



SAN ANTONIO REGIONAL HOSPITAL



**Community Benefit Program
Highlights, Inventory, and Economic Valuation 2018**

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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 363-bed regional medical facility with over 2,400 employees and a medical staff of nearly 600 physicians.

The hospital's main campus in Upland opened the largest expansion in its history on January 6, 2017. The 179,000 square foot addition, which includes a new 52-bed emergency department and 92-bed patient tower, 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 includes the Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Nursing Officer, Vice President of Business Development and Community Outreach, Vice President of Human Resources, 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.

San Antonio Regional Hospital's Community Benefits

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 2018, \$1,529,457 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 \$21,382,992 in unreimbursed costs incurred in providing care and treatment for Medi-Cal patients, while other uncompensated care (bad debts) totaled \$1,146,109 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.

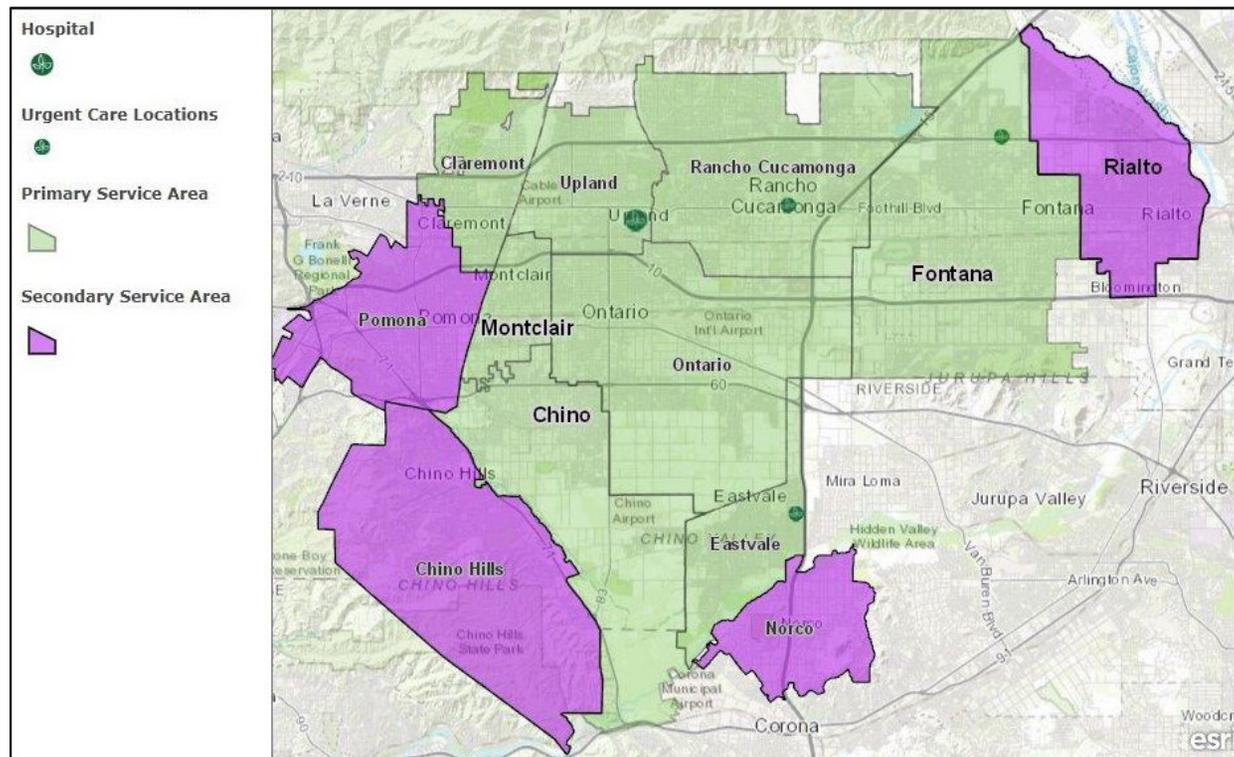
Community Profile

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 represents 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, Norco on the southeast, and Rialto at the eastern edge of the service area.

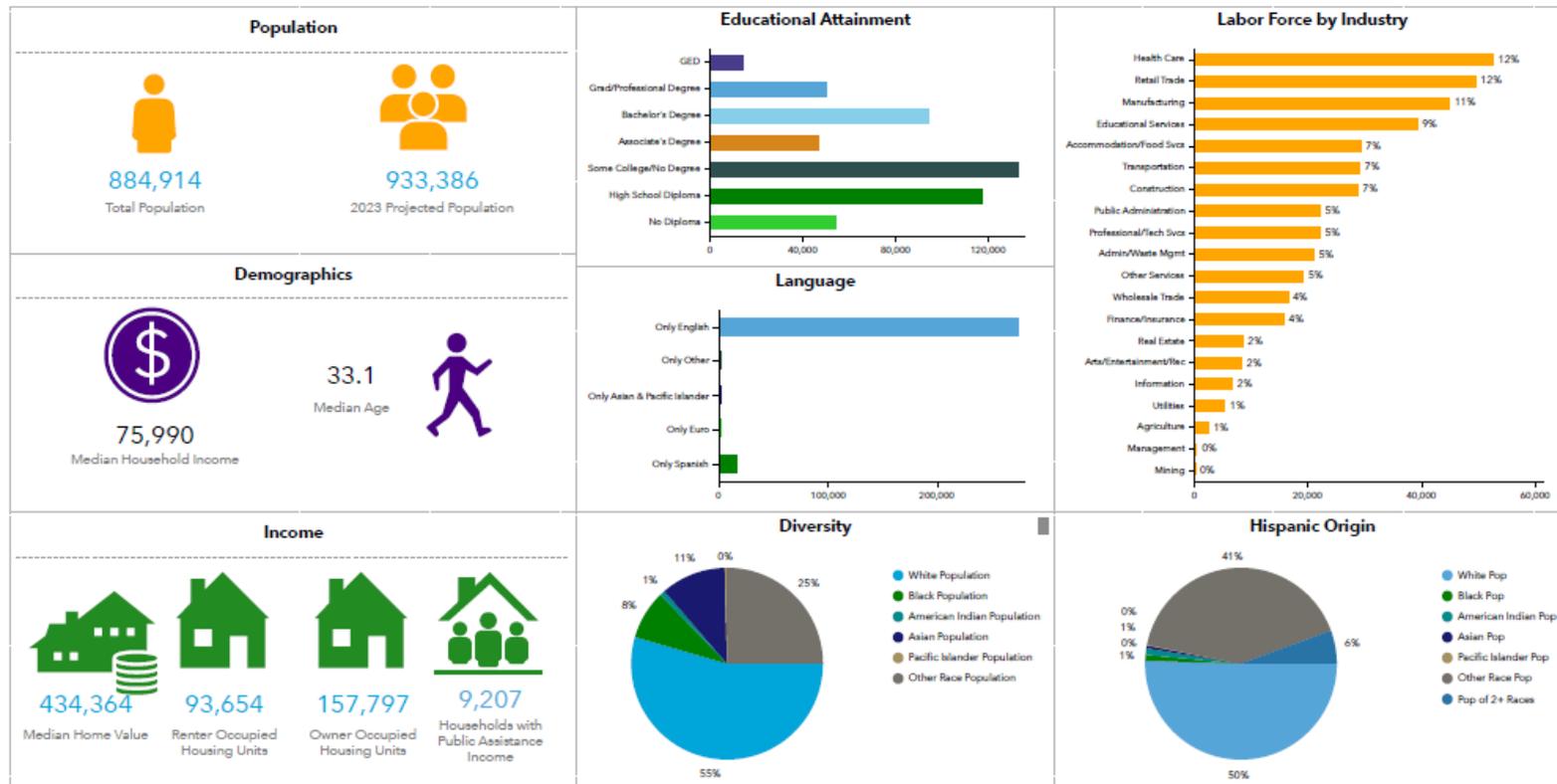
San Antonio Regional Hospital Service Area Map



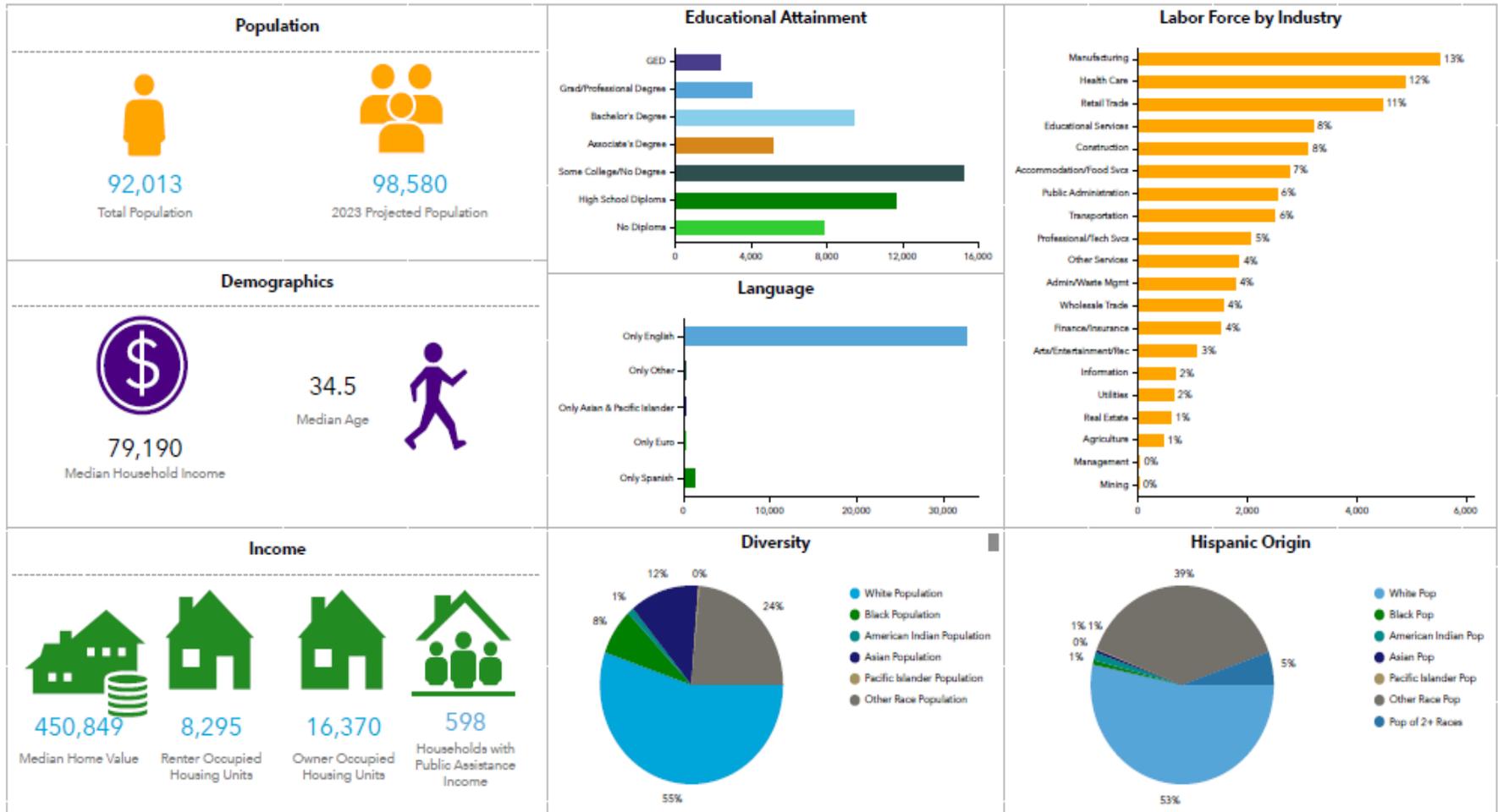
Service Area Key Characteristics

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 growth, 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. The following infographics were completed using ESRI'S (Environmental Systems Research Institute) 2018 Community Analyst data.

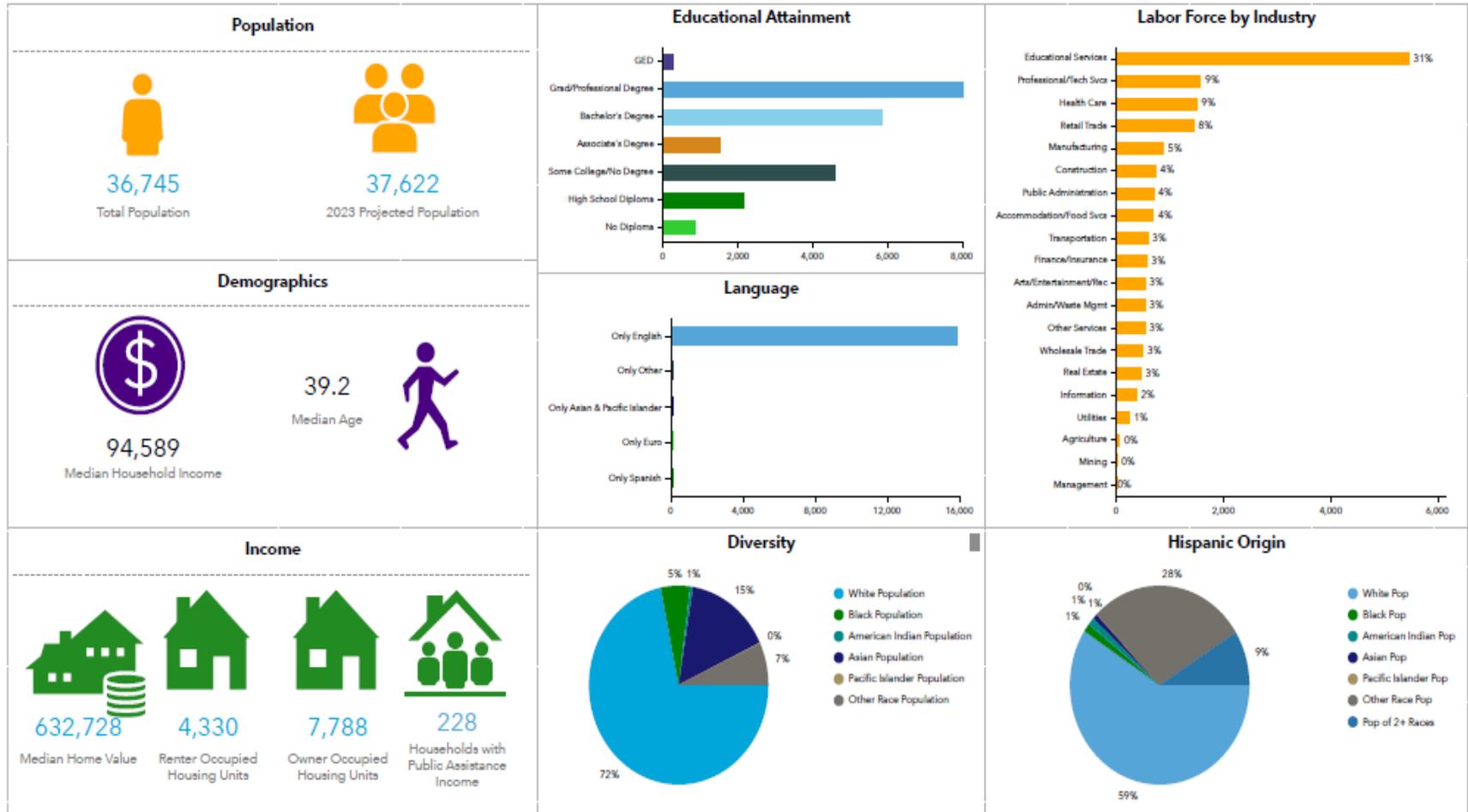
San Antonio Regional Hospital Primary Service Area



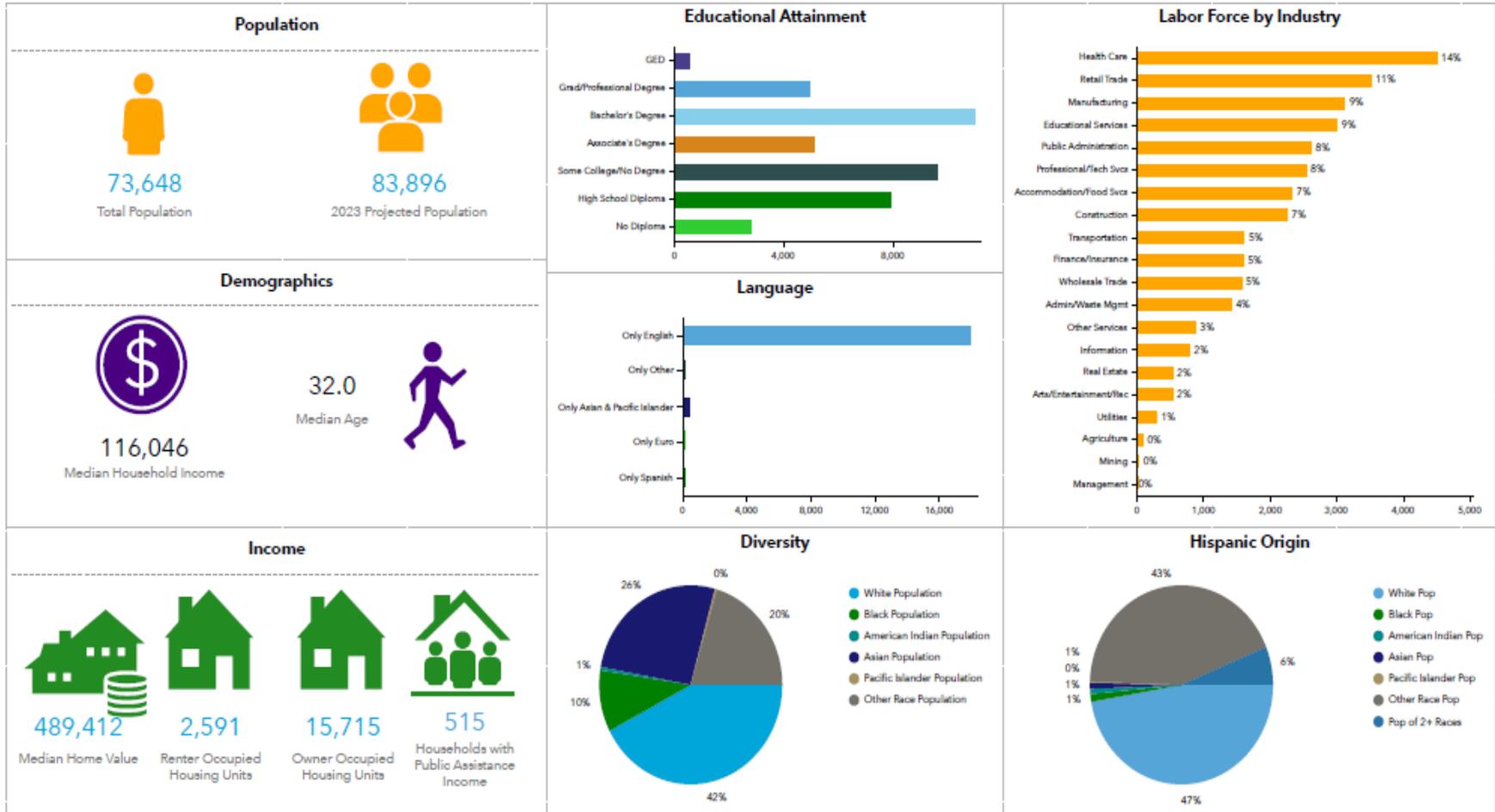
City of Chino



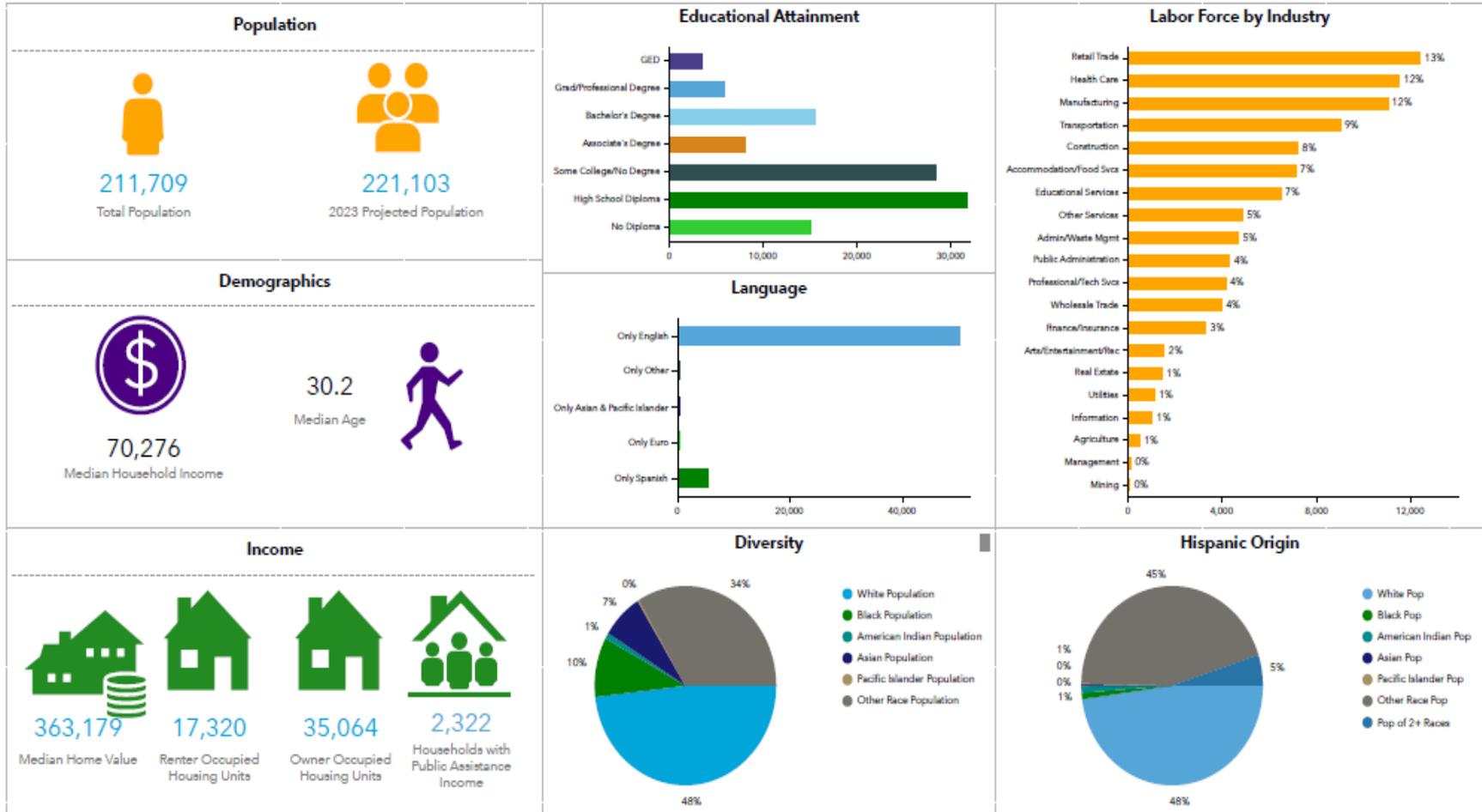
City of Claremont



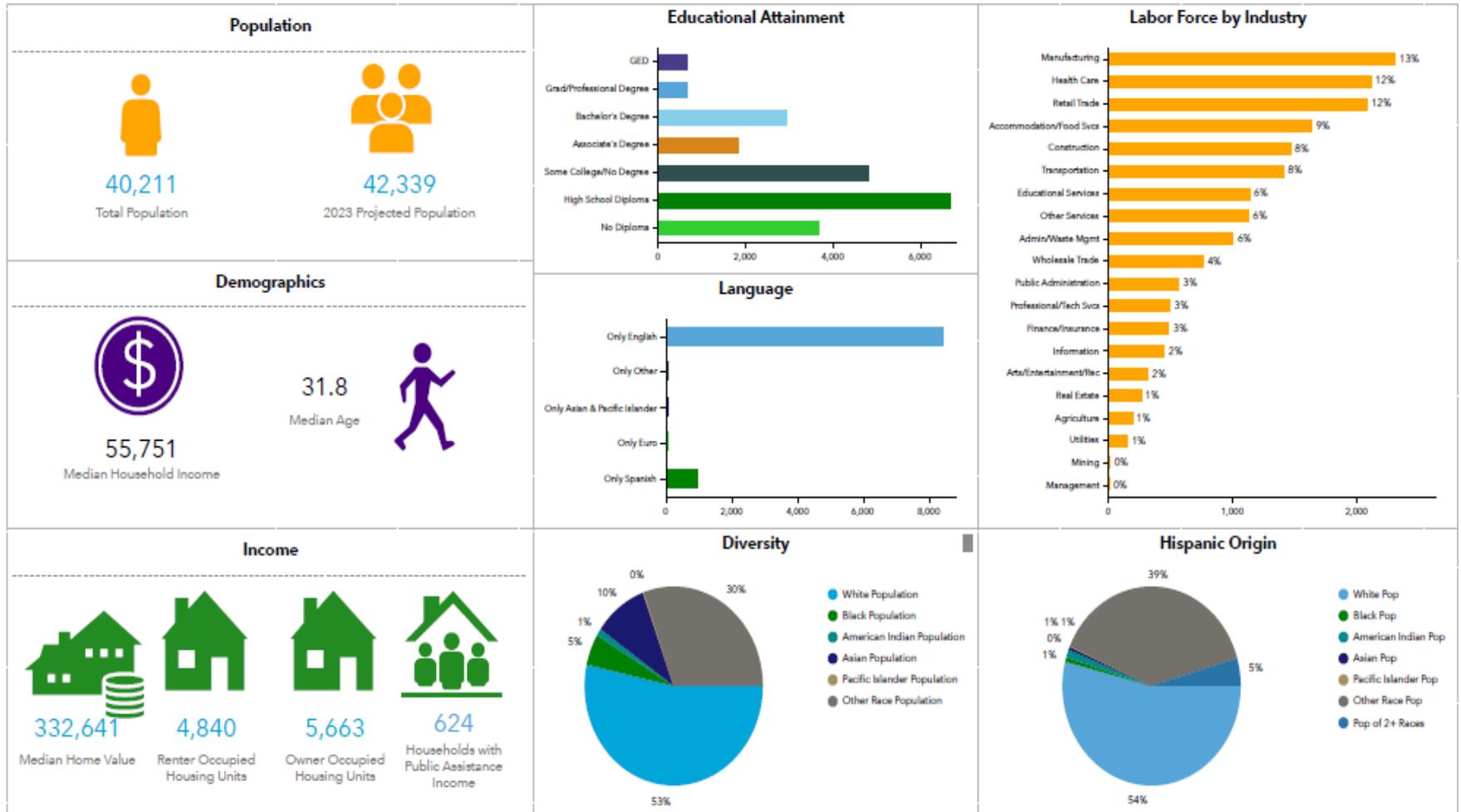
City of Eastvale

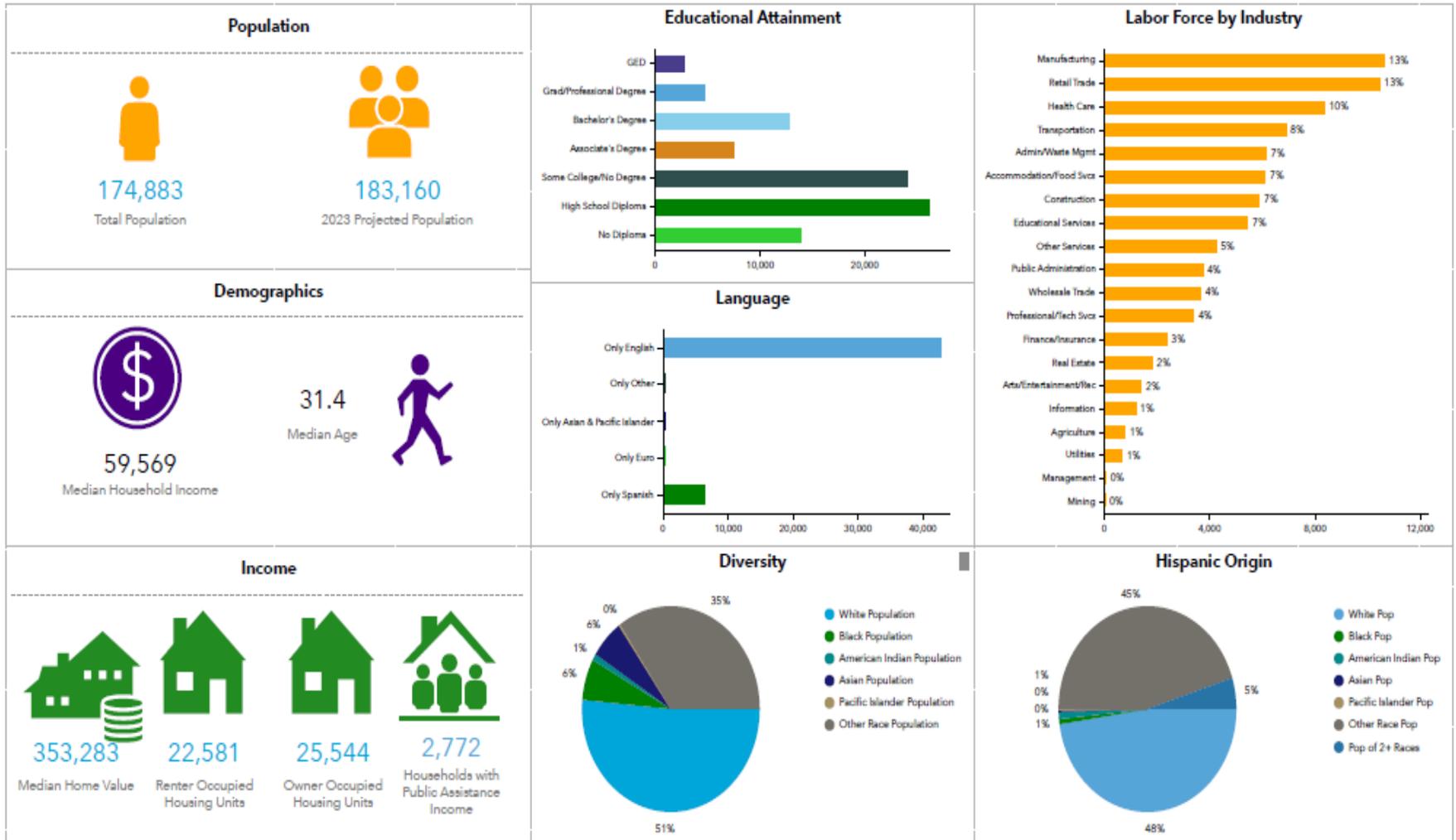


City of Fontana

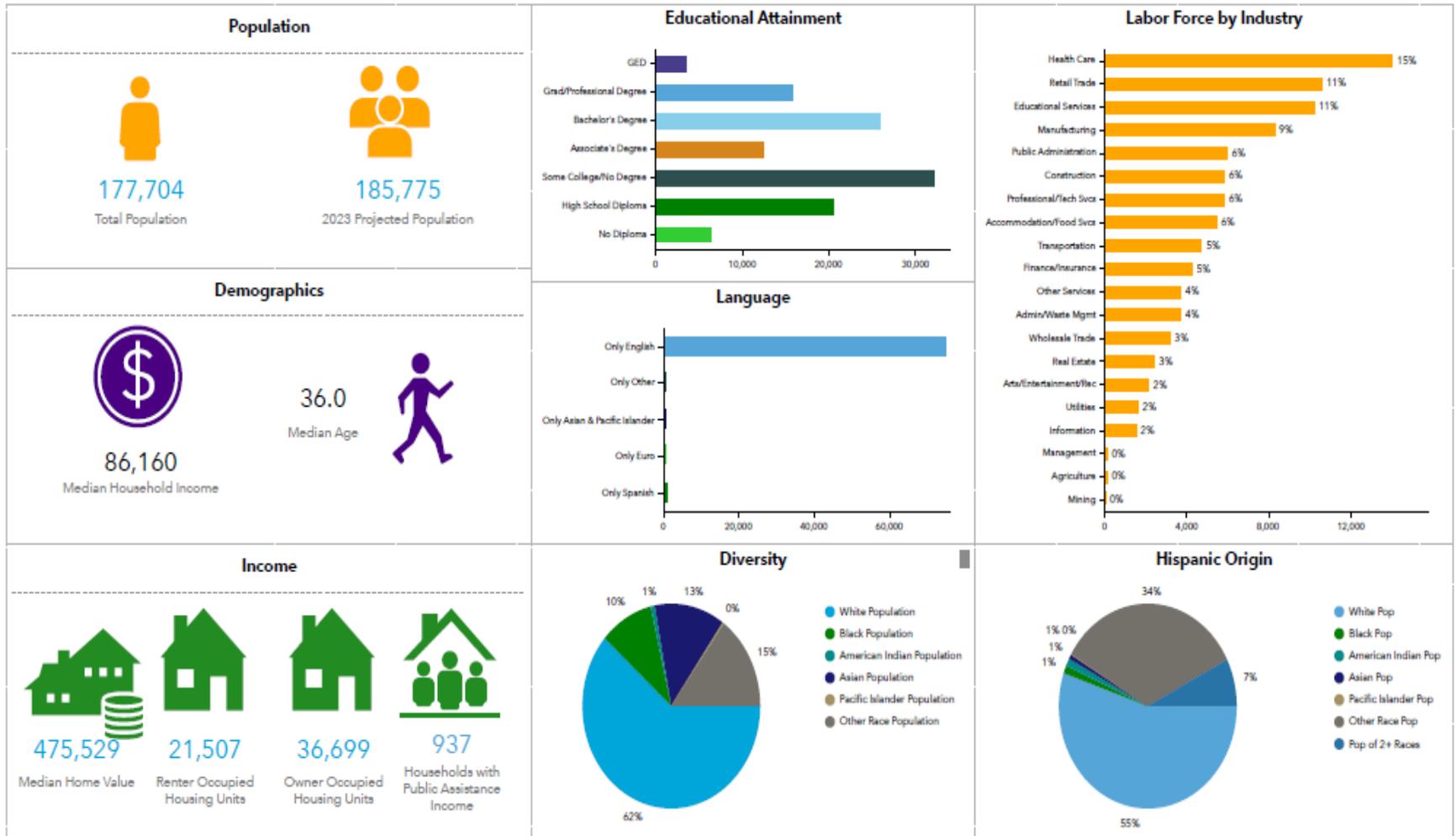


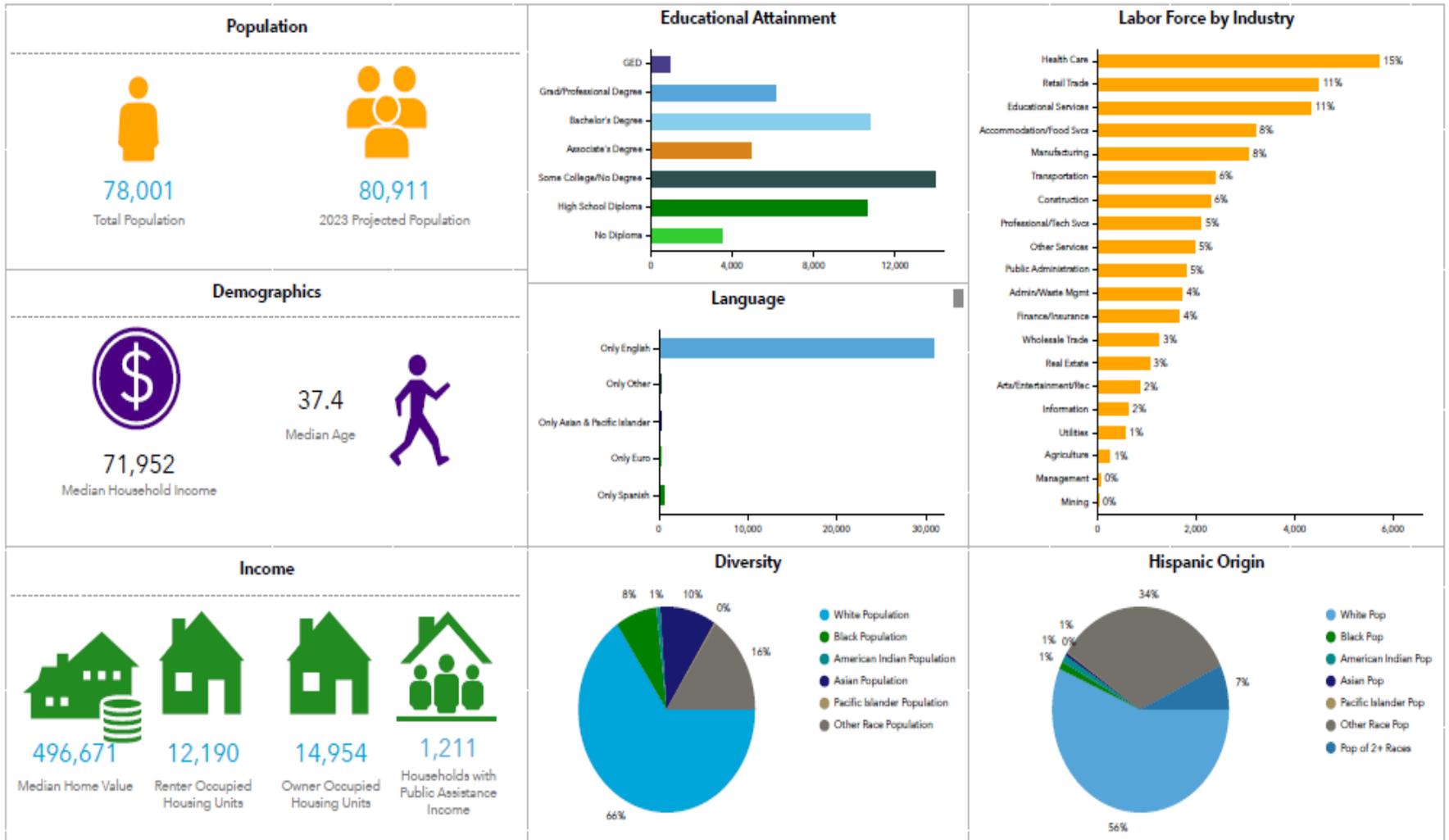
City of Montclair





City of Rancho Cucamonga





Community Health Needs Assessment (CHNA) Overview

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 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 2018, highlighting a few 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 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 Geronimo Memorial Hospital

The collaborative effort of HASC and these hospitals resulted in a 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 were 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 also included 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 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			
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
- Prevention and Wellness
- Behavioral Health
- Chronic Disease Management
- Healthy Environment

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					
INITIATIVE	ACCESS TO HEALTHCARE	CHRONIC DISEASE MANAGEMENT	PREVENTION AND WELLNESS	HEALTHY ENVIRONMENT	BEHAVIORAL HEALTH
<i>HELP Elementary Expansion</i>	X	X	X		
<i>Community Health Improvement Program (CHIP) Expansion</i>	X	X	X		
<i>Know Your Numbers (KYN) Expansion</i>	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

2018 Implementation Strategy Accomplishments

The following table provides a brief description of the major accomplishments achieved in each initiative during 2018.

Initiatives	Strategies	Accomplishments
Healthy Eating and Lifestyles Program (<i>HELP</i>)	Expand <i>HELP</i> Elementary School	<i>HELP</i> was reevaluated in 2017. The program was rebranded as <i>wHealth</i> (Wellness + Healthcare), and a revised curriculum for elementary students was developed and implemented in 2018.
Community Health Improvement Program (<i>CHIP</i>)	Expand <i>CHIP</i> program coaches and participants	During 2018, <i>CHIP</i> added 43 student coaches and 68 patients. A total of 165 student coaches have been trained to serve 238 patients.
Know Your Numbers (<i>KYN</i>)	Expand <i>KYN</i> program participants	<i>KYN</i> served 500 participants across four health hubs in 2018, including 330 new participants. The program achieved a 57% retention rate among the 330 new participants.
BUILD (Bold, Upstream, Innovative, Local, Data-drive) Program	Expand <i>BUILD</i> case management program	BUILD clinical community health worker case management increased by 123 new participants in 2018, and 57% remained active throughout the year.
Workforce Development (<i>HELP</i> 12+)	Expand <i>HELP</i> program to reach high school students	During 2017, the <i>HELP</i> program was rebranded as <i>wHealth</i> (Wellness + Healthcare). New HealthCorps curriculum was adopted and in 2018 was delivered to 331 high school and 165 middle school students in Upland and Chaffey Joint Union school districts. Additionally, a Career Day was added to introduce students to Laboratory and Pharmacy careers.
Healthy Communities Leadership Development	Develop Healthy Communities Certificate Program	The program concept was revised in 2018 to provide health policy training directed at decision makers. During 2018 HCI collaborated 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.
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. In addition, mental health was incorporated into the <i>wHealth</i> program through mental resiliency education.

Community Benefit Program Highlights 2018

The following outreach services and programs serve as examples to highlight the actualization of San Antonio's Implementation Strategy and Plan during 2018.

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
- Blood Pressure Guidelines
- Future Trends in Stem Cell and Platelet Therapy for Orthopedics
- Endometriosis
- Measuring the Quality of a Joint Replacement
- Heart Disease Prevention
- Joint Health: Knees, Hips, Shoulders
- New Options for Aortic Valve Replacement

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, cooking demonstrations, and other engagement activities for senior community members. The lectures occur monthly and are led by hospital clinical staff and supported by nutrition interns. Topics for 2018 included:

- A Year of Wellness
- Food Demos: Sweet and Spicy Side Dishes
- Nutrition and Health
- Defeating Diabetes
- Mental Health and Awareness
- Alzheimer's and Brain Health
- UV Safety
- Heart Health and Awareness
- Food Demos: Safe Grilling
- Food Demos: Low Salt Cooking

Health & Hot Rods

The annual men's health event took place on June 9, 2018 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 364 guests and provided screenings to 128 participants, including blood pressure, body mass index (BMI), cholesterol, glucose, and pulmonary function.

Throughout the event venue, educational opportunities were provided in the form of physician lectures, health and wellness booths, posters, and the materials included at registration. Booths provided education on cancer prevention, heart health and early heart attack care (EHAC), stroke awareness and timely response (BEFAST), wellness, physical activity, and nutrition. Representatives from City of Hope, American Cancer Society (ACS), and American Heart Association (AHA) were present to provide additional health education, and American Medical Response (AMR) paramedics provided hands-only CPR training. San Antonio doctors were also present and provided brief lectures on heart health and maintaining overall health and well-being.

Women's Health Event

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* or *Girls' Day Out*. During 2018, multiple cancer prevention events were held throughout our communities during the months of October and December. During October, 264 participants attended various women's health events, titled "Nourish to Flourish," that were primarily delivered to a Spanish-speaking community of need. The number of participants is comprised of attendees from these community presentations, as well as those in attendance at *Generations Ahead* meetings and at our community lectures.

Health presentations were provided by a San Antonio Oncology Nurse Navigator and representatives of the American Cancer Society at community events and at the hospital. Breast nurse navigator, Livia Vargas, RN, presented on breast cancer prevention, with a focus on nutrition, exercise, and prevention, including self-breast exams and screening mammograms based upon age and medical history. Cathy Zappia of the American Cancer Society presented on breast cancer prevention. She highlighted changes in the recommendations for mammography frequency, as well as policies aimed at breast cancer prevention. Both guest speakers provided resources and skills for preventing breast cancer as an individual and as a community.

Community events were supported by multiple partners including the American Cancer Society, San Antonio Cancer Center, San Bernardino County Department of Public Health, Clinical Community Health Workers, and El Sol. Events were broadly publicized and open to the entire community.

Comprehensive screenings, including cholesterol, blood glucose, blood pressure, and BMI were also offered. The message of prevention was consistent with the educational materials distributed upon registration.

At each event, participants were surveyed on 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 received incentive items for their participation. The post-survey included questions that identified knowledge gained from receiving education and participating in activities at the booths.

To complement the hospital's prevention program, a lower cost breast cancer screening program was implemented to address one of the hospital's top five late stage cancer diagnoses, breast cancer. Vouchers were distributed at various events to encourage breast cancer screening activity. During the cancer prevention events described above, education about breast cancer was presented and the screening certificates were explained and distributed to all event participants.

Know Your Numbers

In February 2015, San Antonio Regional Hospital, 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 for the low-income population living in Ontario's "HEAL" (Healthy Eating and Active Living) Zone and surrounding communities. KYN provides health education, social determinant of health assessments, and biometric screenings, including blood pressure, body mass index (BMI), glucose, and cholesterol through community-based point-of-care testing.

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. 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 HOI’s partners, which include 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. San Antonio staff and community partners 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. 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.

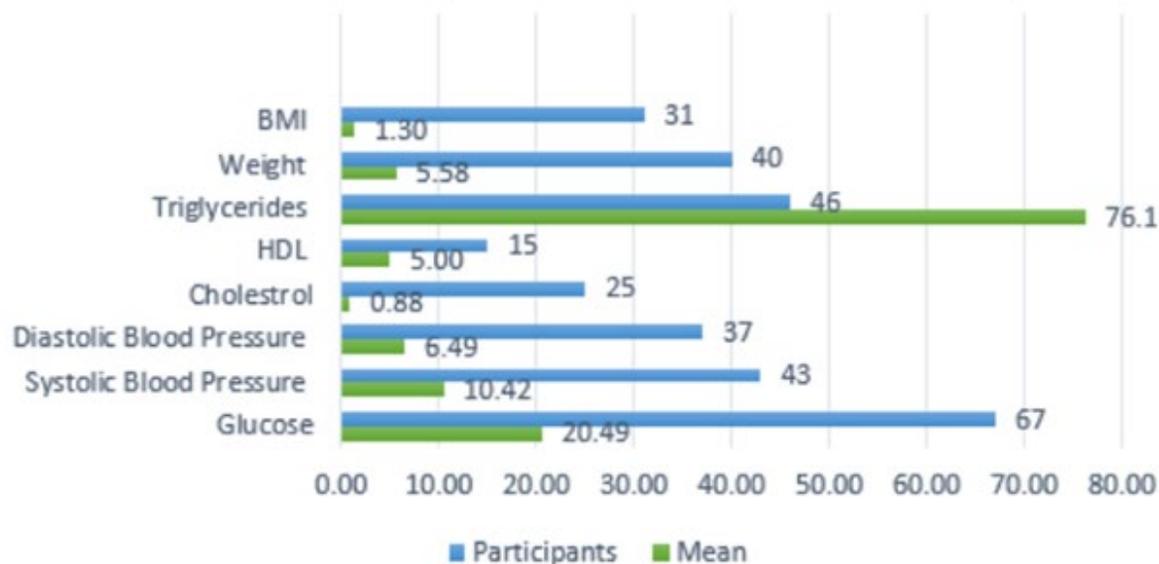
KYN took place in the heart of Ontario, but was open to others within the hospital’s service area. Over the last three years, nearly all participants were Hispanic and the vast majority were women. Women were more likely to participate in case management and Hispanics were also more likely to participate than other ethnicities. In general, participants had low incomes, over a third did not have a high school diploma, and over half were unemployed. Those who were unemployed and who had low education levels were more likely to participate in case management. 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, and one of the specific successes of the KYN program was increasing access to healthcare services.

The Ontario HOI KYN program concluded with the sunset of the grant in 2017. The program’s findings demonstrated KYN maintained a steady number of participants, and was therefore continued through the support of project sponsors including San Antonio Regional Hospital. The KYN program went on to successfully screen approximately 500 participants across four health hubs in 2018, with 330 new participants joining the

program. The 330 new participants attended with a retention rate of 57%. Thirty seven percent (123 participants) were immediately referred for case management, 64 displayed borderline biometrics, 12 had normative biometrics, and 147 were not classified. Additionally, 141 participants were referred to a medical home, such as the Ontario Health Center.

More than 57% of the 123 case management participants were still actively involved in the program after a year. Within the total population, approximately one third 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.

Improvements by each Biometric



Community Health Improvement Program (CHIP)

The Center for Disease Control has reported that six in ten Americans live with at least one chronic disease, like heart disease, cancer, stroke, or diabetes. These and other chronic diseases are the leading causes of death and disability in America, and they are also a leading driver of health care costs. In fact, the CDC has reported that 90% of the nation's \$3.3 trillion in annual healthcare expenditures relate to caring for people with chronic and mental health conditions. The aging population and the continued escalation of patients with chronic conditions is a principle reason San Antonio Regional Hospital developed and implemented the Community Health Improvement Program (CHIP) in January 2015.

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 Dietitian/ Nutrition students. 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. Licensed professionals (registered nurse and physician) oversee the work of the student health coaches, 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.

CHIP successfully recruited 43 students to become health coaches in 2018, and 165 coaches have been trained over the past four years. CHIP enrolled 68 patients in 2018, raising the total number cared for by these health coaches to 238 patients. To date, unnecessary ED Visits were reduced by 33% and hospitalizations by 38% among CHIP participants enrolled for nine months.

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 three program areas: healthcare workforce, health 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. In 2018, HCI collaborated with the County of San Bernardino, the County of Riverside, Western Riverside Council of Governments, San Bernardino County Transportation Authority, and community partners from both counties to develop and support a regional Inland Empire Healthy Communities Conference. HCI participated in the development of the leadership development track sessions and sponsored the services of ChangeLab Solutions who provided a policy makers training on healthy communities policies. This training was attended by councilpersons, city managers, and planners from cities across the Inland Empire.

Additionally, HCI collaborated with San Bernardino County Department of Public health to provide policy training around the topic of health equity at the community level. This training was aimed at community-based organizations and community health workers across San Bernardino County. A unique component included the KYN Clinical Community Health Workers leading a session on equity for their peers. This session was well received and provided our KYN team with the opportunity to lead others in building their community network and promoting equity across the region.

Health Care Workforce

Southern California's Inland Empire Region includes San Bernardino, the largest US geographical county, and Riverside Counties. This region has poorer health status and a greater shortage of healthcare professionals than surrounding communities. Lewis-San Antonio Healthy Communities Institute (HCI) developed a school-based adolescent program called "*wHealth*" (*wellness + healthcare*) to address these two major needs to build healthier outcomes for the future of the Inland Empire.

wHealth supports students in their health career journey by: 1) creating learning opportunities around chronic disease prevention; 2) helping to establish lifelong healthy habits; 3) supporting an interest in healthcare careers; and 4) retaining local students in the region. This program aims to increase knowledge on wellness topics and healthcare professional development training. The wHealth curriculum is adapted from HealthCorps Inc., a national nonprofit, and is aligned to National Health Education Standards focusing on nutrition, fitness, and mental resiliency. The program

goals include: 1) increasing knowledge in nutrition, physical activity, and mental resilience among junior high and high school participants using HealthCorps curriculum; and 2) increasing professional development training for healthcare career preparedness among high school participants. The curriculum utilizes university students from across the region to teach high school wellness in six classroom sessions.

These university students are either in a Masters of Public Health program or a Bachelors level program in Public Health or Health Sciences. The students are not only fulfilling their practicum requirement for their degree; they are being exposed to public health needs within their own communities. During their 120 to 400 hour practicum, the interns instruct high school students, conduct program operations, and collect data in the classroom throughout the program implementation.

Professional development is integrated throughout the program as students conduct instruction. This program also integrates mentorship among various educational levels. The university students are mentors to the high school students as they answer questions on college life, majors, and career planning. Once the high school students complete their six-week HealthCorps program, they have the opportunity to teach the curriculum to junior high students, while gaining peer-to-peer training and building presentation skills for professional development. Following the six-week sessions, high schoolers are invited to submit applications to the Trainer Program. This portion of the program includes a professional skills workshop, group interviews, dress for success, and in-person training sessions for team building and lesson development. The high school students then instruct a simplified version of their wellness lessons to junior high students.

In addition to their learning experience in the classroom, high school students have the opportunity to go on tours within our hospital and at community partner sites such as farms and supermarkets as a complement to the program sessions.

In 2018, the wHealth program underwent many changes from establishing better program structure to increasing program participation on all educational levels. In the winter (January – March) a partnership with California State University San Bernardino was established and two undergraduate interns were added to HCI and the wHealth program team. During this quarter, Chaffey High School was added to our program implementation, introducing a new high school district as well. With this addition, a team of three interns taught three different classes for a total of 81 students at Chaffey High School.

In Spring quarter (March – June), three more Loma Linda Graduate interns and four more Cal State San Bernardino undergraduate interns joined the team as two students completed their internships from the previous quarter. This term also commenced the training for the junior high component of the program. Chaffey High School had 11 trainers and Upland High School had 22 trainers teaching at junior high schools within their district or within close proximity to the high school. Upland High School trainers disseminated the program to all three junior highs within the Upland Unified School District: Upland Junior High (n=18), Pioneer Junior High (n=42), and Foothill Knolls STEM Academy (approximately 60 students) for a grand total of approximately 120 students on the junior high level. Chaffey High School is a part of Chaffey Joint Union High School District, which consists of only high schools, so these trainers presented the curriculum to 22 students at Vina Danks Middle School, which is adjacent to their campus and part of the Ontario-Montclair school district.

In April 2018, HCI hosted its first “Career Day” for 100 Upland High School students. This one-day event featured a field trip to San Antonio Regional Hospital to tour several clinical departments including Laboratory, Pathology, Physical Therapy, and Pharmacy. This experience exposed students to various healthcare careers using a “speed networking” format. Students were placed at round tables manned by a health professional, and after the allotted time the health professionals switched tables which allowed the students to meet each of the professionals and learn about the various health disciplines and career pathways.

In fall quarter (October – December 2018), a new wHealth program year commenced. Nine university interns (three graduate and six undergraduate) disseminated the program to high school students at Upland High School and Chaffey High School, concurrently. There were several changes implemented to this new program. One change is that this program was only offered to 10th – 12th grade high school participants in science classes to reach those who are most likely bound for a career in healthcare; this eliminated the freshmen (9th grade) class from the previous year. Instruction was given to a total of 331 high school students, 166 at Chaffey High School and 165 at Upland High School.

Additional changes in program structure consisted of new intern positions, such as the “Educator” intern role with the duty to instruct the curriculum, and the “Operations” intern role with the responsibility to collect data, document sessions including photography, and facilitate program logistics in the classroom. Our team solidified standard pre and post-tests to both high school and junior high students to assess an increase in knowledge on wellness topics. A “Healthy Checklist” was also added to the program to engage students to do one assignment from the lesson to practice healthy behaviors that will lead to sustainable behavior change.

By the end of 2018, the wHealth program grew to include two major high schools and four junior highs within the primary service area, reaching a total of three school districts. To continue this momentum, planning took place to grow this program within Chaffey Joint Union School District by including Etiwanda High School for the following year. An introduction with Etiwanda High School occurred with a Farm Tour earlier in the year.

Furthermore, 2018 consisted of several farm tours at The Farm at Pomona Fairplex. The Farm Tour is a supplemental educational experience for high school students to learn and apply their knowledge from the classroom into real life. This is a field trip to a local farm where students are immersed in the environment to see first-hand the benefits of organically grown plants and animals in relation to health and healthier environments/ecosystems. These field trips occurred January through May with Upland High School (n=248), Chaffey High School (n=27), and Etiwanda High School (n=50), for a grand total of 325 high school students.

In 2018, the wHealth program expanded tremendously and improved in program logistics and structure. HCI looks forward to continuing the wHealth program’s upward trajectory in 2019, increasing schools once again, particularly with the addition of Etiwanda High School, and ultimately in total numbers. HCI is looking forward to continually improving our system to coordinate and disseminate our program. In addition, we encourage our

students to become trainers and progress on the continuum from high school trainers to college trainers. This will not only help them progress in their health career track, but it will provide more experienced trainers for program stability in the years to come.

The following charts showcase program growth over the last three years:

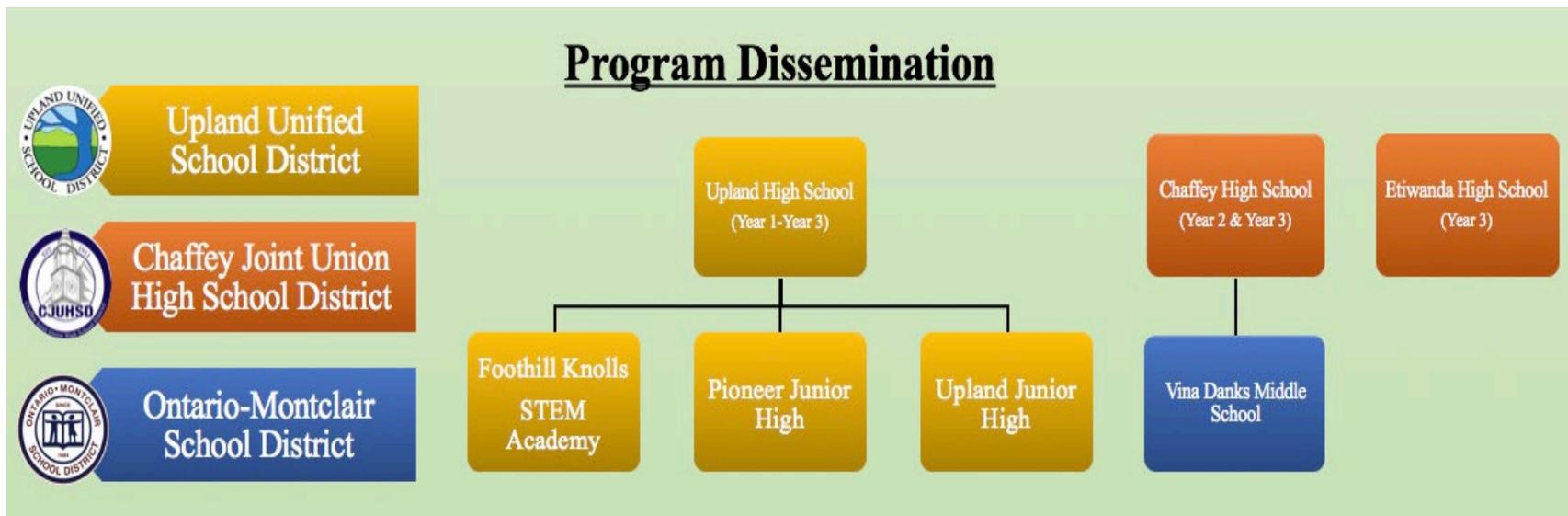


Table 1. Total Program Participation			
Year	High School (HS)	Junior High (JH)	High School Trainers
2016-2017 (Y1)	165	64	17
2017-2018 (Y2)	532	155	33
2018-2019 (Y3)	332	88	18

Non-Clinical Internships

HCI continued to expand San Antonio’s graduate student internship program in 2018, 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. Additionally, students were connected to various health professionals in and out of the hospital, were exposed to the need for health professionals in the local area, and were encouraged to remain in the region while fulfilling their professional aspirations. Thirty four students from the following universities participated in this program:

- California State University San Bernardino – Undergrad & Graduate Students in Health Care Management, Public Health
- Loma Linda University – Graduate students in MPH, MBA, Nutrition (Registered Dieticians in training), Health Promotion and Education
- Claremont Graduate University – MPH, MPH/MBA, Bio Stats/Epi, MD
- USC – MSW (Social Work)
- Pitzer University – Undergrad - Social Impact/Community Engagement
- California Baptist University – MPH
- California State University Fullerton – Nursing

In 2018, intern opportunities expanded within San Antonio Regional Hospital including Health Information Management, Cardiac Care, and Community Outreach. Additionally, a Randall Lewis Health Policy Fellow was added and was placed with Business Development and Physician Recruitment.

Financial Summary of Community Benefits

Inventory

San Antonio Regional Hospital's primary responsibility is to provide healthcare services; however, its mission does not end there. Every effort is made to reach into the community with additional services and programs in response to the community's needs. A summary and valuation of the 2018 community outreach program follows, along with an accounting of the financial losses sustained in providing medical care to uninsured and underinsured patients.

The hospital's community benefit inventory was completed using software developed by the Catholic Hospital Association and VHA, Inc. in partnership with Lyon Software. The Community Benefit Inventory for Social Accountability (CBISA) software allowed San Antonio's activities to be summarized into the broad categories outlined in Senate Bill 697.

Valuation (Replace with new chart of numbers)

The following table summarizes the 2018 community benefit valuation, delineated by major category.

2018 Community Benefit Valuation		
Category		Benefit
Community Health Improvement Services		
	Community Health Education and Support	
	Breast Cancer Support Group	\$ 3,233
	Breast Feeding Class	902
	Cancer Caregiver Support Group	464
	Cancer Support Group	864
	Community CPR & First Aid Classes	378
	Community Education Calendars	42,543
	Community Education Events	139
	Community Health Lectures	7,661
	Diabetes Adult Education Class	402

Diabetes Adult Support	1,988
Family and Friends Infant/Child CPR	478
Generations Ahead	10,457
Healthy Beginnings	225,859
Infant Care Class	968
Kick/Prenatal Yoga	1,085
Medical Minutes	175,353
Men's Health Event and Car Show	16,882
Mom's Embracing the Moment	3,545
Nutrition for Cancer Support	7,181
Nutrition Counseling	508
Pilates for Cancer Health	2,340
Positive Parenting Class	393
Prepared Childbirth	(1,038)
Registered Dietician Support	1,523
Safe Sitter Education	1,503
Sibling Classes	985
Women's Health	7,848
Community Based Clinical Services	
Know Your Numbers Health Screenings	6,587
Influenza Immunization Program	3,886
Healthcare Support Services	
Blood Drive	8,100
Community Health Improvement Program CHIP	578,343
Emergency Medical Services Base Station	521,970
Palliative, Spirituality, & Health	12,540
Taxi Vouchers	11,646
Women's Breast and Imaging Center	377
Other Community Needs	
Access to Clinical Care/Physician Shortage	451,805
Community Outreach	7,798
San Antonio Regional Community Outreach	6,554
Community Health Improvement Services Total	\$ 2,124,050

Health Professions Education		
	Physicians/Medical Students	
	Medical Post-Graduate Education	\$ 30,417
	Other Health Professions Education	
	Chaffey College Radiology Training	113,970
	Educational Support: Colleges & Universities	990
	HCI Non-Clinical Internship Program	16,520
Health Professions Education Total		\$ 161,897
Subsidized Health Services		
	Emergency and Trauma	
	Physician Fees: Indigent Care	\$ 194,153
	Hospital Outpatient Services	
	Sierra San Antonio Urgent Care	117,696
Subsidized Health Services Total		\$ 311,849
Financial and In-kind Donations		
	Cash Donations	
	Cash Donations	\$ 33,500
	In--kind Donations	
	Supplies and Equipment	375
	Meals on Wheels	55,431
Financial and In-kind Donations Total		\$ 89,306
Community Building Activities		
	Coalition Building	
	HCI Food Access	\$ 474
	Community Support	
	HCI Community Activities	9,548
	Leadership Development	
	HCI Policy	16,719
	Program Development/Operations	
	HCI Planning and Operations	67,403
	Workforce Development	
	HCI Healthcare Workforce	19,006

Community Building Activities Total	\$ 113,150
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Community Benefit Operations		
	Dedicated Staff	
	Community Outreach Program Manager	\$ 62,362
	Other Resources	
	Community Health Needs Assessment	7,155
	Community Outreach Planning and Operations	60,885
Community Benefit Operations Total		\$ 130,402
Total Community Benefit		\$ 2,930,654
Unreimbursed Medical Care (based on the fully allocated cost of care)		
Charity Care (care provided at no cost to patients)		\$ 1,529,457
Medi-Cal Shortfall*		\$ 21,382,992
Total Community Benefit Including Unreimbursed Medical Care		\$ 25,843,103
Bad Debt		\$ 1,146,109
Total Including Bad Debt		\$ 26,989,212

*Medi-Cal (reimbursement does not cover the fully allocated cost of care)

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 Angelica Baltazar, Director, Healthy Communities Institute at (909) 920-4773.