementation Strategy:

- Chronic Disease Management
- Access to Healthcare
- Prevention and Wellness
- Healthy Environment
- Behavioral Health

The initiatives delineated in the 2017-2019 Implementation Strategy within each priority area focused on community members noted to be most at risk due to existing or impending health conditions, often compounded by one or more social determinants of health, that were likely to result in adverse health outcomes. The Implementation Strategy articulated San Antonio Regional Hospital's commitment to the community benefit programs and resources required to execute the identified strategies. From 2017 through 2019, hospital staff continued to engage partners and leverage resources to implement the identified strategies and track measurable outcomes demonstrating the impact on community health improvement during the three-year implementation period. The overall evaluation of the impact on the significant health needs addressed in the 2017-2019 Implementation Strategy follows.

Chronic Disease Management

Expand the Community Health Improvement Program (CHIP)

The Community Health Improvement Program (CHIP) is a strategy to address chronic disease management skills thereby reducing hospital readmission rates, minimizing chronic disease morbidities, and improving the quality of life among community members with chronic diseases. University students are recruited and specially trained as health coaches to provide comprehensive care management through a combination of follow-up clinic services and an in-home visitation program. Students engage in the process of education and motivating at-risk members to take an active and meaningful role in their health and well-being. The primary objectives of the health coach are to foster meaningful interactions for boosting cooperation and adherence, while helping to resolve non-medical issues (social determinants of health) that impede effective risk factor management and patient care. CHIP has successfully recruited and trained over 165 coaches over the past four years who provided support to 238 patients. To date, unnecessary ED visits were reduced by 33% and hospitalizations by 38% among CHIP participants enrolled for nine months.

2016 CHNA Priority Area	Implementation Strategy	Measurable Metric	Partners	Status Update
Chronic Disease Management	Expand Community Health Improvement Program (CHIP)	• Health Coaches (#) • Program Participants (#) • ED Visit Reduction (%) • Readmission Reduction (%)	Inland Empire Health Plan	• Coaches recruited and trained (165) • Participants (238) • ED visits reduced (33%) • Readmissions reduced (38%)

Access to Healthcare and Prevention and Wellness

Know Your Numbers Expansion and BUILD Case Management Program

The Know Your Numbers (KYN) program is a strategy to reduce chronic disease incidence in impoverished, uninsured, and underinsured populations through screening and health education. KYN provides biometric screenings for the low-income population living in Ontario's "HEAL" (Healthy Eating and Active Living) Zone and surrounding communities. The program includes health education, social determinant of health assessments, and biometric screenings comprised of blood pressure, body mass index (BMI), glucose, and cholesterol through community-based point-of-care testing.

In 2016, KYN was incorporated into the Healthy Ontario Initiative (HOI), an innovative multi-sectorial collaborative partnership in the City of Ontario. This effort was funded, in part, by a "BUILD" Health Challenge Grant provided by: 1) The Advisory Board Company, 2) de Beaumont Foundation, 3) The Colorado Health Foundation, 4) The Kresge Foundation, and 5) Robert Wood Johnson Foundation. The goal of the BUILD funding partners was to foster and expand meaningful partnerships among hospitals, community-based organizations, and local public health departments to create Bold, Upstream, Innovative, Local, Data-driven solutions to address the complex problems that influence the health of local residents. The remaining funding and other resources for the program were provided by San Antonio Regional Hospital, the City of Ontario, and the San Bernardino County Public Health Department. HOI's goal was to reduce obesity and its associated health impact on vulnerable populations. San Antonio's KYN program served a key role in engaging the community in understanding health issues and healthcare access, as well as empowering participants to take an active role in improving health status individually and across the community.

In 2017, there was a push to further enhance the case management aspect of the program. The Clinical Community Health Worker (CCHW) model was utilized. Community Health workers (CHWs) received professional development in addition to their basic training. San Antonio staff, community partners, and CCHWs worked diligently on developing health curricula for the case management sub-population within the whole population. Case management parameters were created to determine which participants needed individual care and a three tiered system was developed to distinguish level of need and/or service. In addition to the new curriculum, efforts were made to provide individual nutrition education

for participants with the highest need. This education took place in the homes of individual participants presented by one of the hospital's registered dietitians (RD). Home visits allowed for an in-depth analysis of diet patterns and living conditions. This allowed the RD to tailor each plan to the individual, maximizing individual success and satisfaction with the program. A total of eight CCHWs have been developed over the past 3 years.

Quarterly screenings at four health hubs attracted over 500 participants in 2018, with 330 new participants joining the program. The 330 new participants attended with a retention rate of 57%. More than 57% of the case managed populations were still actively involved in the program after a year and 141 participants were referred to a medical home such as the Ontario Health Center. The Ontario HOI KYN program continues to see improvement in BMI and specifically, reduction in waist circumference across all participants.

2016 CHNA Priority Area	Implementation Strategy	Measurable Metric	Partners	Status Update
Access to Healthcare	Know Your Numbers (KYN) Expansion	• Health hubs served (#) • Participants (#) • Medical home referrals (#) • Biometric Values Improved (%)	El Sol Neighborhood Center City of Ontario San Bernardino Department of Public Health American Cancer Society	• Health hubs (4) • Participants (500) • Returning participants (330) • Medical home referrals (141) • Waist circumference reduction (22%) • Triglyceride Improvement (46%) • Glucose Improvement (20%)

Prevention and Wellness

Expand HELP 12+ (Healthy Eating and Lifestyles Program for children 12 years and older)

During 2017, the HELP program was rebranded as wHealth (Wellness + Healthcare). The focus was changed to include nutrition, fitness, and mental resiliency, along with professional development as students are introduced to health careers. Interns from regional universities are recruited as health educators and operations to provide curriculum to high schoolers who receive additional professional development as prospective high school health coaches. The high school health coaches receive career training including: resume building, interviewing and presentation skills. The high schoolers continue to receive supervision from the university interns as they provide instruction to their respective junior high schools. During the last three years, the wHealth program has grown to provide training to 1,029 high schoolers, trained 68 high school health coaches, and instructed 307 junior high students across three high schools and four junior high schools in two school districts. The program continues to grow and is scheduled to expand into another district and two more high schools in the coming year.

2016 CHNA Priority Area	Implementation Strategy	Measurable Metric	Partners	Status Update
Prevention and Wellness	Expand *HELP+* Elementary **Rebranded as *wHealth* in 2017**	• High school student trainers (#) • Curriculum enhancement (Content), School sites (#) • Middle school students (#) • High school students (#)	HealthCorps The Farm at Fairplex Sprouts Chaffey Joint Union High School District Upland Unified School District Ontario-Montclair Unified School District	• High school student trainers **(68)** • **HealthCorps curriculum** offered • High schools **(3)** • School districts **(2)** • Middle school students **(307)** • High school students **(1,029)**
Prevention and Wellness	*BUILD* Case Management Program	• CCHWs (#) • Referrals to medical home (#) • Participation in health/nutrition activities (%) • Biometric Values Improved (%)	El Sol Neighborhood Center City of Ontario San Bernardino Department of Public Health American Cancer Society	• CCHWs **(7)** • Medical home referrals **(141)** • Case managed member participation **(57%)** • Waist circumference reduction **(22%)** • Triglyceride Improvement **(46%)** • Glucose Improvement **(20%)**

Healthy Environment

Healthy Communities Leadership Development

The program concept was revised in 2017 to provide health policy training directed at decision makers. During 2017 and 2018, collaboration occurred with County Department of Public Health from both Riverside and San Bernardino Counties to provide training around healthy communities' policies. The training was part of a regional conference, attended by policy makers from across the Inland Empire including councilpersons, city managers, and city planners, held at the Ontario Convention Center as part of the Healthy Communities Summit. Additionally, a regional Food Recovery Workshop provided by WasteNot OC was facilitated. The purpose was to introduce policy makers and stakeholders to food recovery models to replicate in the region. The County of San Bernardino Department of Public Health has now taken the lead for this region.

2016 CHNA Priority Area	Implementation Strategy	Measurable Metric	Partners	Status Update
Healthy Environment	Leadership Development Revised 2018	• Support and participate in policy maker training	San Bernardino Department of Public Health Riverside County Department of Public Health ChangeLabs Solutions	• Sponsored and participated in development of Healthy Communities policy training events.

Behavioral Health

Local and Regional Policy change and educational awareness

San Antonio supported the Hospital Association of Southern California in its advocacy efforts to raise awareness and create policy change to address unmet behavioral health needs in the region. Additionally, the third pillar of the Healthcorps curriculum used by the wHealth program covers mental resiliency. The curriculum is geared toward adolescents and addresses topics such as bullying, stress, mindfulness, and how to seek help.

2016 CHNA Priority Area	Implementation Strategy	Measurable Metric	Partners	Status Update
Behavioral Health	Behavioral health policy change and educational awareness activities	• Support behavioral health policy change efforts • Provide behavioral health education and awareness training	Hospital Association Southern California HealthCorps	• Supported HASC efforts to raise awareness and create policy change • Mental resiliency education incorporated into *wHealth*

CONNECTING STRATEGY AND COMMUNITY HEALTH

As hospitals move toward population health management, community health interventions are a key element in achieving the goals of reducing the overall cost of healthcare, improving the health of the population, and improving access to affordable health services for the community. One key factor in improving the quality and efficiency of the care hospitals provide is to include the larger community as a part of their overall strategy.

Health systems are stepping outside of the traditional roles of hospitals to begin looking at ways to address the social, economic, and environmental conditions that contribute to poor health in the communities served. Bold leadership is required from healthcare leaders, medical providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This shift will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health goes beyond measuring the overall health of a population; it also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is significantly less healthy. Ideally, such differences would be eliminated or at least substantially reduced. To do so, however, is a daunting challenge that can only be achieved through collective action that is carefully designed and executed.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1) The distribution of specific health statuses and outcomes within a population;
2) Factors that cause the present outcomes distribution; and
3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors;
2) Improve care quality and patient safety; and
3) Advance care coordination across the health care continuum.

San Antonio Regional Hospital's mission is to "improve the health and well-being of the people we serve." Our vision is to "be a leader in creating healthy futures through excellence and compassion." We believe the best way to reimagine our future business model with a major emphasis on population health is by working together with our community. We hope you will join us in our journey to improve the overall health of people in our region.

STRATEGIC PARTNER LIST

San Antonio Regional Hospital supports local partners in our joint efforts to promote a healthier community. Partnership is not used as a legal term, but as a description of the relationships and connectivity that are necessary to collectively improve the health of our region. One of the hospital's objectives is to work in partnership with organizations that share our values and priorities to improve the health status and quality of life of the community we serve. This is an intentional effort to avoid duplication and to leverage the successful work already in existence in the community. Many important systemic efforts are underway in our region. We are working closely with multiple nonprofit agencies and organizations to provide quality care for the underserved in our region. These strategic partnerships include:

California State University, San Bernardino
City of Chino
City of Chino Hills
City of Eastvale
City of Fontana
City of Hope
City of Montclair
City of Ontario
City of Rancho Cucamonga
City of Upland
Claremont Graduate University
County of Riverside Department of Public Health
County of San Bernardino Department of Public Health
El Sol Neighborhood Center
IEEP – Inland Empire Economic Partnership
IEHP – Inland Empire Health Plan
Loma Linda University
Sprouts
Social Impact Artists

FINANCIAL ASSISTANCE POLICY

San Antonio Regional Hospital's Financial Assistance Policy and related forms, in English and Spanish, may be downloaded from our website:

https://www.sarh.org/about_us/community_outreach/community_outreach_publications/

DOCUMENT ACCESS

San Antonio Regional Hospital's 2019 CHNA was adopted by the Board of Trustees on November 5, 2019 and may be viewed via the hospital's website (www.sarh.org). The complete 2019 CHNA may be downloaded using the following link:

https://www.sarh.org/about_us/community_outreach/community_outreach_publications/

San Antonio Regional Hospital's 2020 – 2022 Community Benefit Implementation Strategy was approved by the Board of Trustees on December __, 2019. To request a copy or to provide comments regarding current or previous community health needs assessments or the foregoing implementation strategy, please contact:

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