SAN ANTONIO REGIONAL HOSPITAL

Community Benefit Program Highlights

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History and Organizational Structure

About San Antonio Regional Hospital

San Antonio Regional Hospital was founded by Dr. William Howard Craig in 1907 to meet the healthcare needs of local residents. As the community surrounding the hospital grew, it became apparent that larger, more modern facilities were needed. Community leaders rallied to raise the needed capital and the hospital moved to its current location on San Bernardino Road in 1924. Through community support, the hospital grew – from its modest beginning with 18 beds, 5 physicians, and limited staff — to a 373-bed regional medical facility with over 2,300 employees and a medical staff of more than 550 physicians.

The hospital's main campus in Upland opened its largest expansion in its 110-year history. The 179,000 square foot addition, which includes a new 52-bed emergency department and 92-bed patient tower, officially opened to the public on January 6, 2017. The project incorporated the latest healthcare architectural design and advanced technological features with the goal of meeting the needs of the growing population in the west end of California's Inland Empire.

In addition to the main campus, the hospital has satellite locations in Rancho Cucamonga, Fontana, and Eastvale. These facilities provide outpatient care in a close, convenient setting for the region's growing population.

Leadership

San Antonio Regional Hospital is governed by a 15-member Board of Trustees. The hospital's Medical Staff President-Elect, President, and Immediate Past President are members of the board by virtue of their offices. At least two additional physicians are elected from the medical staff, and the remaining members are elected from the community at-large. The Board of Trustees, with physician leaders comprising a significant portion of its membership, sets the direction for the hospital's Community Benefits Program.

The Executive Management Group directs the hospital's strategic planning process and allocates resources for community benefit activities. The Executive Management Group is comprised of the Chief Executive Officer, Chief Financial Officer, Chief Nursing Officer, Senior Vice President of Administrative Services and Compliance, Vice President of Human Resources, Vice President of Business Development and Community Outreach, and President of the Hospital Foundation.

Department directors are responsible for the operation and management of individual departments. The directors encourage employee participation in community benefit activities, and it is this support that ensures the ultimate success of the hospital's Community Benefits Program as delineated in its triennial Implementation Strategy and Plan.

Mission Statement and Commitment to the Community

Our Commitment

The leadership at San Antonio 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.

Mission

Our mission is to improve the health and well-being of the people we serve.

Vision

Our vision is to be a leader in creating healthy futures through excellence and compassion.

Values

Patient Centered

We engage patients as our partners in care.

Safety

We make safety our highest priority for patients, visitors and our care team.

Compassion

We treat everyone with dignity and respect.

Respect

We value every individual through our words and actions.

Integrity

We do the right thing - ethically, legally, and morally.

Excellence

We embrace the principles of a high reliability organization.

Caring for Our Community

Community benefits are more than just numbers. They represent people— children, parents, grandparents, and those who may be both disadvantaged and disenfranchised. This report highlights how San Antonio Regional Hospital goes above and beyond the delivery of essential patient care services to promote healthier lifestyles, early detection of disease, and enhanced access to basic healthcare services.

As a regional healthcare provider, San Antonio is committed to maintaining the highest quality of care for those we serve. As a nonprofit hospital, all of our resources are devoted to providing healthcare services. Any surpluses generated from hospital operations are used to purchase new or upgraded equipment, expand services, and provide care for vulnerable populations.

While the Inland Empire is a maturing economic market, many individuals and families are at significant risk during a medical crisis. Often this is due to an inability to access health insurance or the result of inadequate insurance coverage. The hospital's charity care policy provides relief to these families who would otherwise face medical bankruptcy. During 2017, $1,519,034 in charity care was provided for patients entering the hospital's emergency department who were either treated and released or required an inpatient stay. The hospital absorbed $13,513,242 in unreimbursed costs incurred in providing care and treatment for Medi-Cal patients and $541,100 for Medicare Patients, while other uncompensated care (bad debts) totaled $953,179 in actual costs incurred by the hospital to treat these patients. In addition to direct medical care, San Antonio Regional Hospital reaches out to its community in a variety of ways that go well beyond the traditional care provided by an acute care hospital. An inventory of these programs and activities is provided later in this report.

In many communities within the hospital's service area, needs far exceed accessible resources. San Antonio understands the power of collaboration and seeks alliances with other health and social service providers to develop community-based programs with defined goals and measurable outcomes. These partnerships help to leverage the community's resources to achieve the maximum benefit for its residents.

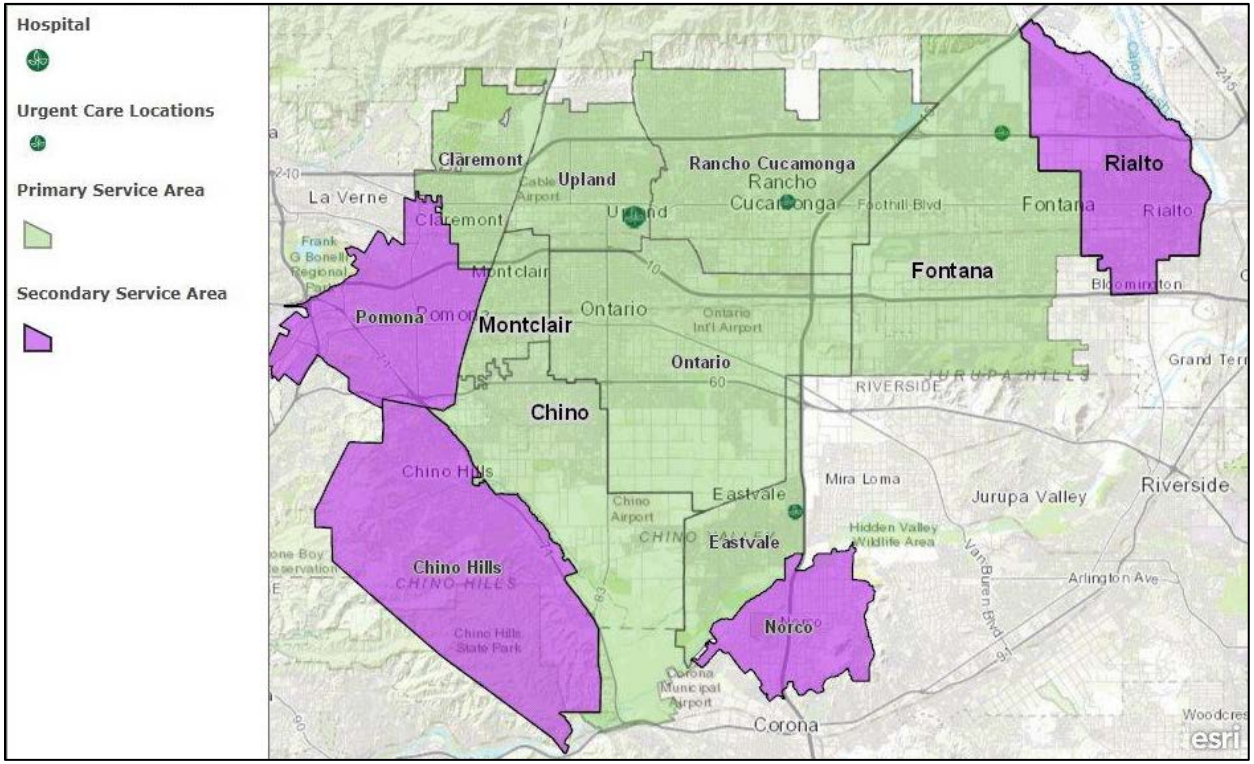
Community Profile

A community is seen as having both physical and geographic components, as well as the 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. In this report we defined a community as the geographic area served by San Antonio Regional Hospital and the populations it serves.

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. As illustrated on the map below, San Antonio’s primary service area, denoted in green, is comprised of the cities of Chino, Claremont, Eastvale, Fontana, Montclair, Ontario, Rancho Cucamonga, and Upland. San Antonio’s secondary service area, shaded in purple, extends to Pomona on the west, Chino Hills to the southwest, Corona and Norco on the southeast, and Rialto at the eastern edge of the service area.

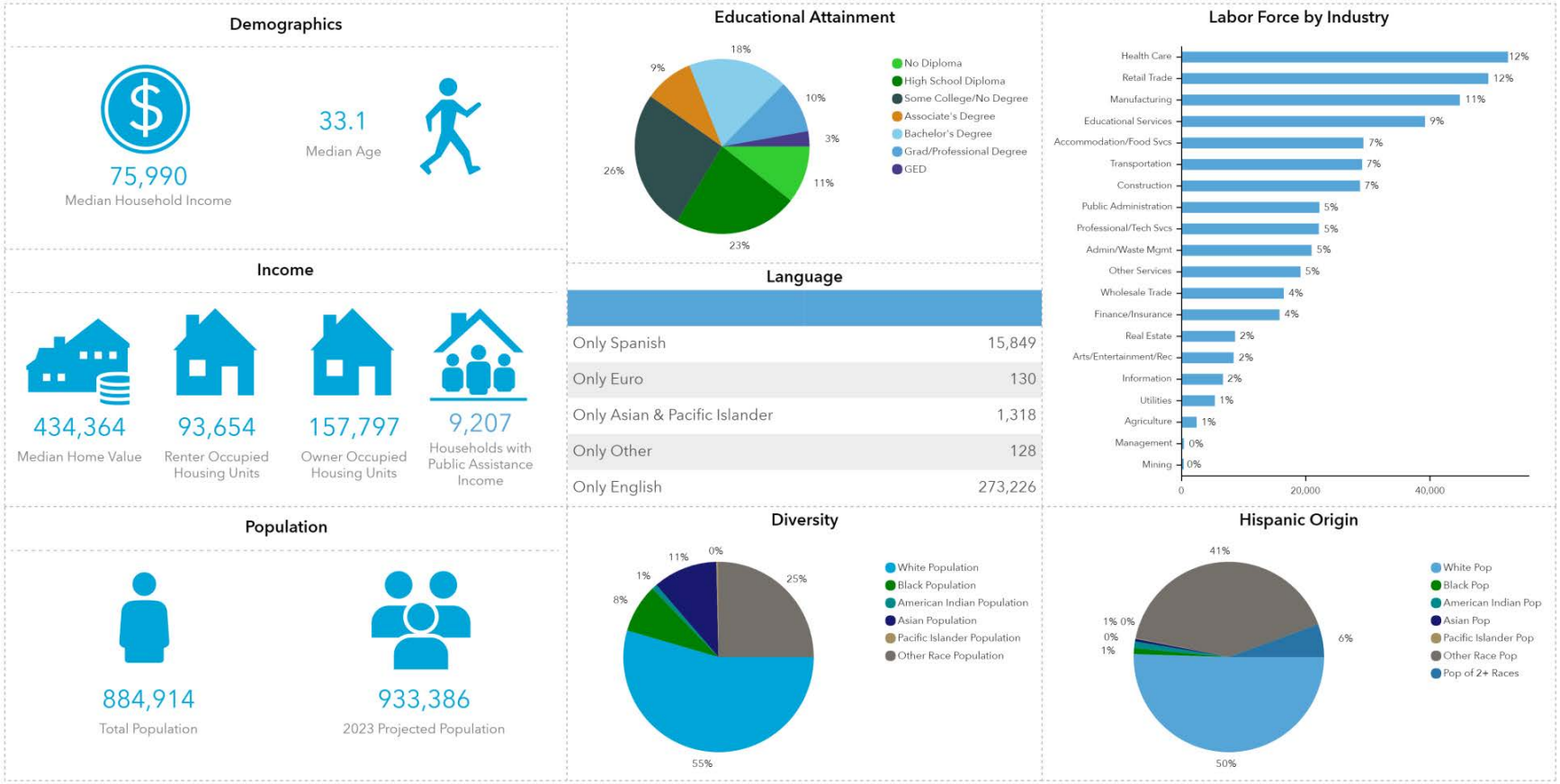
San Antonio Regional Hospital Service Area Map

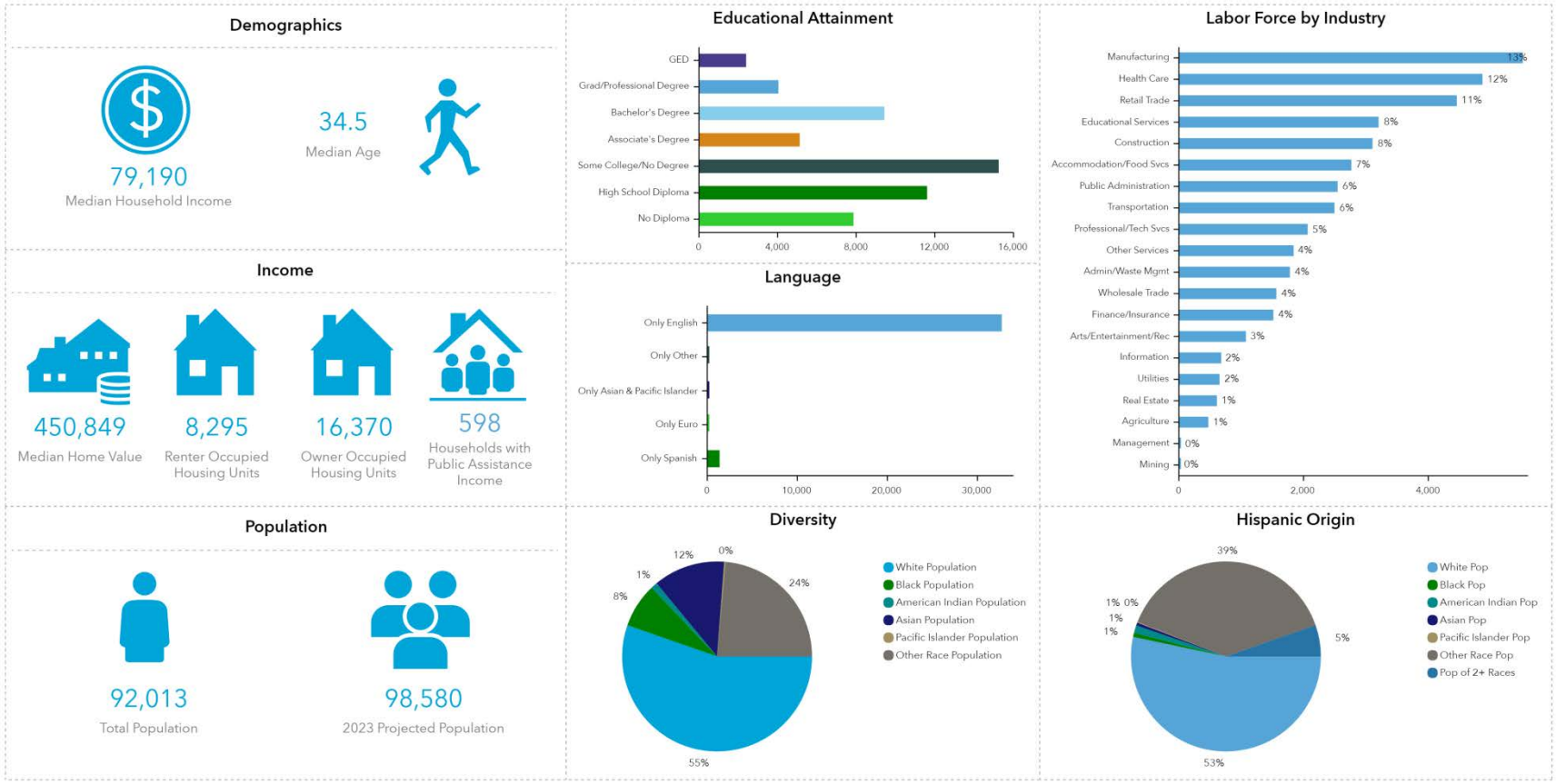


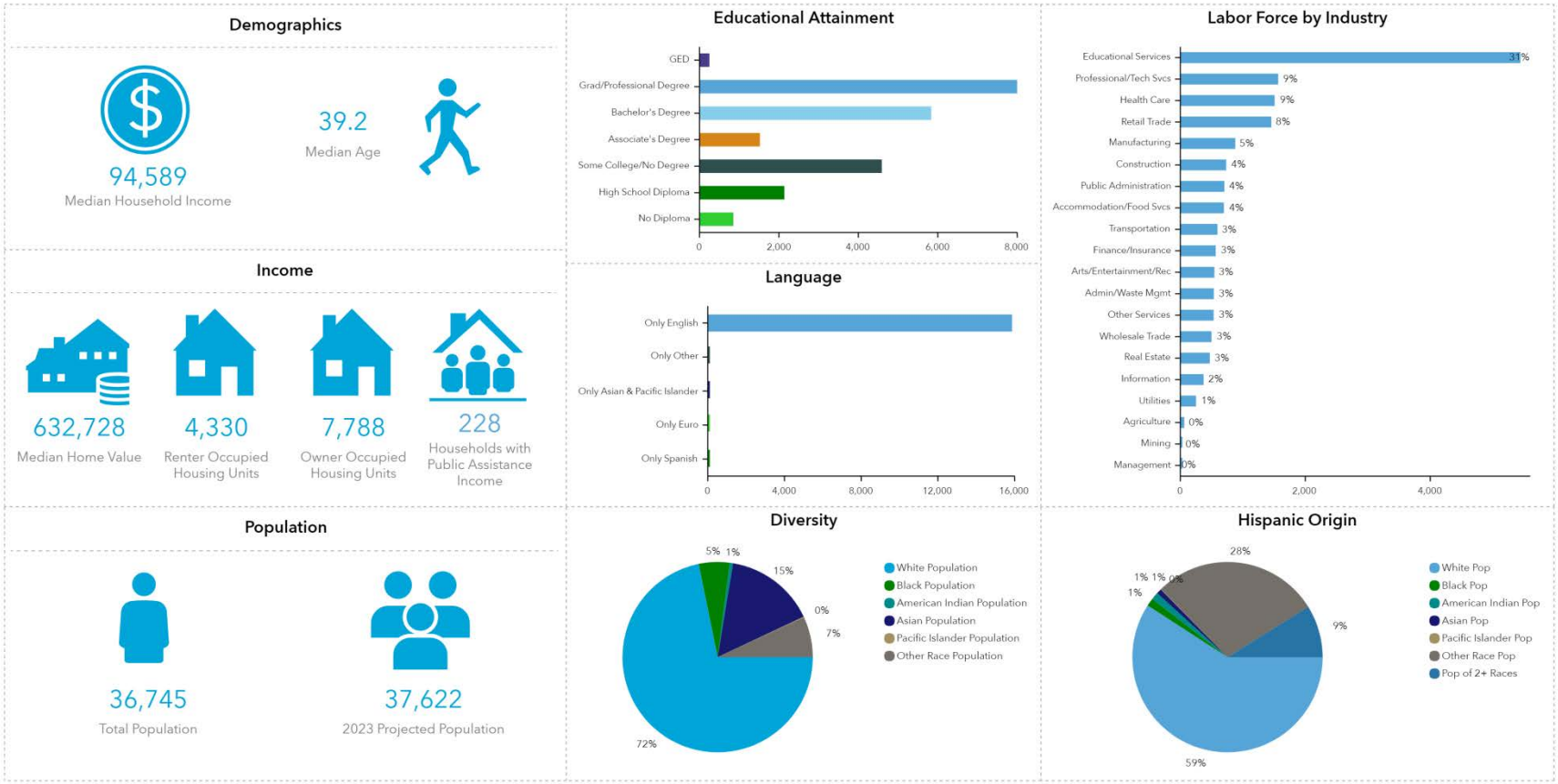
Service Area Key Characteristics

The following pages illustrate key characteristics of the hospital's primary service area (PSA) as a whole, as well as each city within the PSA. While many areas across the state and nation are experiencing slow to moderate grow, the hospital's PSA will generate a robust 2.5% average annual growth rate over the next five years, although growth rates vary among the cities. Similarly, there is significant variation in the social determinants of health; for example, the median household income in Montclair is $56,000 compared to $116,000 in Eastvale, and Claremont's educational attainment is substantially higher than other cities. Social determinants of health play a key role the hospital's community benefit planning efforts.

San Antonio Regional Hospital Primary Service Area




Demographics
79,190
Median Household Income
34.5
Median Age
Income
450,849
Median Home Value
8,295
Renter Occupied Housing Units
16,370
Owner Occupied Housing Units
598
Households with Public Assistance Income
Population
92,013
Total Population
98,580
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
4,000
8,000
12,000
16,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
10,000
20,000
30,000
Diversity
12%
0%
1%
24%
8%
55%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Labor Force by Industry
Manufacturing 13%
Health Care 12%
Retail Trade 11%
Educational Services 8%
Construction 8%
Accommodation/Food Svcs 7%
Public Administration 6%
Transportation 6%
Professional/Tech Svcs 5%
Other Services 4%
Admin/Waste Mgmt 4%
Wholesale Trade 4%
Finance/Insurance 4%
Arts/Entertainment/Rec 3%
Information 2%
Utilities 2%
Real Estate 1%
Agriculture 1%
Management 0%
Mining 0%
0
2,000
4,000
Hispanic Origin
39%
1% 0%
1%
1%
5%
53%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
94,589
Median Household Income
39.2
Median Age
Income
632,728
Median Home Value
4,330
Renter Occupied Housing Units
7,788
Owner Occupied Housing Units
228
Households with Public Assistance Income
Population
36,745
Total Population
37,622
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
2,000
4,000
6,000
8,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
4,000
8,000
12,000
16,000
Diversity
5%
1%
15%
0%
7%
72%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Labor Force by Industry
Educational Services
Professional/Tech Svcs
9%
Health Care
9%
Retail Trade
8%
Manufacturing
5%
Construction
4%
Public Administration
4%
Accommodation/Food Svcs
4%
Transportation
3%
Finance/Insurance
3%
Arts/Entertainment/Rec
3%
Admin/Waste Mgmt
3%
Other Services
3%
Wholesale Trade
3%
Real Estate
3%
Information
2%
Utilities
1%
Agriculture
0%
Mining
0%
Management
0%
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2,000
4,000
Hispanic Origin
28%
1%
1%
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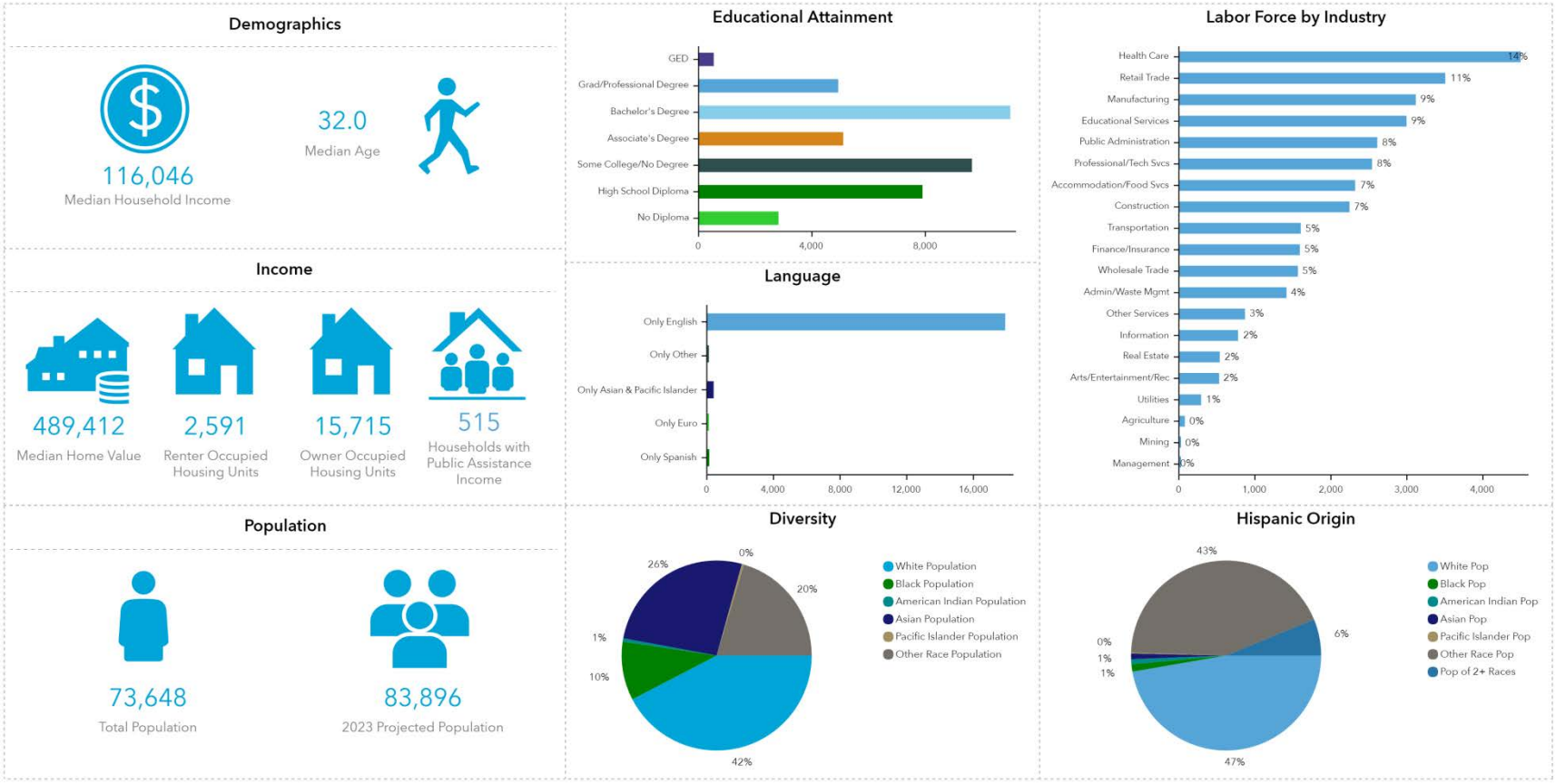
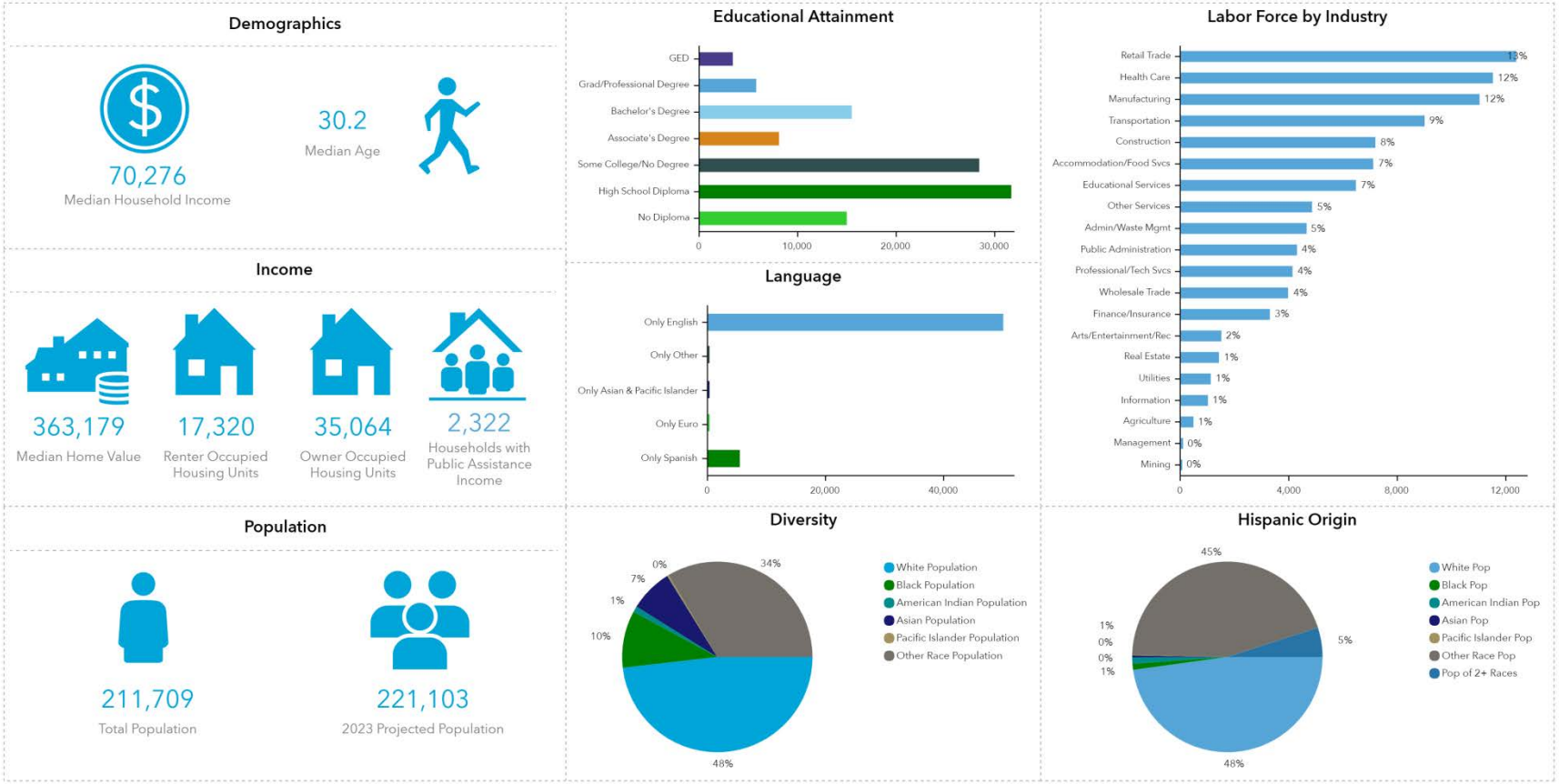
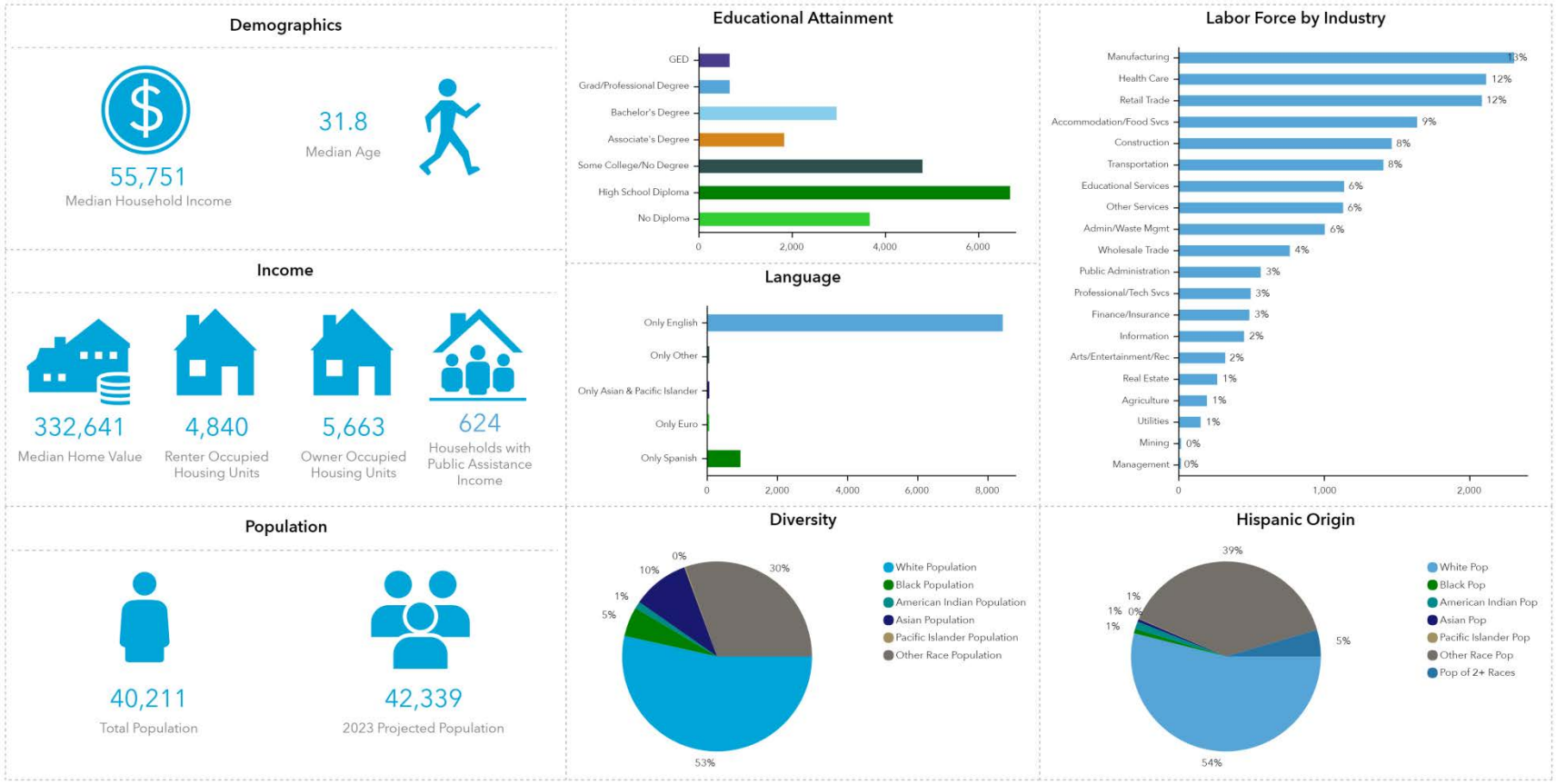
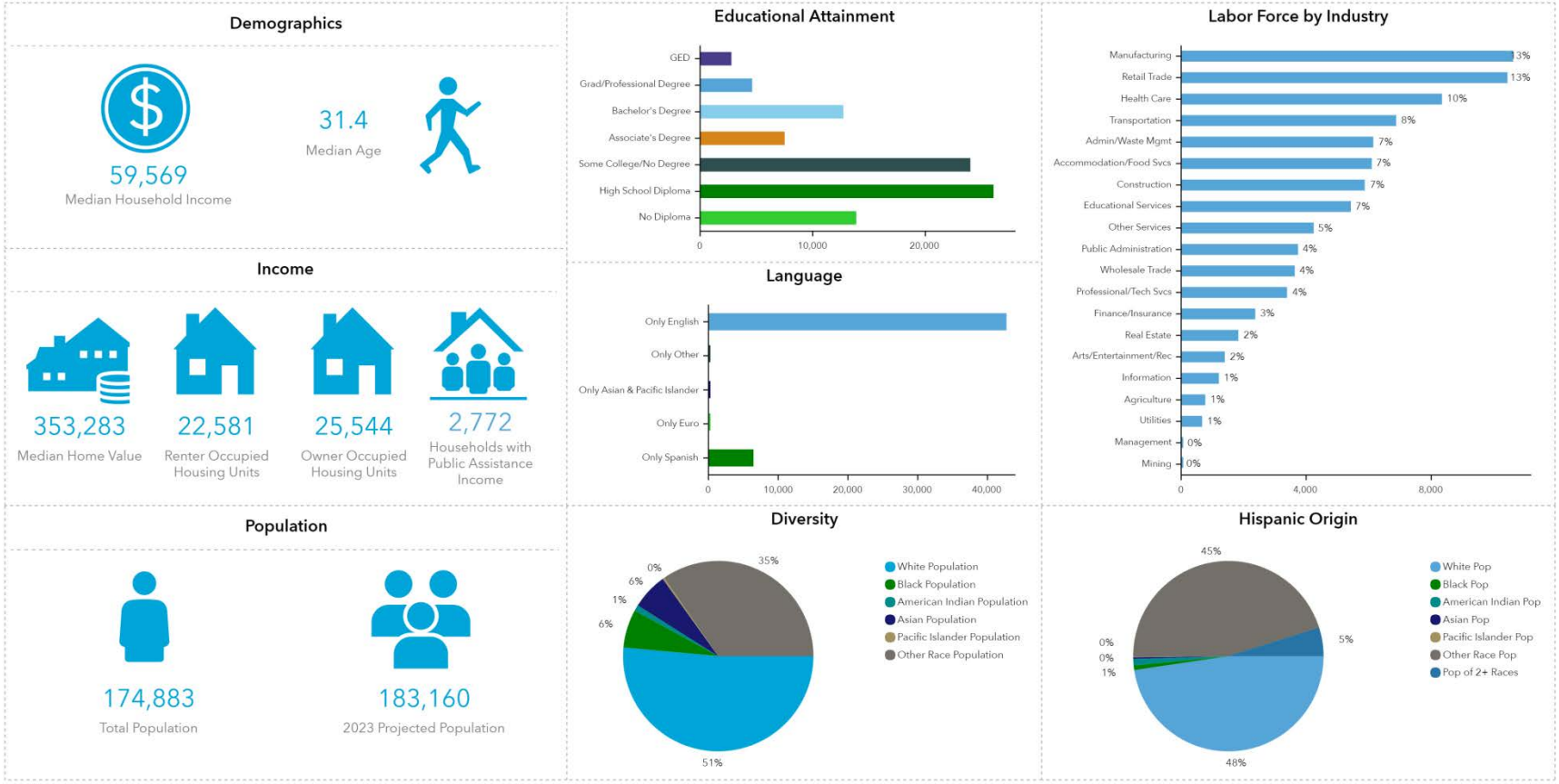
1%
9%
59%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
116,046
Median Household Income
32.0
Median Age
Income
489,412
Median Home Value
2,591
Renter Occupied Housing Units
15,715
Owner Occupied Housing Units
515
Households with Public Assistance Income
Population
73,648
Total Population
83,896
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
4,000
8,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
4,000
8,000
12,000
16,000
Labor Force by Industry
Health Care 14%
Retail Trade 11%
Manufacturing 9%
Educational Services 9%
Public Administration 8%
Professional/Tech Svcs 8%
Accommodation/Food Svcs 7%
Construction 7%
Transportation 5%
Finance/Insurance 5%
Wholesale Trade 5%
Admin/Waste Mgmt 4%
Other Services 3%
Information 2%
Real Estate 2%
Arts/Entertainment/Rec 2%
Utilities 1%
Agriculture 0%
Mining 0%
Management 0%
0
1,000
2,000
3,000
4,000
Diversity
0%
26%
20%
1%
10%
42%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Hispanic Origin
43%
6%
0%
1%
1%
47%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
70,276
Median Household Income
30.2
Median Age
Income
363,179
Median Home Value
17,320
Renter Occupied Housing Units
35,064
Owner Occupied Housing Units
2,322
Households with Public Assistance Income
Population
211,709
Total Population
221,103
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
10,000
20,000
30,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
20,000
40,000
Labor Force by Industry
Retail Trade 13%
Health Care 12%
Manufacturing 12%
Transportation 9%
Construction 8%
Accommodation/Food Svcs 7%
Educational Services 7%
Other Services 5%
Admin/Waste Mgmt 5%
Public Administration 4%
Professional/Tech Svcs 4%
Wholesale Trade 4%
Finance/Insurance 3%
Arts/Entertainment/Rec 2%
Real Estate 1%
Utilities 1%
Information 1%
Agriculture 1%
Management 0%
Mining 0%
0
4,000
8,000
12,000
Diversity
0%
34%
7%
1%
10%
48%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Hispanic Origin
45%
1%
0%
0%
1%
5%
48%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
55,751
Median Household Income
31.8
Median Age
Income
332,641
Median Home Value
4,840
Renter Occupied Housing Units
5,663
Owner Occupied Housing Units
624
Households with Public Assistance Income
Population
40,211
Total Population
42,339
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
2,000
4,000
6,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
2,000
4,000
6,000
8,000
Diversity
0%
10%
30%
1%
5%
53%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Labor Force by Industry
Manufacturing
Health Care
Retail Trade
Accommodation/Food Svcs
Construction
Transportation
Educational Services
Other Services
Admin/Waste Mgmt
Wholesale Trade
Public Administration
Professional/Tech Svcs
Finance/Insurance
Information
Arts/Entertainment/Rec
Real Estate
Agriculture
Utilities
Mining
Management
12%
12%
9%
8%
8%
6%
6%
6%
4%
3%
3%
3%
2%
2%
1%
1%
1%
0%
0%
0
1,000
2,000
Hispanic Origin
39%
1%
1%
0%
1%
5%
54%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
59,569
Median Household Income
31.4
Median Age
Income
353,283
Median Home Value
22,581
Renter Occupied Housing Units
25,544
Owner Occupied Housing Units
2,772
Households with Public Assistance Income
Population
174,883
Total Population
183,160
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
10,000
20,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
10,000
20,000
30,000
40,000
Diversity
35%
0%
6%
1%
6%
51%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Labor Force by Industry
Manufacturing 13%
Retail Trade 13%
Health Care 10%
Transportation 8%
Admin/Waste Mgmt 7%
Accommodation/Food Svcs 7%
Construction 7%
Educational Services 7%
Other Services 5%
Public Administration 4%
Wholesale Trade 4%
Professional/Tech Svcs 4%
Finance/Insurance 3%
Real Estate 2%
Arts/Entertainment/Rec 2%
Information 1%
Agriculture 1%
Utilities 1%
Management 0%
Mining 0%
0
4,000
8,000
Hispanic Origin
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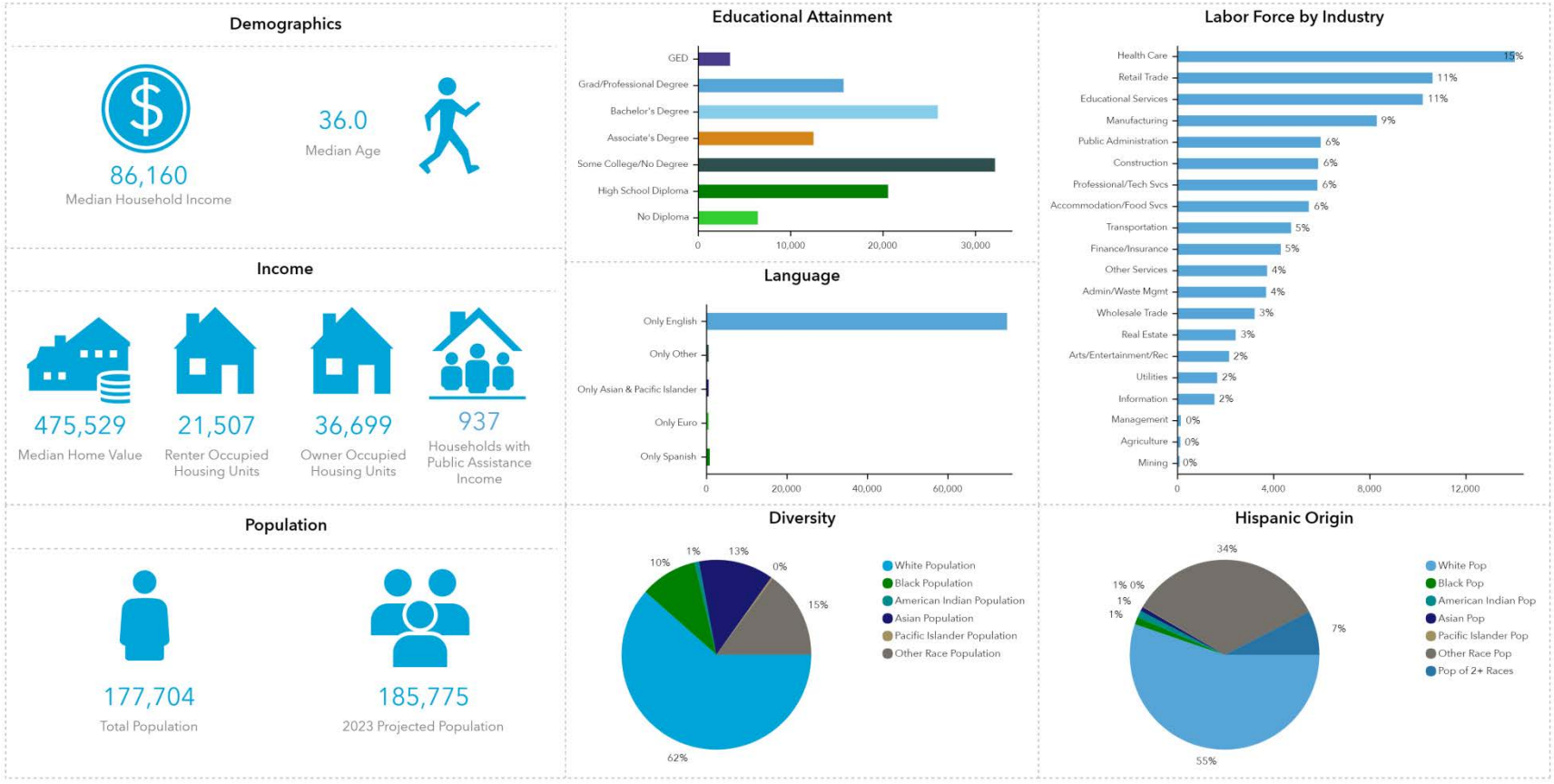
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
86,160
Median Household Income
36.0
Median Age
Income
475,529
Median Home Value
21,507
Renter Occupied Housing Units
36,699
Owner Occupied Housing Units
937
Households with Public Assistance Income
Population
177,704
Total Population
185,775
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
10,000
20,000
30,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
20,000
40,000
60,000
Labor Force by Industry
Health Care 15%
Retail Trade 11%
Educational Services 11%
Manufacturing 9%
Public Administration 6%
Construction 6%
Professional/Tech Svcs 6%
Accommodation/Food Svcs 6%
Transportation 5%
Finance/Insurance 5%
Other Services 4%
Admin/Waste Mgmt 4%
Wholesale Trade 3%
Real Estate 3%
Arts/Entertainment/Rec 2%
Utilities 2%
Information 2%
Management 0%
Agriculture 0%
Mining 0%
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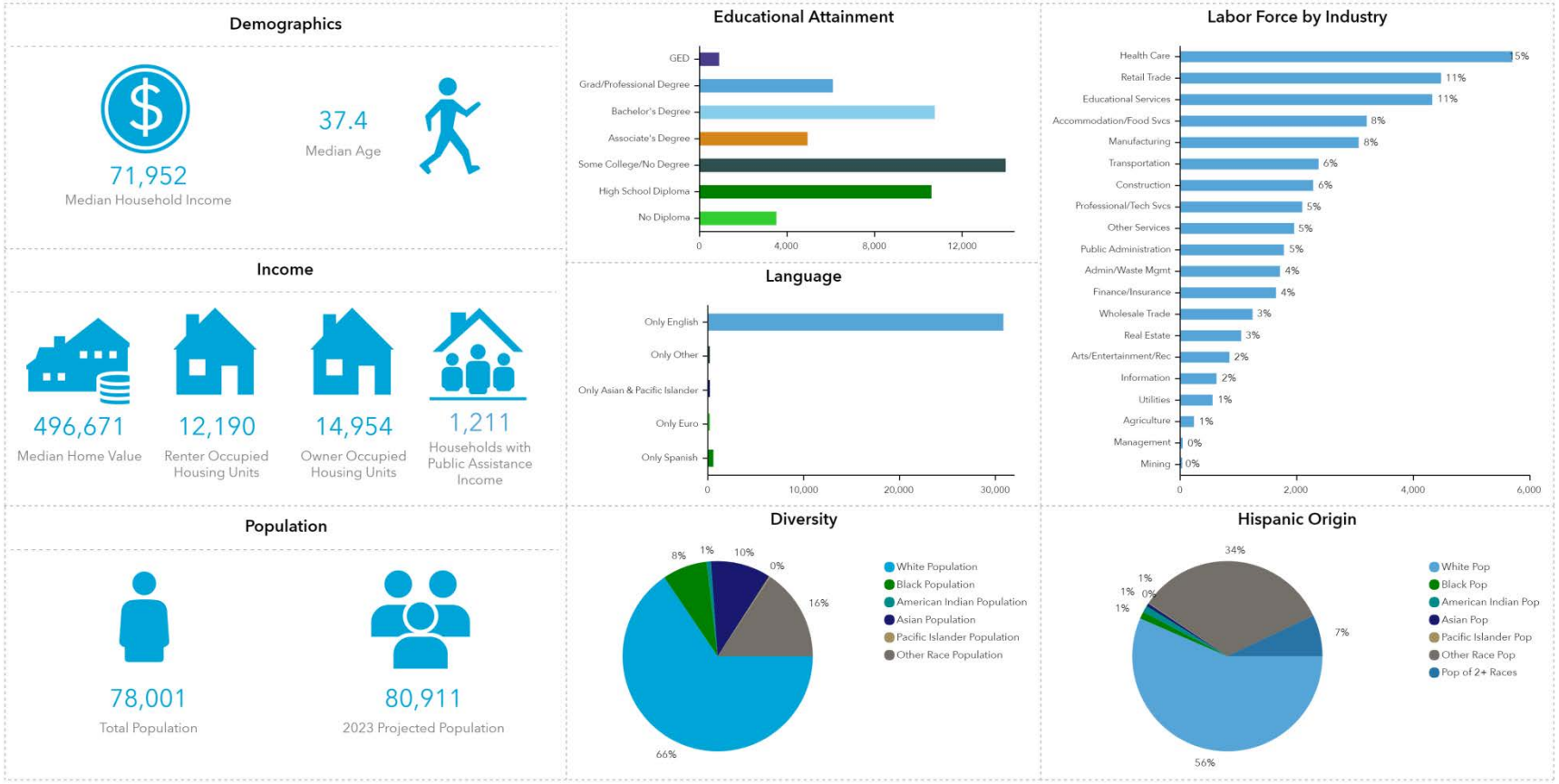
4,000
8,000
12,000
Diversity
10%
1%
13%
0%
15%
62%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Hispanic Origin
34%
1% 0%
1%
1%
7%
55%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races


Demographics
71,952
Median Household Income
37.4
Median Age
Income
496,671
Median Home Value
12,190
Renter Occupied Housing Units
14,954
Owner Occupied Housing Units
1,211
Households with Public Assistance Income
Population
78,001
Total Population
80,911
2023 Projected Population
Educational Attainment
GED
Grad/Professional Degree
Bachelor's Degree
Associate's Degree
Some College/No Degree
High School Diploma
No Diploma
0
4,000
8,000
12,000
Language
Only English
Only Other
Only Asian & Pacific Islander
Only Euro
Only Spanish
0
10,000
20,000
30,000
Diversity
8%
1%
10%
0%
16%
66%
White Population
Black Population
American Indian Population
Asian Population
Pacific Islander Population
Other Race Population
Labor Force by Industry
Health Care 5%
Retail Trade 11%
Educational Services 11%
Accommodation/Food Svcs 8%
Manufacturing 8%
Transportation 6%
Construction 6%
Professional/Tech Svcs 5%
Other Services 5%
Public Administration 5%
Admin/Waste Mgmt 4%
Finance/Insurance 4%
Wholesale Trade 3%
Real Estate 3%
Arts/Entertainment/Rec 2%
Information 2%
Utilities 1%
Agriculture 1%
Management 0%
Mining 0%
0
2,000
4,000
6,000
Hispanic Origin
34%
1%
1%
1%
7%
56%
White Pop
Black Pop
American Indian Pop
Asian Pop
Pacific Islander Pop
Other Race Pop
Pop of 2+ Races

CHNA Requirements

The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010 included new requirements for nonprofit hospitals to maintain their tax-exempt status. The final regulations and guidance on these requirements, which are contained in section 501(r) of the Internal Revenue Code, were published in Internal Revenue Bulletin 2015-5 on February 2, 2015. Included in the new regulations is a requirement that all nonprofit hospitals conduct a community health needs assessment (CHNA) and develop an implementation strategy to address those needs every three years. In addition, Schedule H was added to nonprofit hospitals' Form 990 annual tax filing submitted to the Internal Revenue Service.

The State of California, through its Office of Statewide Health Planning and Development, implemented the requirements for a community health needs assessment (CHNA), the development of a community benefit plan, and the reporting structure for nonprofit hospitals' community benefit programs as legislated through Senate Bill 697. San Antonio Regional Hospital has a conducted a CHNA and developed a Community Benefit Implementation Plan every three years since SB697 became effective in 1995. The CHNA conducted in 2016 informed the hospital's implementation plan for 2017 – 2019. The report that follows presents the inventory and valuation for 2017, and also highlights some of the targeted efforts that have been initiated through the Implementation Plan.

2016 Inland Empire Regional CHNA

The Hospital Association of Southern California (HASC) works with hospitals to advance quality healthcare delivery and supports hospital community benefit planning through an Inland Area Community Benefit Stakeholder Committee representing the major hospitals in Riverside and San Bernardino Counties. In preparation for the 2016 CHNA cycle, HASC led an effort among member hospitals to conduct an Inland Empire Regional CHNA. The HASC Community Benefit Committee worked collaboratively to design the overall CHNA strategy and the coordination of primary and secondary data collection in collaboration with the Departments of Public Health in both Inland Empire counties. The hospitals that participated in the regional CHNA included:

- Loma Linda Medical Center Children's Hospital
- Loma Linda University Behavioral Medicine Center
- Loma Linda University Medical Center
- Loma Linda University Medical Center – Murrieta
- Montclair Hospital Medical Center
- Parkview Community Hospital Medical Center
- Redlands Community Hospital
- Ridgecrest Regional Hospital
- San Antonio Regional Hospital
- San Bernardino Mountains Community Hospital
- San Gorgonio Memorial Hospital

The collaborative effort of HASC and these hospitals resulted in the first regional CHNA among a large group of geographically diverse hospitals in the Inland Counties Region of Southern California (Inland Empire). Given the rapid growth of the Inland Empire, the higher rates of poverty, significant health needs, and inadequate primary care infrastructure, this collaboration not only supported the completion of the required reporting, but also fostered the opportunity for more unified and strategic thinking to address population needs in the region. The CHNA served as the beginning of a collaborative effort to support the health of the region.

San Antonio and each of the participating hospitals was responsible for developing its own implementation strategy and plan using the data from the CHNA. However, the goal of the HASC Community Benefits Committee is to identify areas that the region will work on collectively and in collaboration with partners outside of the healthcare system.

Health Needs Reviewed for the Two-County Region

The regional CHNA was built on the community health improvement process initiated by the San Bernardino County Department of Public Health, Community Vital Signs. As healthcare continues to evolve and systems of care become more complex, the CHNA process is becoming a key component to inform the collective efforts of communities in addressing their most pressing health needs. The CHNA viewed health with a collective lens and included not only health outcomes and clinical care components but social determinants and health indicators from the built environment.

The process for determining community health needs requires collecting reliable public health data or metrics measured against a benchmark (i.e. state averages) and engaging the community to solicit their input on the needs they perceive to be the most pressing in their community. The CHNA process also requires that the community participate in prioritizing health needs and that a hospital identify potential resources available to address those needs. The criteria and process used for prioritizing the health needs is not defined by the IRS, but considerations typically include factors

such as the severity of the health need, the number of community members impacted, or the presence of health inequities among segments of the community.

The regional CHNA incorporated three distinct data methodologies that, when interpreted together, provide a deeply rich picture of the health landscape of the communities. The assessment contained a plethora of health indicators (hospitalizations, social determinants of health, maternal and child health, mortality and morbidity) gathered from multiple primary and secondary sources. This quantitative data illustrates the current snapshot of health statistics in the communities that the member hospitals serve and also how they compare across geographical boundaries. The quantitative data was stratified by common public health groupings and service areas allowing a targeted identification of unique challenges and opportunities surrounding health status, quality of life, and risk factors in the region and in each hospital's individual service area.

The full assessment provides a detailed review of health in the Inland Empire with clear similarities and variability across the two counties and hospital service areas. Several health indicators stand out as desirable and others indicate an opportunity for additional study and outreach. The top chronic health conditions identified through data compilation include (in alphabetical order):

- Asthma
- Chronic obstructive pulmonary disease
- Diabetes
- Heart Disease
- Mental illness
- Obesity
- Substance abuse

Voices from the Community

A community health "quality of life" survey (QOL) was administered to obtain community input regarding the strengths and areas of opportunity that exist in each community. The survey was available in English and Spanish and was disseminated through a variety of channels across hospital service areas. A total of 541 individuals completed the QOL survey. Of those who completed the survey, 50% were between the ages of 40-65, 12.6% were seniors who were 65 years or older, 30% had an annual household income of $25,000 or less, and 60% were Hispanic. Qualitative data was also garnered through the use of eight community member, health expert, and key stakeholder focus groups. The focus groups, conducted in both English and Spanish, revealed thoughts and perceptions and augmented the quantitative data collected in the assessment process. The focus groups allowed a deep understanding of the issues respondents believe are important. The assessment displays data at the county level and when available several health indicators are provided for each hospital's service area.

The quality of life surveys and focus groups were tailored to assess the direct and indirect needs of the communities throughout the Inland Empire. The information shared gave insight into some of the concerns individuals had for their community. Community concerns ranged from the quality of the education system, access to mental health services, pollution, economy, homelessness, climate change, and the overabundance of fast food restaurants.

The top health challenges identified for the communities involved in the regional CHNA are provided in the table that follows.

Health Outcomes	Social Determinants	Clinical Care	Built Environment
Diabetes (Higher rates among Hispanics/Latinos)	High rates of poverty	Shortage of primary care physicians	Affordable housing shortages
Behavioral Health	Lower median incomes	Lack of or failure to access preventive screenings for cancer	Lack of access to healthy foods
Heart Disease and Stroke	Lower educational attainment	Inadequate prenatal care	
Chronic Obstructive Pulmonary Disease			
Colorectal Cancer			
Lung Cancer			
Obesity			

Several common themes emerged through the compilation and analysis of the CHNA findings, and the identified health needs were summarized into the following categories:

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

Everyone participating in the CHNA recognized that the causes of community health needs are both complex and challenging to articulate. Equally challenging is the task of addressing these needs in meaningful and impactful ways. With the completion of the CHNA and the prioritization process, the San Antonio team embarked on the next step to develop and refine an array of Community Benefit Programs aimed at addressing the health needs identified in the CHNA. During this process, the team developed goals, objectives, and initiatives to address the priority health needs that were identified. Using primary and secondary data from the CHNA, the team offered input regarding opportunities to address health issues, identified potential challenges, and provided insight into established activities and programs that currently address the health priorities. San Antonio's 2017 – 2019 Implementation Strategy and Plan reflects the results of this process.

2017 – 2019 Community Benefit Implementation Strategy and Plan

To complement the 2016 CHNA, a Community Benefit Implementation Plan was created with specific strategies and programs to address identified health needs. The five areas of focus in the 2017-2019 Implementation Plan include; chronic disease management, increasing healthcare access for vulnerable populations, improvement of health through prevention and wellness, improvement of the health environment, and increasing access to behavioral health awareness and education opportunities. The synergy among these five priority areas enabled the hospital to employ the lessons learned through its extensive CHNA to develop a cohesive and effective three-year strategic Community Health Implementation Plan to address the identified health needs.

The Implementation Plan serves as a guiding document for the planning and programming of community benefit activities targeting health issues identified through the CHNA. The plan focuses 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 are likely to result in adverse health outcomes. The implementation plan is closely aligned with San Antonio's strategic plan, mission, and values.

San Antonio is committed to focusing its Community Benefits resources on increasing evidence-based and evidence-informed prevention programs for the community, measuring program impact, and advancing care coordination and service integration.

Implementation Strategy Matrix

The following matrix identifies the strategic initiatives included in the 2017 – 2019 Implementation Strategy and Plan. Each initiative addresses one or more of the five focus areas derived from the significant health needs identified in the 2016 CHNA.

FOCUS AREAS ADDRESSING SIGNIFICANT HEALTH NEEDS					
INITATIVE	ACCESS TO HEALTHCARE	CHRONIC DISEASE MANAGEMENT	PREVENTION AND WELLNESS	HEALTHY ENVIRONMENT	BEHAVIORAL HEALTH
HELP Elementary Expansion	X	X	X		
Community Health Improvement Program (CHIP) Expansion	X	X	X		
Know Your Numbers (KYN) Expansion	X	X	X	X	
BUILD Case Management Program Expansion	X	X	X		X
Workforce Development *(Healthy Eating Lifestyle Program 12+ Expansion)*	X		X		
Leadership Development (Healthy Cities Certificate Program)	X	X	X	X	
Support Local and Regional Behavioral Health Policy Change and Educational/Awareness Initiatives	X		X		X

2017 Implementation Strategy Accomplishments

The following table provides a brief description of the major accomplishments achieved in each initiative during 2017.

Initiatives	Strategies	Accomplishments
Healthy Eating and Lifestyles Program (*HELP*)	Expand *HELP* Elementary School	*HELP* was reevaluated in 2017. The program will be rebranded as *wHealth* (Wellness + Healthcare), and a revised curriculum for elementary students will be developed and implemented in 2018.
Community Health Improvement Program (*CHIP*)	Expand *CHIP* program coaches and participants	During 2017, *CHIP* added 45 student coaches and 60 patients. A total of 122 student coaches have been trained to serve 170 patients.
Know Your Numbers (*KYN*)	Expand *KYN* program participants	*KYN* served 318 participants in 2017, with 182 new participants and 136 returning. A total of 526 participants were served through KYN during the two-year program.
BUILD (Bold, Upstream, Innovative, Local, Data-drive) Program	Expand *BUILD* case management program	BUILD clinical community health worker case management increased by 158 participants in 2017.
Workforce Development (*HELP 12+)*	Expand *HELP* program to reach high school students	During 2017, the *HELP* program was rebranded as wHealth (Wellness + Healthcare). New HealthCorps curriculum was adopted and delivered to 450 high school and 120 middle school students in Upland and Chaffey Joint Union school districts.
Healthy Communities Leadership Development	Develop Healthy Communities Certificate Program	The program concept was revised in collaboration with the regional council of governments (COG's) to establish a policy maker training series scheduled to launch in 2018.
Behavioral Health	Support local and regional behavioral health policy change and educational awareness initiatives	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. Mental health was incorporated into the wHealth program through mental resiliency education.

Community Benefit Program Highlights 2017

The following outreach services and programs serve as examples to highlight the actualization of San Antonio's Implementation Strategy and Plan during 2017.

Community Lectures

Every month San Antonio Regional Hospital hosts a Community Health Education Lecture. These lectures are open to the public for the purpose of engaging the community and increasing education related to specific health topics. Lectures are led by the hospital's physicians or other clinical staff. Topics included the following:

- Breast Cancer
- Colorectal Cancer
- Diabetes Management
- Gynecologic Cancer
- Healthy Cooking Demonstrations
- Heart Disease Management
- Joint Health: Knees, Hips, Shoulders
- Metabolic Syndrome
- Prostate Cancer
- Seasonal Allergies
- Stroke Risks and Treatment

Generations Ahead Workshops

San Antonio understands the importance of supporting healthy lifestyle choices at all ages. Generations Ahead is the hospital's senior program, which provides targeted services and programs designed to assist older adults in maintaining their health and vitality. Seniors have enriched the community and in return the hospital constantly strives to recognize their contributions by helping them maintain their health and vitality. In addition to health lectures for the broader community, the hospital hosts lectures for senior community members. These lectures occur monthly and are led by hospital clinical staff. Topics for 2017 included:

- Arthritis
- Balance
- Blood Pressure
- Breast Cancer
- Healthy Eating
- Heart Disease
- Joint Health: Knees, Hips, Shoulders
- Physical Therapy for Chronic Disease
- Seasonal Allergies
- Stroke Prevention
- Restorative Chair Yoga for Stability and Flexibility

Health & Hot Rods

The annual men's health event took place on June 10, 2017 from 8 am to 12 pm. This event is offered to community members in the hospital's service area, making it convenient for men to receive health screenings and education, while enjoying the display of classic cars and hot rods. The event was broadly publicized and open to the entire community. The event served nearly 150 guests and provided screenings to 85 participants in 2017.

Throughout the event venue educational opportunities were provided in the form of physician lectures, booths, posters and the materials included at registration. Booths included; San Antonio Cancer Center, San Antonio Heart Center, 4URHealth Wellness Program, Stroke, and Nutrition. Representatives from the American Cancer Society (ACS), the American Heart Association (AHA), and the American Medical Response (AMR) organization were present to provide additional health education. In 2017, the education topics included lung cancer prevention and smoking cessation, presented by San Antonio doctors.

Girls' Day Out

For several years, San Antonio Regional Hospital has hosted a series of cancer awareness events during the month of October, with a special prevention event called *Girls' Night Out*. In 2017, while maintaining the same prevention focus as previous years, the title was changed to *Girls' Day Out*. The event was held from 10 am to 3 pm and welcomed a total of 150 registered participants. The event was broadly publicized and open to the entire community.

The message of prevention was consistent throughout the event, beginning with the educational materials distributed at registration to the posters containing key cancer prevention messages displayed throughout the event venue. A multitude of educational booths were present such as the

American Cancer Society, San Antonio Cancer Center, San Antonio Women's Breast and Imaging Center, American Lung Association, San Antonio's Heart and Stroke Centers, American Heart Association, and the 4URHealth Wellness Program. A member of San Antonio's medical staff and representatives of the American Cancer Society and the American Lung Association provided health presentations. Dr. Kimberly Bekemeier focused on lung cancer prevention, with an emphasis on healthy nutrition, regular exercise, maintaining mindfulness, and the importance of lifestyle changes, especially smoking cessation. Cathy Zappia of the American Cancer Society presented on the impact of tobacco use and tobacco-related illnesses. She highlighted the decline in smoking rates, as well as policies aimed at smoking prevention. Terry Roberts of the American Lung Association presented on overall lung health and the connection to air pollution. She emphasized lung cancer effects on women and provided information on lung cancer screening. Both guest speakers provided resources and skills for preventing lung cancer as an individual and as a community. Those in attendance were encouraged to take advantage of the hospital's low cost lung cancer screening promotion by taking the screening tool received at registration to their personal physician for evaluation of eligibility for the screening. Non-smokers were encouraged to share this opportunity with friends and family members who may be smokers. Event participants completed surveys measuring cancer prevention knowledge, including alcohol consumption, physical activity, screening activities and leading cancer deaths. The pre-survey established a baseline of health knowledge related to cancer and cancer prevention. Survey participants were also encouraged to complete a post-survey. Those who completed both the pre-survey and post-survey were entered into a prize drawing to encourage participation. Comprehensive screenings, including cholesterol, blood glucose, blood pressure, and BMI were also offered.

Know Your Numbers

In February 2015, San Antonio, in collaboration with Loma Linda University Masters of Public Health students, initiated the Know Your Numbers (KYN) program in Ontario, California. The goal of the program was to reduce chronic disease incidence in impoverished, uninsured, and underinsured populations through screening and health education. KYN provides biometric screenings in Ontario's "HEAL Zone", including blood pressure, body mass index, blood glucose, and blood cholesterol point-of-care tests among the low-income population living in surrounding communities.

KYN is a self-management and health education program designed around the health belief model that assumes health-related actions depend on a participants' belief that he/she is susceptible to significant health issues that improve through a prescribed health recommendation. Participants consult with a registered nurse (RN) following the screening to learn about their own numbers and the impacts these factors have on health status. Following consultation, participants are paired with a Clinical Community Health Worker (CCHW) and are connected to additional resources through referrals, educational materials, and community programs.

The initial screening program included 50 participants, of which 72% were Hispanic, 22% were uninsured, 48% did not have a primary care physician, and 36% had never visited a hospital. Thirty-four percent of the participants had high blood pressure and 20% displayed numbers indicative of a hypertensive crisis. Fifty percent of the participants were clinically obese and 34% were overweight as indicated by their BMI metrics. Due to the success of the pilot program, KYN was expanded to include several screening locations residing in and around the Healthy Eating and Active Living (HEAL) Zone of Ontario.

In 2016, KYN was incorporated into the Healthy Ontario Initiative (HOI), an innovative multi-sectorial collaborative partnership in the City of Ontario. 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. This 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. 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. San Antonio staff and community partners worked diligently on developing health curriculum for the case management sub-population within the whole population. Case management parameters were created to determine which participants needed individual care. 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.

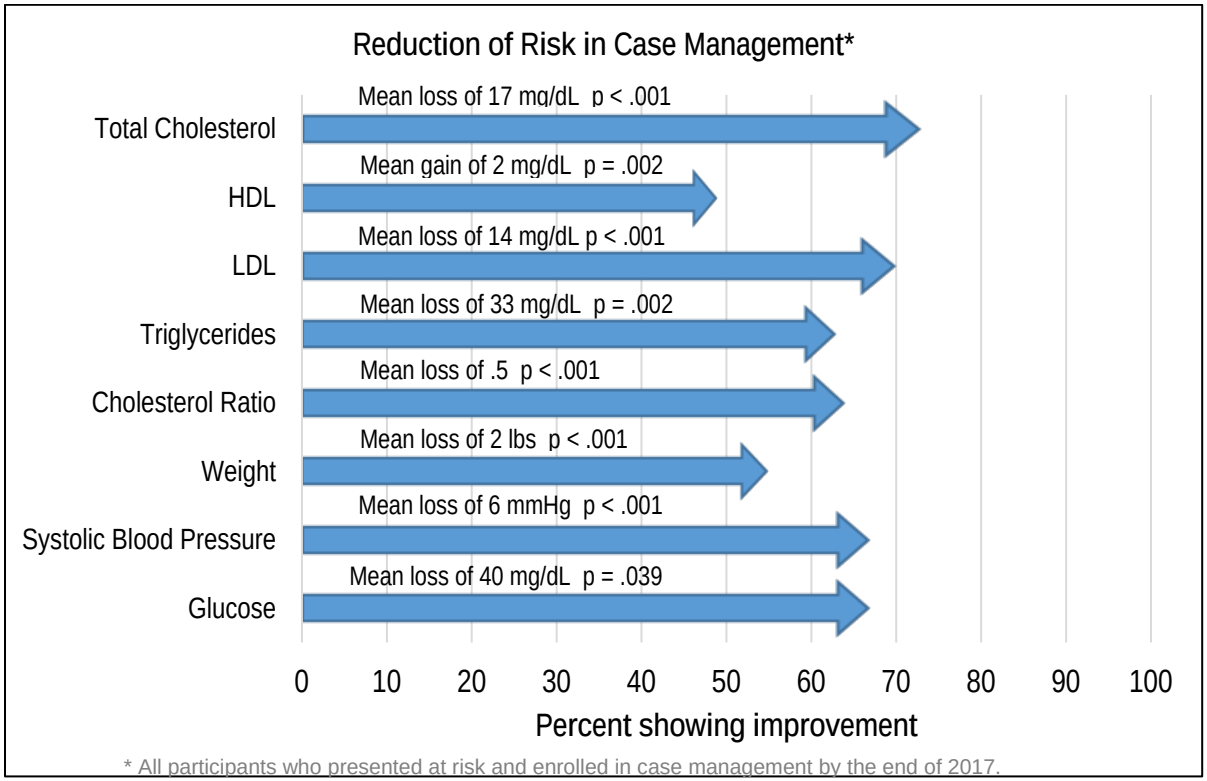
KYN took place in the heart of Ontario, but was open to others within the hospital's service area. Over the last two years, nearly all participants were Hispanic and the vast majority were women. Women were more likely to participate in case management and Hispanics were also more likely to participate than participants of other ethnicities. In general, participants had low incomes, over a third did not have a high school degree, and over half were unemployed. Those who were unemployed and who had low education levels were more likely to participate in case management. This program was specifically successful at increasing access to healthcare services. About half of all participants did not have a primary care physician and about half did not have health insurance. Those without a primary care doctor and health insurance were most likely to participate in case management. This demonstrates the need for increased access within the hospital's service area.

The Ontario HOI KYN program concluded with the sunset of the grant in 2017. The program's findings demonstrate KYN maintained a steady number of participants, successfully screening 318 in 2017, some came once and some came up to four times. Of the 318, 182 were new

participants and 136 were returning. The percent of the population found at-risk were as follows; total cholesterol 41%, systolic blood pressure 47%, BMI 82%, and glucose 8%.

Of the 318 participants, 166 participated in case management. More than 20% of case management participants were still actively involved in the program after a year and a half and nearly 30% were active after one year. Within the total population, approximately half of participants returned for a follow-up within one year. All participants, including the healthy and those at-risk but not choosing to participate in case management, were offered educational materials and invited to monitor their health by returning for a follow-up screening.

Outcomes for the population revealed the following health improvements:



The chart shows that the majority of case management participants not only slowed the increase in their biomarkers, but reduced their risk by lowering biomarker levels. This includes individuals who were just starting the case management program at the end of 2017. Overall, weight and HDL were the hardest to change. Significant decreases were achieved in all categories, with the mean change and p-value listed. Regular screening and educational materials raise health awareness, but the biggest value of KYN is in referring at-risk participants into case management intervention.

Results of this pilot study were positive and lifted KYN as a model for a dual-county initiative to prevent pre-diabetes and type II diabetes. This initiative, known as Bridging for Health, is funded in part by the Robert Wood Johnson Foundation. It leverages a collective impact strategy to identify community health needs and to develop an innovative, sustainable financing model. The Inland Empire (Riverside County and San Bernardino County) is one of five communities in the nation selected to receive the small start-up grant for this effort. San Antonio staff dedicated significant time and effort in 2017 to work with partners on developing an enhanced version of the KYN model to be implemented in 2018.

Community Health Improvement Program (CHIP)

The continued escalation of patients with chronic conditions is a principle reason San Antonio developed and implemented the Community Health Improvement Program in January 2015. The Centers for Disease Control has reported that, as a nation, 86% of our healthcare dollars are expended in treating chronic diseases. These persistent conditions have contributed to the burgeoning healthcare costs that have created new structures to address the growing demand and escalating costs. “Medical homes” and “accountable care organizations” (ACOs) have emerged in the belief that they will improve healthcare quality and slow the growth of healthcare spending in America.

The Community Health Improvement Program (CHIP) is one of the initiatives San Antonio developed to: 1) diminish healthcare gaps, 2) promote the delivery of evidence-based care, and 3) reduce unnecessary emergency room visits and hospitalizations. Coordinated by a dedicated interdisciplinary healthcare team employing a series of individualized continuous care algorithms, this program focuses on appropriate patient identification, prevention, evidence-based disease management, and exemplary treatment of individuals with chronic conditions.

Each participating CHIP member is closely monitored in accordance with an individualized Comprehensive Health Profile (CHP), Quality Care Plan (QCP), and longitudinal patient scorecard. A novel stratification scale that assesses socioeconomic status, education/assimilation capacity, mental health history, adherence potential, psychological stress factors, and support is utilized along with data mining and standardized clinical assessments to individualize evidence-based clinical strategies based upon each person’s respective needs and capabilities.

A unique aspect of CHIP is the training and utilization of student health coaches. In addition to the CHIP interdisciplinary clinical team, members are monitored by health coaches trained through an innovative credit-based collaborative educational seminar and internship program with California

State University San Bernardino Schools of Public Health, Nursing, Biology, and Kinesiology; Western University of Health Sciences, College of Graduate Nursing; and Cal Poly Pomona. After appropriate screening, selected students participate in a seminar taught by our interdisciplinary team of healthcare professionals including physicians, nurses, nutritionists, social workers, and hospital administrators. The work of the student health coaches is overseen by licensed professionals (registered nurse and physician) as needed and their scope of activities are consistent with their competence and the training and demonstrated skills provided through the program.

Once trained, student health coaches provide in-home visits and phone interactions. Students engage in the process of educating 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.

In 2017, CHIP successfully recruited 45 students to become health coaches and has now trained a total of 122. CHIP enrolled 60 patients in 2017 raising the total number cared for by these health coaches to 170 patients.

Lewis-San Antonio Healthy Communities Institute

The Lewis-San Antonio Healthy Communities Institute (HCI) was established in April 2016 to identify opportunities, solutions, and partners to positively impact the health of our region. HCI is currently focusing on four program areas: healthcare workforce, food recovery, policy education, and non-clinical healthcare internships.

Leadership Development/Training for Community Members

The Healthy Communities Leadership Academy (HCLA) was reevaluated mid-2017, with the remainder of the year dedicated to revising the approach. HCI collaborated with two regional councils of government (COG's) to establish a policymaker training series. The series is to be directed to their membership to discuss programs and practices that can improve health on a community wide basis. COG membership includes policymakers from throughout the entire Inland Empire region including commissioners, council members, and city management staff.

Health Care Workforce

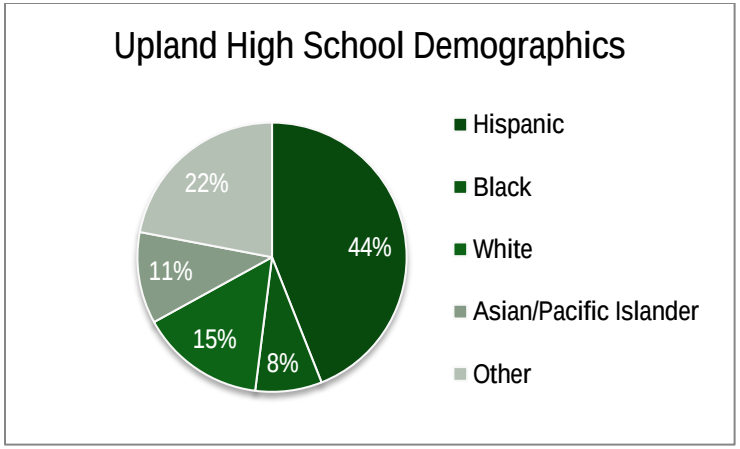
HCI supports youth interested in health careers by promoting higher education programs, engaging students through a health and wellness curriculum, and providing connections to role models/mentors majoring in health disciplines from colleges and universities in the region. The program is called "wHealth" (Wellness + Healthcare). During 2017, HCI expanded its partnerships with Upland Unified School District and began planning

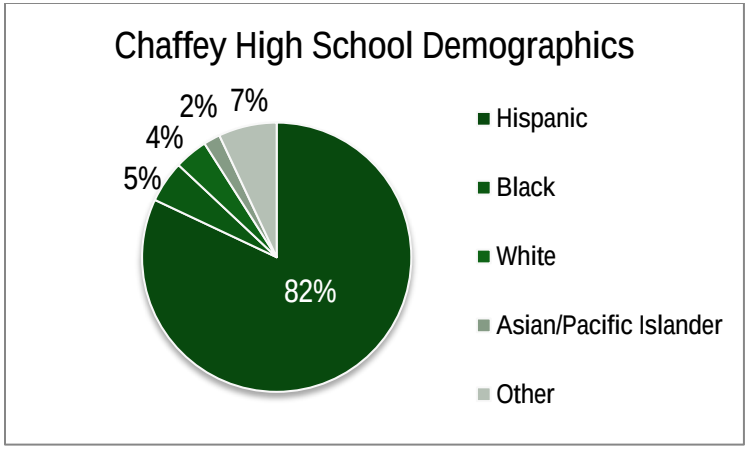
within Chaffey Joint Union High School District. In Upland, HCI worked directly with Upland High School's HOPE (Health Occupations Preparation Education) Academy. At Chaffey Joint Union, HCI worked with Chaffey High School in Ontario. The goal of wHealth is to support students in their health career journey by creating learning opportunities around chronic disease prevention, exposure to health professionals, and tours with community partners such as farms and supermarkets. Additionally, it not only encourages careers in health disciplines, but also helps to retain local students in the region.

High school students received instruction from hospital staff, Randall Lewis Health Policy Fellows, and local university interns from across the region. The fellows and interns were not only instructors, but also role models, as the students looked to them for answers to questions on college life, majors, and career planning. The wHealth curriculum is adapted from HealthCorps, a national non-profit, and aligned to National Health Education Standards focusing on nutrition, fitness, and mental resiliency.

Once the high school students completed their six-week HealthCorps program, they had the opportunity to teach the curriculum to middle school students, while providing peer to peer training and building presentation skills. HCI also introduced the *Know Your Numbers* program to the high school students and interested parents. The goal is to promote a better understanding of personal health and to help establish lifelong healthy habits, while supporting an interest in healthcare careers.

In 2017, HCI interns provided the wHealth program to 450 high school and 120 junior high students from Upland. Planning for Chaffey High School occurred with the district throughout the fall, prepping teachers in the high school and the junior high for this new program to begin in January 2018. HCI staff and interns also supervised biometric screenings of the high school participants (n=114), collected data, and provided overall program evaluation. The wHealth program is in high demand, with further expansion planned in 2018 to include additional districts and the inclusion of community college students as mentors.





Non-Clinical Internships

HCI expanded San Antonio's graduate student internship program in 2017, bringing students from various health disciplines on-site and in the community for practicum experiences. Students ranged from undergrad, graduate, and doctoral levels pursuing degrees in public health, social work, healthcare administration, nutrition, and business administration. These students were matched with projects that met their practicum requirements and supported a community need such as nutrition education and program evaluation. Many were also instructors for the *wHealth* program, providing mentorship and insight on higher education pathways. Additionally, students were connected to various health professionals in and out of the hospital, exposed to the need for health professionals in the local area, and encouraged to remain in the region. Ten students participated in these opportunities throughout 2017.

Contact

Additional information regarding San Antonio Regional Hospital, its history and its future, is available at www.sarh.org. Questions regarding this report or the hospital's community benefit activities should be directed to Cathy Rebman, Vice President, Community Outreach, at (909) 920-4802.