ADVANCING HEALTH EQUITY 2025

University Health

Thinking beyond

Introduction

For more than 100 years, University Health has been here to heal, advance the practice of medicine and improve health. As the only locally owned and operated health system in San Antonio and Bexar County, University Health takes to heart its responsibility to serve the health needs of our community today and into the future.

The mission of University Health is to improve the good health of the community through high-quality, compassionate patient care, innovation, education and discovery. Our vision is to be one of the nation's most trusted health institutions. University Health includes more than 50 Bexar County locations. We are the primary teaching facility for UT San Antonio and the only Level I trauma center for adults and pediatrics in South Texas.

At University Health, we understand addressing health disparities is key to improving the well-being of our community. Central to these efforts is our Institute for Public Health, which was launched in 2022 and plays a pivotal role in championing, coordinating and reporting on health equity initiatives for our organization.

In this third annual report, we describe our patient population and highlight University Health's efforts to reduce health disparities and advance health equity. As we look to the future, we remain steadfast in our commitment to build a healthier community for all. Together with our dedicated employees, providers, community partners and patients, we continue to innovate and advocate so every individual has the opportunity to thrive.

The Institute for Public Health team at University Health Vida.

Serving a Diverse Population

In 2025, University Health served more than 285,000 patients from Bexar County and beyond. The map on the following page highlights our patient volume by ZIP code, offering insight into the communities we serve.

Understanding the demographic characteristics of our patient population and Bexar County helps us tailor initiatives, enhance patient-provider communications, foster a culture of trust, reduce health disparities and improve health outcomes. People who identify as Hispanic make up 65% of the University Health patient population, as compared to 60% in Bexar County overall (Figure 1). The majority (54%) of our patients are under the age of 40 years (Figure 2). For 17% of our patients, Spanish is their preferred language (Figure 3).

More than half (57%) of the patient population served by University Health live in areas identified as highly vulnerable according to the Social Vulnerability Index (SVI) (Figure 4). These communities experience greater levels of poverty, lower household income, higher unemployment, limited access to transportation and unstable or inadequate housing. University Health is strategically located in high-need communities, improving access to care for vulnerable populations.

Figure 1: Population by Race/Ethnicity

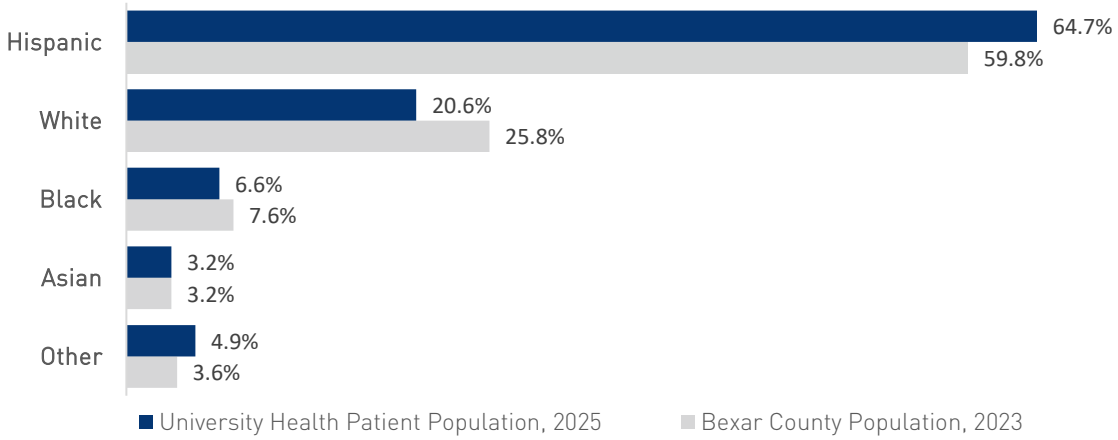


Figure 2: University Health's Patient Population by Age, 2025

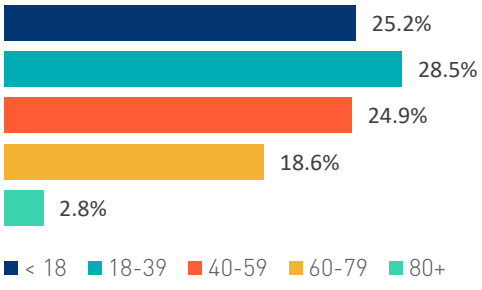


Figure 3: University Health's Patient Population by Language, 2025

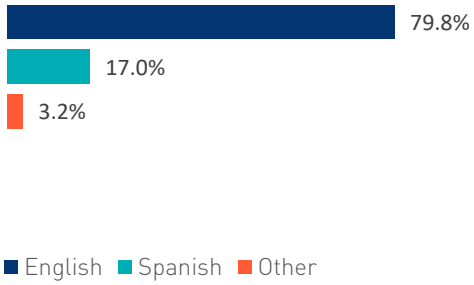
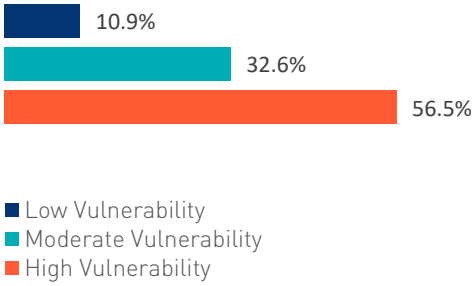
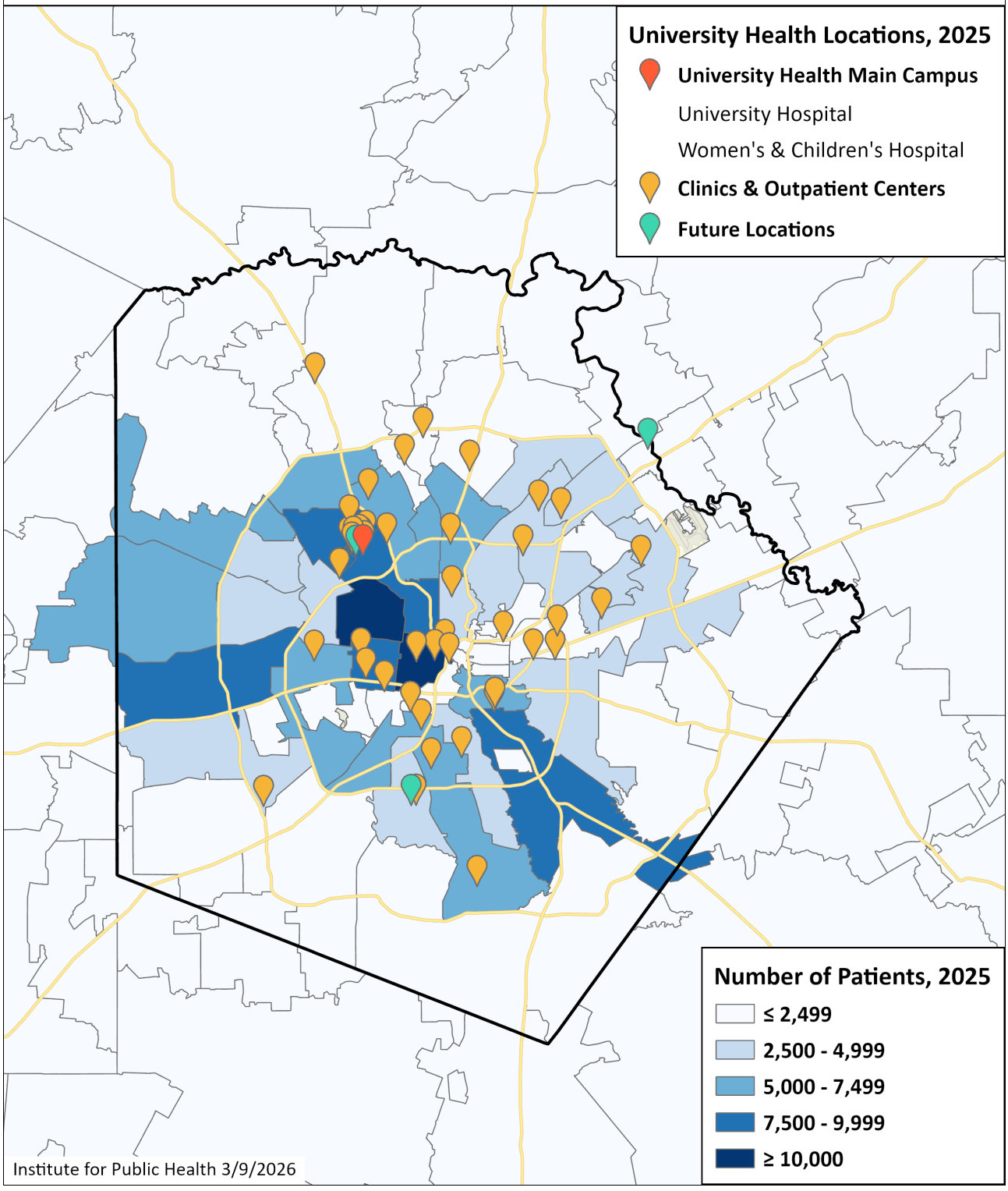


Figure 4: University Health's Patient Population by SVI, 2025



University Health Locations and Patient Concentration by ZIP Code of Residence



ZIP codes on the map above reflect where patients live, with deeper shades of blue indicating areas with greater patient density.

Advancing Health Equity as a Strategic Priority

Defining University Health's ongoing commitment to advance health equity

Karla Cortez and Sarah Mohmedali at the Wellness Week resource fair, sharing University Health's health equity efforts.

University Health is committed to improving the good health of our community. In March 2025, University Health's Board of Managers adopted the 2025 "Health Equity through Action and Leadership Strategic Plan" and "Advancing Health Equity Report." The plan establishes accountability across the organization, aligns our actions with regulatory priorities and supports our long-term investment in health equity initiatives. The report provides a comprehensive summary of our strategies, progress and resources directed toward health equity initiatives. It highlights University Health's ongoing efforts to improve access, bridge gaps in care and create a healthier community for all. The plan and report are available on the Institute for Public Health website.

To support and guide the implementation of the health equity strategic plan, the Institute for Public Health convened 20 leaders from across the health system to form the 2025 Health Equity Leadership Team. Representing a broad range of clinical, operational and administrative areas, the team reviewed progress on priority strategies, identified and addressed barriers and elevated opportunities for collaboration. This forum helped ensure alignment, shared accountability and sustained momentum for advancing health equity across the organization.

University Health team members participating in the Institute for Public Health's Wellness Week event, Public Health Lotería.

The Institute for Public Health engaged and educated our team members and providers on the plan and report through multiple communication channels. Information was shared across internal platforms, including the infoLINE newsletter and infoNET intranet site, as well as during leadership meetings.

In 2025, the Institute hosted events during National Public Health Week and participated in activities led by other departments, including Wellness Week resource fairs and safety fairs. These events helped educate University Health team members about our commitment to health equity and the services and resources available.

Enhancing Internal Processes and Programs to Support Health Equity

Enhancing our data infrastructure to support health equity

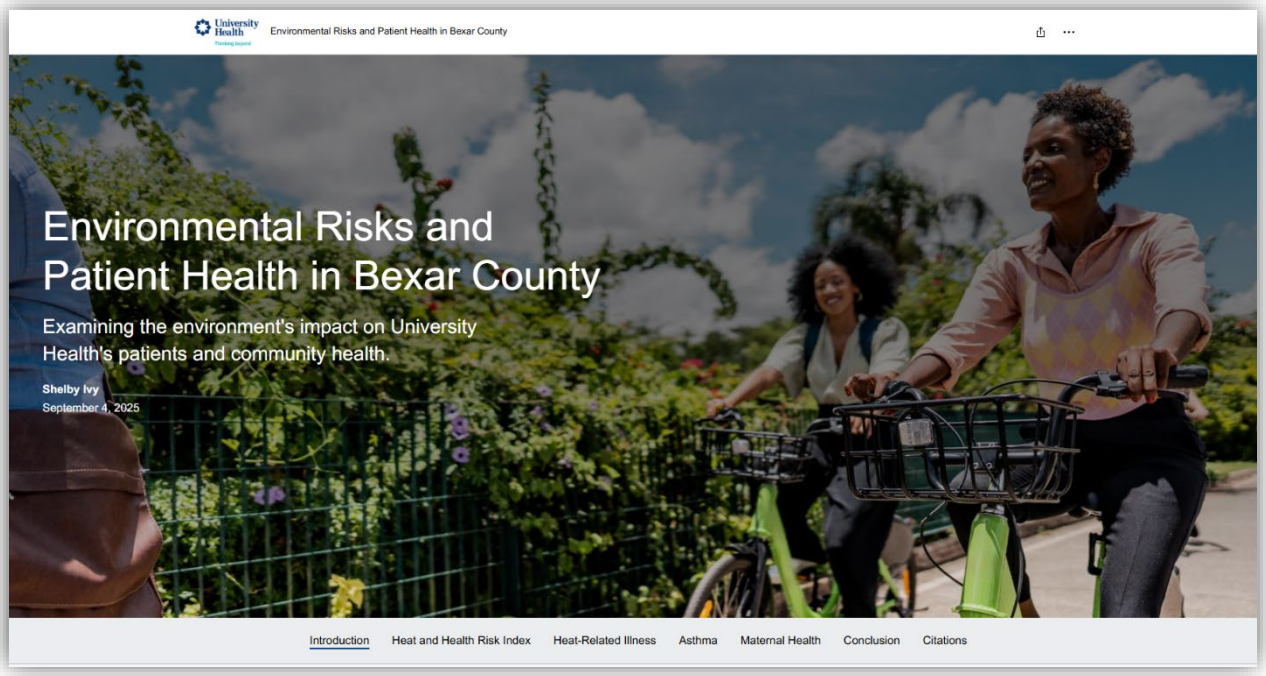
Robust systems for collecting, analyzing and sharing accurate information allows University Health to identify disparities, monitor progress and make informed, data-driven decisions.

In 2024, the Institute for Public Health assessed the current state of our demographic data system to better understand potential gaps in how we capture race, ethnicity and other essential patient information. This assessment revealed opportunities to strengthen data collection processes to improve consistency and comparability.

In December, 97% of patient records had demographic data documented in alignment with national standards.

Building on this work in 2025, the Health Equity Leadership Team recommended changes to the race and ethnicity options within Epic, our electronic health record, to align with upcoming revisions to national standards. Epic and Patient Access leaders implemented the updates and trained staff on how to support accurate and consistent data collection moving forward.

Understanding our data capabilities also creates new opportunities to measure external factors that influence health. For example, environmental conditions are correlated with health outcomes. Changes in climate, air quality and heat index levels may contribute to higher rates of asthma and hospitalizations



The Institute for Public Health's report visualized how environmental factors may influence health.

related to cardiovascular disease, pregnancy and other heat-sensitive conditions. Strengthening our capacity to measure these environmental impacts helps us identify the most significant risks, quantify their effects and design more targeted interventions.

In 2025, the Institute released a report which identified several potential correlations between environmental conditions and health care utilization, including increased emergency department and urgent care visits during months with higher levels of pollution and allergens. It revealed that temperatures and heat-related emergency visits both consistently peaked between the months of May and August.

Promoting employee health, workforce connections, belonging and career growth at University Health

At University Health, promoting employee well-being, fostering a sense of belonging and investing in opportunities for professional growth are core priorities that strengthen engagement, reduce burnout and increase retention.

Non-medical drivers of health, such as access to food, financial stability and supportive environments, directly influence employee well-being and their ability to thrive both at work and at home. The Retention Recruitment Recognition Council launched an employee food pantry in 2025 to help address food insecurity among team members. This new initiative, in addition to the low monthly benefit premiums, employee assistance program benefits and support from the University Health Foundation, helps staff have access to healthy, essential items, reinforcing University Health's commitment to foster a workplace that supports the whole person and their dependents.

In-House Panty for team members experiencing financial hardship.

In 2025, the Wellness Committee, co-chaired by Executive Directors Jessica Gavia and Sarah Sebton, brought together team members from across the health system to plan and deliver successful fall and spring Wellness Weeks. These events promoted employee health and well-being and featured over 40 activities, including sound therapy sessions, walking groups, a mini plant bar and a comprehensive health and wellness fair where individuals connected with vendors and accessed exclusive resources and offers.

University Health team members at the Texas Diabetes Institute participating in the Grounding with Nature event as part of Wellness Week.

University Health continues to prioritize professional growth and workforce development to build a strong, resilient workforce equipped to meet the needs of our organization today and in the future. Investments in leadership development, continuing education and skill-building programs empower team members to advance in their careers and navigate an evolving health care environment. Our award-winning team at the Center for Learning Excellence is dedicated to providing University Health team members with professional development opportunities. For example, the Leadership Development Academy's Leading Others program is specifically designed to enhance leadership skills, foster strategic thinking and cultivate an effective leadership culture within our organization. This in-person dynamic learning journey features a variety of subject matter expert speakers that equip participants with the required tools and mindset to lead confidently, drive positive change and support their teams in achieving our mission. In 2025, 33 team members completed the Leading Others program, and employees across the system collectively completed more than 349,600 hours of continuing education.

Graduates of the 2025 Leadership Development Academy Leading Others Program.

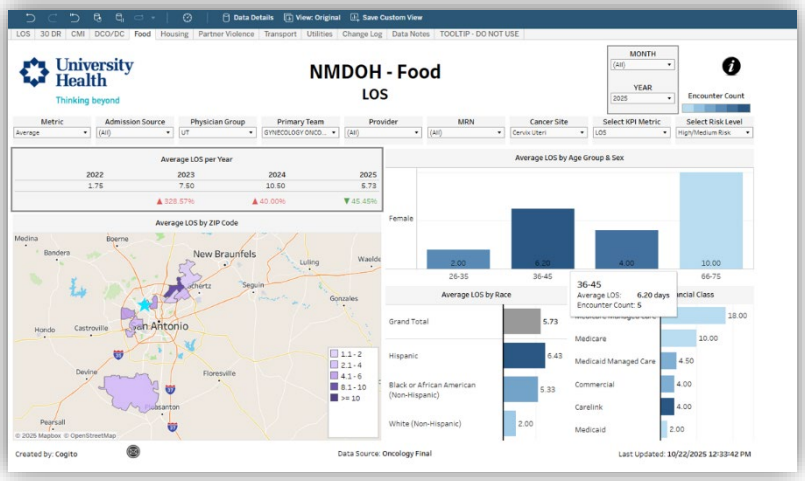
Identifying Health Disparities

Analyzing access, process, utilization and outcomes data by geography, socioeconomic and other demographic variables to identify where disparities exist

In 2025, the Institute for Public Health worked with teams across University Health to analyze priority health conditions, with a focus on identifying disparities to guide improvements in patient care and outcomes related to cancer, hypertension and diabetes. Health condition profiles were published on the Institute for Public Health Website to share findings with team members, providers and the broader community.

Oncology

The Institute for Public Health supported oncology service line leaders in developing the Oncology Dashboard, which integrates data on length of stay, readmissions and case mix index, and stratifies it by sex, age, race, ZIP code and financial class to identify groups that may be disproportionately affected. The dashboard also incorporates non-medical drivers of health (NMDOH) screening data, helping users examine differences in utilization based on identified risk factors.



Screenshot of the oncology dashboard that incorporates the five NMDOH for which patients are screened during hospital admissions.

Insights from the dashboard helped the care transitions team tailor their program to better meet the needs of oncology patients.

CareLink

CareLink is University Health's financial assistance program for individuals who do not qualify for other coverage. While it is not insurance, CareLink helps make health care services more affordable for those who are eligible, and provides a medical home with a consistent health record. In partnership with University Health's CareLink team, the Institute for Public Health analyzed readmission, emergency department (ED) utilization, hospitalization rates and prevalence of chronic conditions to better understand this population and their health outcomes. Our teams analyzed the data by race and ethnicity, language, sex, age and the Social Vulnerability Index, then compared the results with University Health's insured population. Key findings from the analysis include:

- CareLink patients experience a higher prevalence of chronic disease compared with the insured population; however, health outcomes related to these conditions are similar across both groups.
- Compared with insured patients, CareLink patients have higher rates of emergency department visits and hospital admissions, which are correlated with high rates of health-related social needs.

Findings from this analysis are used to guide CareLink's disease prevention and management program, as well as its medical management program, which assists patients with frequent hospitalizations.

Bexar County Community Health Needs Assessment

Every three years, University Health partners with local organizations to conduct a community health needs assessment for Bexar County. This comprehensive assessment examines health outcomes and contributing factors, considers both upstream and downstream influences and incorporates data and feedback from across the community. Wherever possible, data are disaggregated by race/ethnicity, age, sex and geography to identify disparities. The assessment incorporates insights from community members and key stakeholders, ensuring a broad and inclusive perspective on the county's health needs and assets. In October 2025, the Bexar County Health Collaborative released the 2025 Bexar County Community Health Needs Assessment. Key issues emerged, including:

- In 2023, 19% of the total population was food insecure, up from 14% in 2019, and higher than the national average. Disparities by race/ethnicity and geography persist.
- Hospital discharge rates for opioid poisonings are declining for all ages, but a broader measure of drug poisoning discharges is increasing for patients under 18 years.
- An estimated 60% of 2023 births were to mothers who received prenatal care in the first trimester, down from 75% in 2019. Disparities by race/ethnicity, geography and age persist.
- The top two causes of death are heart diseases and malignant neoplasms, but the rates vary widely by race/ethnicity and sex.

The Institute will use the 2025 Bexar County Community Health Needs Assessment to guide the development of University Health's community health implementation strategy, which will serve as University Health's health equity strategic plan for 2026 and beyond.

Cover of the 2025 Bexar County Community Health Needs Assessment released by the Bexar County Health Collaborative.

Implementing Evidence-Informed Interventions to Reduce Health Disparities

Enhancing organizational capacity to reduce health disparities

Advancing health equity requires a coordinated approach that strengthens our workforce, integrates equitable care practices, deepens community partnerships and expands access to care. Throughout 2025, University Health focused on building organizational capacity to reduce disparities by investing in Community Health Workers, embedding trauma-informed and patient- and family-centered practices across service lines, partnering with community-based organizations and bringing care closer to the communities that need it most.

Community Health Workers

Team members trained as Community Health Workers (CHW) help our patients overcome barriers and reduce disparities by linking patients to critical resources and offering culturally responsive support. Building on the progress made in 2024, leaders began the process of standardizing CHW job descriptions and roles, as well as developing a framework for a new CHW Collaborative. Our assessment identified opportunities to create clearer career pathways and opportunities for advancement. Strengthening knowledge sharing within our teams will further improve our ability to serve patients. In 2026, we will launch the CHW Collaborative, providing quarterly sessions where our CHWs can learn about new resources, connect with peers and other team members across the health system and engage in continuing education to support their professional growth.

Integrating Practices and Concepts

Incorporating trauma-informed care, patient- and family-centered care, and public health practices across our service lines is vital to delivering well-rounded, compassionate care. This approach not only addresses the clinical needs of patients but also supports their emotional and social well-being, promoting a more equitable and effective health care experience for all. In 2025, University Health's Patient Family Advisory Council (PFAC) was recognized by the Institute for Patient- and Family-Centered Care for its innovative efforts in advancing the principles of

Attendees of April's "Putting Patients First: Strategies for Strengthening Patient- and Family-Centered Care" training.

Patient- and Family-Centered Care (PFCC), strengthening partnerships among patients, families and team members. A 90-minute PFCC training, now a required part of orientation for all Patient Family Advisors (PFA), has been incorporated into the onboarding process for team members in select departments. This collaborative training, involving PFAs and team members, fosters shared learning and establishes a strong foundation for ongoing collaboration.

The Institute for Public Health and the PFAC also collaborated with the Center for Learning Excellence to integrate PFCC and health equity concepts into the leadership training program. As University Health team members are promoted into leadership roles, they participate in this training to gain a deeper understanding of how these principles drive more inclusive, compassionate care, and they are empowered to model and reinforce these values across their teams and departments.

Building on these efforts, the Trauma-Informed Care (TIC) team is revamping its advocate program and introducing TIC Talks. Each month, department TIC advocates share a specific TIC tip or principle during huddles to reinforce trauma-informed practices within their departments. This initiative aims to foster a continuous culture of learning, ensuring TIC principles remain front-of-mind and are integrated into daily interactions.

Partnering to Advance Health Equity

Co-locating community-based service organizations fosters innovation and collaboration in addressing non-medical social needs for patients and the broader community. University Health Vida's Community Commons Suite will bring partners together to enhance patient access, strengthen integration and encourage shared problem-solving, grant collaboration and knowledge sharing. In 2025, 10 community partners signed agreements to co-locate at University Health Vida beginning in 2026, advancing aligned, community-focused care and driving improvements in health equity across the communities we serve.

The Institute for Public Health hosted the MLK March Subcommittee Meeting at the new University Health Wheatley community space.

Improving Access to Care

Access to reliable transportation, financial stability and geographic proximity can all affect an individual's ability to receive care when needed. At University Health, we aim to expand services in areas with the greatest need. Our efforts to increase access to care include mobile health units, flu vaccination drives, screenings at community health fairs and the opening of new clinics in underserved areas, bringing accessible care to all.

In 2025, University Health:

- Hosted four flu vaccination drives, one in each of Bexar County's four precincts.
- Expanded access to care in historically underserved areas with the openings of Judson ISD Health Center, Susan Hall Health Center in Southside ISD, University Health Surgery Center at Morgan's Multi-Assistance Center (MAC), University Health Wheatley and University Health Vida.
- Provided complimentary allergy testing, serving 73 individuals at a back-to-school fair.
- Participated in 47 health fairs and outreach events, offering services such as health screenings, vaccinations and education on University Health programs.
- Hosted 47 Stop the Bleed training classes and supported an additional 108 classes, educating 2,604 individuals in life saving and injury prevention skills.

University Health team member administering a flu vaccine at a community flu drive.

University Health team members participating in a Stop the Bleed training in May 2025.

In addition to increasing access to care, University Health provides access to interpreter services to ensure individuals can access care in their preferred language. University Health utilized qualified medical interpreter services for a total of 426,780 patient encounters and translated 650 documents in 2025. Patients with Limited English Proficiency had access to these services 24/7 through live video and telephone modalities, as well as in-person with our Nationally Certified Medical Interpreter staff and authorized vendors. Approximately 20% of University Health patients prefer to receive information about their health care in a language other than English. Through the utilization of qualified medical interpreters we ensure these patients are communicated with in a way they can understand which improves patient safety, cultivates trust and supports compliance with treatment plans. These services allow us to preserve patient dignity irrespective of ethnic background, disability, or language needs as we improve the health of our community.

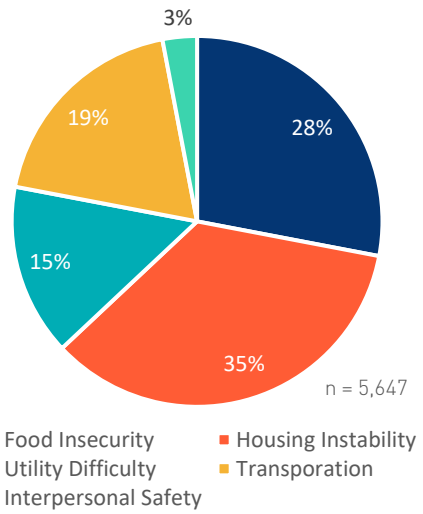
Recognizing and addressing the non-medical drivers that negatively affect the health of patients

Addressing non-medical drivers of health improves health outcomes and advances health equity. In 2025, University Health continued to strengthen its approach to identifying and addressing patients' social and economic needs through systematic screening, strategic community partnerships and improved care coordination. These efforts included targeted interventions and strengthened referral processes and laid the groundwork for more integrated, outcomes-driven approaches to addressing food insecurity and other health-related social needs.

In 2025, the Inpatient Care Coordination team screened 77% of hospitalized patients aged 18 years and older for non-medical drivers of health, exceeding our goal of 75%. Among those screened, 28% reported at least one identified need. These findings highlighted food and housing as the most common barriers affecting our patients' health and well-being (Figure 5).

When food insecurity emerged as a leading need, the Institute for Public Health partnered closely with the San Antonio Food Bank (SAFB) to enhance utilization and improve information sharing through our electronic health record. In 2025, our team members made over 1,600 referrals to the SAFB. This partnership is laying the foundation for the upcoming year, with a focus on refining how referrals are routed to community-based organizations that address health-related social needs. Additionally, we are establishing a streamlined system for reporting and tracking patient outcomes, ensuring that results are communicated back to the health system in a format that is easily measurable and actionable. This work improves coordination, resource allocation and enhanced outcomes for individuals in need.

Figure 5: Patient Non-Medical Needs Identified by Type



As the Institute for Public Health continues to refine its processes with the SAFB, we are also partnering with ambulatory leaders and the health innovation team to design a pilot program focused on screening for food insecurity within the ambulatory care setting. In preparation for a 2026 launch, our cross-department teams have identified team members responsible for administering the screenings, established the referral process, selected tools to share with patients and determined the approach for follow-up. The efforts are paving the way for a more structured and effective approach to addressing food insecurity at the point of care, ensuring that patients are connected with the resources they need in a timely and coordinated manner.

Reducing the burden of disease and improving quality of life and life expectancy for all people who have, or are at risk for, the most common health conditions

Diabetes

Diabetes continues to disproportionately affect Bexar County residents, with prevalence exceeding both state and national rates. Recognizing the significant impact of diabetes on life expectancy, quality of life and health system utilization, University Health remains committed to prevention, early intervention and comprehensive disease management for individuals living with or at risk for diabetes. In 2025, University Health:

University Health provided free glucose screenings and diabetes education during Diabetes Alert Day in March.

- Engaged more than 296 patients and community members with diabetes education, screening information and prevention resources during Diabetes Alert Day and World Diabetes Day events.
- Expanded access to specialized care with the opening of a Limb Salvage Clinic at the Texas Diabetes Institute in September 2025. The clinic addresses the root causes of limb loss, including poor circulation, arterial disease and chronic wounds using a whole-person approach.
- Provided targeted disease education, medication management and primary prevention services through the Community Care Clinic pharmacist, supporting 448 patients in improving diabetes-related health outcomes.

Eye exam provided to a patient at our World Diabetes Day event in November.

- Enrolled 235 CareLink patients in the Salud Por Vida program, which delivers culturally responsive education focused on diabetes and hypertension prevention and management.

- Enhanced community access to evidence-based information by expanding diabetes-related educational content on the Institute for Public Health website, including new resources focused on kidney health and diabetes-related complications.

Collectively, these initiatives reflect University Health's comprehensive approach to reducing diabetes-related disparities, improving clinical outcomes and empowering individuals and communities with the knowledge and resources to manage and prevent chronic disease.

University Health partnered with local restaurant Aldaco's for a cooking demonstration of healthy pozole verde at World Diabetes Day.

Maternal Health

Maternal health is another priority for University Health, as disparities in maternal morbidity and mortality continue to disproportionately affect women in underserved communities. Addressing these challenges requires a comprehensive approach that strengthens access to prenatal and postpartum care, integrates behavioral and social supports, and centers care around the needs of birthing individuals and their families.

In 2025, University Health:

- Delivered 5,455 babies in our Women's & Children's Hospital, a designated Level IV maternity center.
- Opened the Women's Heart Center in September, bringing together a multidisciplinary team of obstetricians, gynecologists, maternal-fetal medicine specialists, anesthesiologists, cardiovascular surgeons and pulmonologists. The center addresses complex cardiovascular conditions that can arise during pregnancy and the postpartum period. As cardiovascular disease remains the leading cause of pregnancy-related mortality, the Women's Heart Center provides specialized care for individuals whose pregnancies are complicated by heart conditions.

Women's Heart Center Team at One Medical: Dr. Ildiko Agoston; Nina Sisavath; Cynthia Gonzales-Zuniga, RN; Vanessa Soto, LVN and Justin Juarez, LVN.

- Expanded care coordination and education through the Mama Bexar and Baby Bexar grant-funded programs, which supported 1,923 pregnant individuals by connecting clinical care with community-based resources and providing education to promote healthy pregnancies and postpartum recovery.

By expanding access to services and aligning clinical care with community-based supports, University Health is working to reduce preventable complications and promote healthier starts for families across Bexar County.

Nayely Briones, Baby Bexar program manager, sharing information about the Baby Bexar program and services at a community event hosted by Operation Brave.

Partnering with the Community to Advance Health Equity

Improving the community conditions that affect health

In 2025, University Health strengthened its commitment to health equity by deepening community partnerships, expanding workforce development efforts and making strategic investments that support long-term community well-being. Through structured collaboration, targeted engagement and philanthropic support, these initiatives collectively advanced access to care, economic opportunity and sustainable health outcomes across the communities we serve.

Adopting a Framework to Guide Collaboration

Developing a structured framework to optimize collaboration with community partners advances health equity and strengthens community impact. In 2025, the Institute adopted a framework designed to enhance alignment, coordination and accountability across partnerships. The framework describes each partner's level of integration with University Health, enabling the Institute to identify opportunities to strengthen collaboration, target support and strategically invest in partner-led programs, services and events that address shared community priorities. To date, more than 290 partners have been identified.

University Health Vida community partner kick-off event held at Texas A&M University - San Antonio in May 2025.

Building a Workforce Pipeline

Partnering with community organizations and schools is essential to building a strong, sustainable workforce pipeline while promoting economic opportunity in underserved areas. University Health has made a concerted effort to partner with local school districts and higher education institutions to serve as a training site for certificate and workforce development programs. In 2025, 398 high school students from seven school districts completed clinical rotations at University Health while pursuing certifications in roles such as medical assistant, pharmacy technician and certified nursing assistant. Recognizing that approximately 15% of the health system workforce is non-clinical, the Center for

Learning Excellence expanded its student placement program in 2025 to include non-clinical internships. As a result, 30 students were placed across departments throughout the health system. Education partners supporting this effort include UT San Antonio, Texas A&M University-San Antonio and the Reddix Center. Additionally, University Health hired 69 pharmacy technicians who successfully completed our organization's intensive, fast-paced 12-week training program and passed the National Pharmacy Technician Certification Exam. Since the launch of the Pharmacy Technician Training Program in 2023, University Health has graduated seven cohorts, expanded class capacity to a maximum of 15 students per cohort, and achieved a 100% program completion rate and a 98% national certification exam pass rate. Through these collaborations and programs, we are expanding pathways to careers in health care, strengthening local talent and supporting community-driven growth that advances long-term health equity.

Graduates of the Pharmacy Technician Training Program, Summer 2025 Cohort.

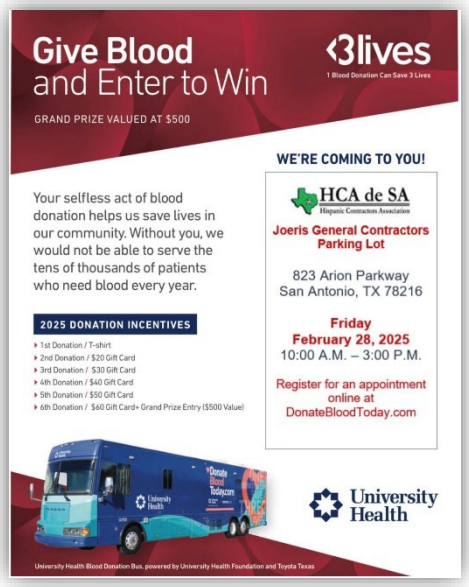
High school students receive a demonstration from a University Health clinical team member during a student tour.

Vendor Engagement

Strengthening relationships with qualified local vendors, particularly small and underutilized businesses, advances economic opportunity and health equity. University Health is experiencing a period of significant growth, including the construction of two new hospitals and the expansion of clinics across Bexar County. This growth creates opportunities to invest in the local economy through partnerships with small and local vendors. In 2025, small and local businesses accounted for 74% of the vendors supporting the construction of the Palo Alto hospital, 78% of the Retama hospital, 86% of the Vida clinic and 73% of the Wheatley clinic.

In 2025, the Vendor Engagement team partnered with the Hispanic Contractors Associations to host a community blood drive, demonstrating a shared commitment to community well-being. The team also hosted its largest vendor open house to date with more than 500 individuals in attendance, giving local businesses the opportunity to learn about doing business with University Health and explore available

contracting opportunities across the health system. The Vendor Engagement team continues to identify ways to engage with our vendors, including hosting Stop the Bleed and CPR trainings at their safety fairs and providing resources and education that support workforce development and community health. These efforts strengthen partnerships, foster collaboration and promote the growth of a diverse and resilient local vendor network.



Flyer promoting a blood drive University Health hosted in partnership with the Hispanic Contractors Association of San Antonio.

Advancing Health Priorities through Strategic Investments

Strategic philanthropic investments in 2025 supported innovative clinical programs, workforce development, and expanded access to critical services across University Health. Through targeted grants and community partnerships, the University Health Foundation advanced initiatives designed to improve patient outcomes, strengthen the workforce and reduce barriers to care.

In partnership with the University Health Transplant Institute, the University Health Foundation secured funding in 2025 to expand the GLADIATOR program (lunG transpLAnt Developing resIliency And sTrength thrOugh Rehabilitation), an at-home rehabilitation program for patients awaiting lung transplant. The program delivers individualized exercise, nutrition and mental health interventions to help patients build strength and resilience prior to transplant. The program is demonstrating favorable outcomes, including reduced hospital lengths of stay and fewer discharges to inpatient rehabilitation facilities. Prior to receiving the 2025 CHEST Community Impact Grant, the GLADIATOR program served approximately 50 patients; grant funding enabled expansion of the program to all eligible patients across the facility.

To further support workforce development, the University Health Foundation awarded scholarships to 26 team members pursuing advanced degrees. The Foundation awarded $1,000 scholarships to 10 graduating high school seniors who are the sons or daughters of University Health employees.

The University Health Foundation strengthened early detection and diagnostic access through a $10,000 contribution from the Alamo Breast

The 2025 recipients of the University Health Foundation's "Our Sons & Daughters Scholarship" and their parents.

Cancer Foundation. These funds support diagnostic testing for patients who are uninsured or unable to afford follow-up care after receiving a positive mammogram through the mobile mammography unit.

In May 2025, the Foundation was awarded $300,000 in grant funding to support the University Health Milk Bank, the first of its kind in the region. This funding will significantly expand access to pasteurized donated human milk, a critical resource for premature infants and for cases when a mother's own milk is unavailable. The milk bank will help ensure that University Health's most vulnerable patients receive lifesaving nutrition during their earliest and most critical stages of care.

Together, these investments reflect the University Health Foundation's continued commitment to advancing innovation, equity and excellence across University Health, while addressing both immediate patient needs and long-term system capacity.

Looking Ahead

As we move forward, University Health will continue to build on the progress made this year by strengthening partnerships, advancing health equity and investing in our people and communities. Our focus remains steadfast as we work to:

- Enhance partnerships that expand our reach and deepen our impact
- Integrate innovative practices and targeted interventions that improve health outcomes
- Connect patients to resources that reduce health-related social needs
- Address adverse non-medical drivers of health in our community
- Identify and eliminate health disparities.

Through these efforts and investments, we are positioning our organization to meet the evolving needs of our community and sustain meaningful impact well into the future.

2025 Health Equity Leadership Team

A multidisciplinary group of leaders provided strategic guidance and oversight of the 2025 Health Equity through Action and Leadership Strategic Plan. University Health thanks these individuals for their time, dedication and support.

Health Equity Leadership Team Executive Champions

Carol Huber, DrPH

Bryan J. Alsip, MD, MPH

Katherine Reyes, MA

Health Equity Leadership Team

Sarah Mohmedali, MS (chair)

Sara Alger, CFRE

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