

Sharp Coronado Hospital and Healthcare Center Community Health Needs Assessment – Implementation Plan Fiscal 2017-2020

Identified Community Health Need: Access to Care	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	<p>1. Increase coverage for patients seen in the Emergency Room by providing assistance to secure health coverage for all individuals entitled to the benefit; also provide payment options for individuals that chose not to secure coverage or are not currently eligible for health benefits. Secure benefit concurrent with hospital stay when Medi-Cal Presumptive Eligibility rules apply.</p>	<p>a. Continue to provide services to help every unfunded patient received in the Emergency Department find coverage options - including PointCare questionnaire to generate personalized coverage options that are filed in patients' accounts for future reference and accessibility.</p> <p>In addition, Sharp staff use the PointCare on-line survey to direct patients to the Covered California website for health coverage or Medi-Cal enrollment as Presumptively Eligible and/or full scope benefits.</p>	<p>Supervisor, Patient Assistance Navigators</p>	<p>Access to care Education</p>	<p>The PointCare program continues to collect metrics on number of individuals served and cost savings. Via this program, Sharp served 9,384 self-pay patients since October 01, 2015 through 07/31/2016.</p> <p>PointCare has expanded its website to also provide linkage to Covered CA as appropriate. The tool interfaces patient screening information in the GE record.</p> <p>Sharp Healthcare’s Patient Access Services department has processed real-time Medi-Cal eligibility determinations under the Hospital Presumptive Eligibility Program for 234 unfunded patients, YTD FY 2016.</p> <p>Thus far in FY 2016, Sharp Healthcare’s Patient Access Services department has assisted 309 recipients in maintaining Medi-Cal eligibility after the HPE period lapse via advanced advocacy efforts.</p> <p>Continued unknowns in understanding the efficacy of our efforts are the increase in the patient out of pocket responsibility resulting from health plan coverage purchased off the exchange and the transition of qualified unfunded patients directly to</p>

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					Medi-Cal. Sharp has initiated a process of trending straight self-pay collections separate from balance after insurance collections in an effort to closely monitor these two distinct populations.
	2. Provide payment options and support high-risk, uninsured, underinsured, and patients admitted to hospital facilities with an inability to pay their financial responsibility after health insurance.	a. Provide the Maximum Out of Pocket Program to patients who express an inability to pay their financial responsibility after health insurance.	All Revenue Cycle Staff	Access to care Education	The Maximum Out of Pocket Program was launched in October 2014. Sharp provides one-on-one interviews during the hospital stay focusing on educating the patient regarding their health insurance benefits, accessing care, and payments options with a compassionate approach while promoting healing.
		b. Provide a Public Resource Specialist through the system-level Patient Financial Services Department for uninsured and underinsured patients, in order to offer support to patients needing advanced guidance on available funding options.	Patient Financial Services (system-level) Public Resource Specialists	Access to care Education	In 2015, positions were created within Sharp’s Patient Financial Services department (system level) entitled Public Resource Specialists – to support patients at all Sharp hospitals (including SCHHC) needing extra guidance on available funding options. These Public Resource Specialists also perform what is traditionally called “field calls” (home visits) to patients who have left the hospital and require assistance in completing a process to facilitate coverage. Anticipate implementation of tracking tool in FY 2017.

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		<p>c. Patient Assistance Team will continue to assist patients in need of assistance gain access to free or low-cost medications. Patients are identified through usage reports, or referred through case management, nursing, physicians or even other patients. If eligible, uninsured patients are offered assistance, which can help decrease readmissions due to lack of medication access. The team members research all options available including programs offered by drug manufacturers, grant-based programs offered by foundations, copay assistance, low-cost alternatives, or research where the patient might find their medication at a lower cost.</p>	<p>Supervisor, Patient Assistance Navigators</p> <p>Manager Patient Financial Services, Self-Pay Patients</p>	<p>Access to care Education</p>	<p>Cost savings for replacement drugs is monitored through pharmacy and supply chain. The patient accounting staff remove the charges from the patient statement.</p> <p>Sharp was the first health system in San Diego to gain Certification through the Covered CA program, training over 20 employees to become Certified Enrollment Counselors for CoveredCA. This, along with Hospital Presumptive Eligibility, has reduced the unfunded population at our hospitals significantly.</p> <p>Sharp also tracks each individual that has applied for financial assistance. The patient account is noted with the findings, and a specific adjustment code is used to track the dollars associated with these reviews.</p>
		<p>d. Continue to offer ClearBalance – a specialized loan program for patients facing high medical bills. Through this collaboration with San Diego-based CSI Financial</p>	<p>Supervisor, Patient Assistance Navigators</p>	<p>Access to care Education</p>	<p>To date in FY16, more than 1,830 Sharp patients been assisted through the ClearBalance loan program.</p>

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		Services, both insured and uninsured patients have the opportunity to secure small bank loans in order to pay off their medical bills in low monthly payments.	Manager Patient Financial Services, Self- Pay Patients		
		e. Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.	Sharp Coronado Hospital and Healthcare Center (SCHHC) Chief Financial Officer, VP of Clinical Services	Access to Care	Project HELP funds are tracked though an internal database. From FY10 – FY15, SCHHC Project HELP funds totaled ~\$33.
		f. Patient Assistance Team will continue to help patients in need of assistance gain access to free or low-cost medications. Patients are identified through usage reports or referred through case management, nursing, physicians or other patients. If eligible, uninsured patients are offered assistance. The team members research all available options	Supervisor, Patient Assistance Navigators Manager Patient Financial Services, Self- Pay Patients	Access to care Education	Cost savings for replacement drugs is monitored through pharmacy and supply chain. The patient accounting staff remove the charges from the patient statement so the savings is noted in their total charges. Sharp was the first health system I in San Diego to gain Certification through the Covered CA program, training over 20 employees to become Certified Enrollment Counselors for Covered CA. This, along with Hospital Presumptive Eligibility, has reduced the unfunded

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		including programs offered by drug manufacturers, grant-based programs offered by foundations, copay assistance, low-cost alternatives, or research where the patient might find their medication at a lower cost.			<p>population at our hospitals significantly.</p> <p>Sharp also tracks each individual that has applied for financial assistance. The patient account is noted with the findings, and a specific adjustment code is used to track the dollars associated with these reviews.</p>
	3. Improve access to health and social services for high-risk community members, particularly San Diego’s homeless population.	a. Provide data to St. Vincent de Paul for Permanent Supportive Housing Cost Effectiveness Study– which provides housing and social services to San Diego’s chronically homeless community members.	Vice President, Sharp HealthCare (SHC) Government Relations	Access to Care Collaboration Care Management	This effort concluded in FY15, and has led to the state’s adoption of the model for distribution in other regions, via the Whole Person Care program funded by the Medicaid Waiver; and continuation (via the City/County Project One for All which will include wraparound services for defined population of homeless.
		b. Participate in collaboration with the San Diego Organizing Project and Multicultural Primary Group to provide follow-up medical and case management services to high-risk patients (homeless, etc.)	Vice President, SHC Government Relations Care Transitions Program Manager	Access to Care Collaboration Care Management	<p>This project concluded in 2016.</p> <p>This project tracks hospital service utilization and cost savings. Currently (as of July, 2015) Sharp is tracking service utilization for 50 individuals. Program began in spring, 2013.</p>

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		c. Continue to collaborate with the San Diego Rescue Mission to discharge chronically homeless patients to the Rescue Mission’s Recuperative Care Unit. These patients receive follow-up care through SCHHC in a safe space, in addition to psychiatric care, substance abuse counseling and other services through the San Diego Rescue Mission.	Vice President, SHC Case Management	Access to Care Collaboration Care Management	Program tracks the number of referrals made to the Rescue Mission as well as cost data for patients for whom Sharp covers the cost of post-discharge treatment (at a Sharp facility). Data for the latter are tracked via Sharp’s Case Management Department’s cost reports.
		d. Continue to partner with Father Joe’s Villages to support Project SOAR - designed to facilitate and expedite the processing of Social Security and disability applications for homeless individuals with urgent health care needs.	Vice President, SHC Case Management	Access to care Collaboration Care Management	Eligibility for Project SOAR’s programming is incorporated into Sharp’s current eligibility review process for all patients; patient files are assessed for Project SOAR eligibility and then referrals are conducted for qualified patients. Currently there are no mechanisms in place to track cost or volume on this program, as it is a cooperative with no direct costs for Sharp. Thus, it is difficult to measure any savings that Sharp might experience.

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		e. Continue and strengthen partnership with Meals on Wheels San Diego County to serve homebound seniors and other vulnerable community members.	Manager, SCHHC Patient and Administrative Relations	Senior Health Food Insecurity Social Isolation Access to Care Collaboration	<p>SCHHC continues to partner with Meals on Wheels San Diego County, and in FY 2015 the hospital delivered nearly 5,000 meals to Coronado seniors in their homes.</p> <p>In addition to meals service delivery seven days a week, SCHHC’s partnership with Meals on Wheels San Diego County includes the provision of sliding scale payment programs, free pet food, daily wellness checks and more to men and women who are elderly, homebound, disabled, frail or at-risk. Meals on Wheels volunteers also observe the client’s environment for potential health and safety issues and are trained to obtain emergency response if needed. This partnership helps promote independence, reduce social isolation and improve the quality of life and health of participating community members.</p>
		f. Continue to explore opportunities for collaboration with community organizations to provide medical care, financial assistance, psychiatric and social services to high-risk, chronically ill, and/or chronically homeless patients	Care Transitions Program Manager Program Manager, Community Benefits and	Access to Care Collaboration Care Management	With the success of Sharp Grossmont Hospital’s Care Transitions Intervention (CTI) pilot (see line item below), Sharp is exploring the concept of expanding this model of care (connection to resources for food insecurity, transportation, and other social supports) to other high-risk patient populations at Sharp’s hospital entities. In progress.

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			Health Improvement Vice President, SHC Government Relations		

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Identified Community Health Need: <u>Behavioral Health</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	<p>1. Raise awareness and reduce stigma of behavioral health issues, with specific focus on seniors.</p>	<p>a. Provide behavioral health education, screening and resources to community members, specifically seniors.</p>	<p>Manager, SCHHC Patient and Administrative Relations</p>	<p>Senior Health Behavioral Health Collaboration Education Stigma</p>	<p>SCHHC is in the planning stages for a collaboration with Coronado CARES, as well as Sharp Mesa Vista Hospital due to community request for behavioral health event for seniors. The event will be held in conjunction with the annual flu clinic. Event planned for FY17 (October).</p> <p>In October, 2015, Sharp Coronado Hospital staff participated in Mental Health First Aid - an internationally-renowned program that teaches front-line staff the signs and impacts of addiction and mental illness, including a 5-step action plan to assess and de-escalate situations, and local resources. This is a peer-reviewed, proven-effective program and is listed in the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices. Sharp HealthCare is the first hospital/health system to participate in this training, currently funded by the County of San Diego.</p> <p>Although Behavioral Health is identified as a priority health need in the primary communities served by SCHHC, the facility is not licensed to comprehensively address this priority. The behavioral health needs of Sharp Coronado Hospital’s patient community are addressed primarily through the programs and services provided through Sharp Mesa Vista Hospital (SMV) and</p>

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					Sharp McDonald Center (SMC) – the major providers of behavioral health and chemical dependency services in San Diego County. As part of this effort, SMV dispatches PET (Psychiatric Evaluation Team) staff to SCHHC’s ED in order to identify patients that should be transferred to SMV.

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Identified Community Health Need: <u>Cardiovascular Disease</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	<p>1. Empower community members with cardiovascular and cerebrovascular disease through education and support; promote accountability and behavioral change through education on chronic disease self-management.</p>			<p>Cardiovascular Health Education Care Management</p>	<p>Currently exploring opportunities for community event participation – especially those serving older adults.</p> <p>Free, Healthier Living Workshops are provided to community members through Sharp HealthCare’s medical group, Sharp Rees-Stealy, including in areas served by SCHHC. The six-week class teaches how to manage the challenges of living with a chronic disease, including diabetes, high blood pressure, asthma, arthritis and other conditions. Topics include: appropriate exercise for maintaining and improving strength, flexibility and endurance; appropriate use of medications; communicating effectively with family, friends and health professionals; nutrition to improve well-being; techniques to deal with frustration, fatigue, pain and isolation often associated with chronic disease. Family members or friends of someone with an ongoing health condition, as well as community members interested in becoming more physically and socially active, are welcome to attend.</p> <p>In addition, this need is addressed by currently existing support groups across Sharp HealthCare, including: Women With Heart Disease, Congestive Heart Failure, Heart Transplant/Family Support Group and Young Enthusiastic Stroke Survivors (YESS).</p>

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	2. Increase access to cardiovascular health screenings and educational resources for community members, with a focus on underserved populations.	a. Provide cardiovascular health education, screenings, resources to community members.	Manager, SCHHC Patient and Administrative Relations	Cardiovascular Disease Education Screenings Access to Care	<p>SCHHC conducted a health & wellness event in FY 16 with attendance of over 100 community members. Cardiovascular health education was provided including Emergency Dept., Clinical Nutrition Services, and Food & Nutrition Services provided a cooking demo of heart healthy meals and samples were given to community members.</p> <p>Currently exploring opportunities for community event participation – especially those serving older adults – in FY16 and the future.</p>
		b. Conduct system-wide (across SHC) community-wide screening effort through at least 5,000 free community based individual biometric health screenings, including BMI, cholesterol and blood pressure screening. Locations in Coronado included the Coronado Community Pharmacy.	Sharp HealthCare Chief Experience Officer	Cardiovascular Disease Screening Education Collaboration	<p>In FY 2015, Sharp HealthCare hosted 75 community health screening events throughout SDC, screening more than 5,200 San Diegans and providing more than 110,000 hours in support of the effort.</p> <p>From the inception of the screenings Sharp HealthCare participated in nearly 200 community health screenings events across San Diego – ultimately screening more than 14,000 San Diegans.</p> <p>The screening program concluded in early 2016.</p> <p>Screenings provided personalized health information at no charge to community members over the age of 18.</p>

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					Participants were not asked to provide personal information, nor were they required to show proof of insurance or have any relationship with Sharp to be eligible for the screening. To encourage participation, identifying and follow-up information was not collected. Appointments were not required, and community members retained the only copy of their results. Community members also received personalized strategies to improve their overall health and well-being.
	3. Collaborate with other health care organizations in San Diego on stroke education and prevention efforts.	a. Continue participation in San Diego County Stroke Consortium	Sharp HealthCare VP of Ortho/Neuro Service Line SCHHC Manager of Emergency Department	Cardiovascular Disease Collaboration Education	Sharp team members continue to serve as part of the San Diego County Stroke Consortium and the Sharp HealthCare Stroke service line team once again participated in the “Strike Out Stroke” event at the Padres in June 2016, with more than 25,000 attendees.

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	<p>1. Increase education of signs and symptoms of diabetes throughout San Diego, particularly underserved and minority populations in the community.</p>	<p>a. Participate in educational forums, health fairs and events throughout San Diego, including Coronado.</p>	<p>Manager, SCHHC Patient and Administrative Relations</p> <p>SHC Diabetes Service Line Leadership Team</p> <p>SHC Program Manager, Community Benefits and Health Improvement</p>	<p>Diabetes Education Collaboration Access to care Food Insecurity</p>	<p>In Summer, 2016 SCHHC reached out to the Imperial Beach (IB) community through participation in the new annual community health fair. This outreach, including the Chamber of Commerce, local organizations and faith-based community, resulted in connection to the IB community’s “Hunger Collaborative.” SCHHC connected community organizations from the Hunger Collaborative with resources at the San Diego Food Bank, to provide nutrition education classes to seniors with fresh produce provided. Outcomes data forthcoming.</p> <p>In addition, SCHHC is also exploring collaboration with SHC’s Diabetes Service Line Leadership Team to identify diabetes education opportunities for the IB community, in response to community concern. Plan may also include neighborhood focus groups to help identify barriers to healthy food choices.</p> <p>The SHC Diabetes Leadership Team meets annually with the SHC Program Manager of Community Benefits and Health Improvement to evaluate community programs over the previous year and identify opportunities for community outreach and collaboration. In 2016, this resulted in connection with SCHHC and the IB community.</p>

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					Feedback is collected from community members on educational courses provided, in order to improve and refine educational resources for community member needs.
		b. Explore opportunities with new venues/ community groups, and community clinics to provide additional resources and education to vulnerable populations.	Manager, SCHHC Patient and Administrative Relations SHC Diabetes Service Line Leadership Team SHC Program Manager, Community Benefits and Health Improvement	Diabetes Education Access to care Collaboration Food insecurity	SCHHC has been in the process of locating sites in IB to provide pre-diabetes education and resources. In Summer, 2016 SCHHC identified potential sites to hold screenings/classes in Imperial Beach, planning with SHC Diabetes Service Line Leadership. Planning in progress. SHC Program Manager, Community Benefits and Health Improvement to evaluate opportunities/potential collaborations through the 2016 CHNA. Will keep SCHHC’s Manager of Patient and Administrative Relations as well as SHC’s Diabetes Service Line Leadership updated on opportunities.

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Identified Community Health Need: Diabetes	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		c. Utilize findings from the FY 2016 CHNA to assess existing community resources and explore areas where additional diabetes education and resources may be needed.	SHC Program Manager, Community Benefits and Health Improvement SHC Diabetes Service Line Leadership Team Manager, SCHHC Patient and Administrative Relations	Diabetes Education Access to Care Collaboration	SHC Program Manager, Community Benefits and Health Improvement and the SHC Diabetes Leadership Team meet regularly to assess additional opportunities for outreach and education. In Summer 2016, this resulted in the connection to SCHHC’s Manager of Patient and Administrative Relations to explore opportunities for diabetes education and resources in the IB community.
		d. Provide diabetes education to food-insecure adults enrolled in Feeding America San Diego’s Diabetes Wellness Project – a collaboration including UCSD’s Student Run Health Clinic in Downtown San Diego.	SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and	Diabetes Education Access to Care Collaboration Food insecurity	New in FY15-FY16, the SHC Diabetes Education Program provided diabetes education to food insecure adults enrolled in Feeding America San Diego’s (FASD) Diabetes Wellness Project, a randomized, controlled trial and collaboration between UCSD’s Student-Run Free Clinic Project, the Third Avenue Charitable Organization (TACO) and Baker Elementary School in Southeast San Diego. The Diabetes Wellness Project

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			Health Improvement		<p>screens adult clinic patients with Type 2 diabetes for food insecurity, and provides them with ongoing medical treatment and diabetes management through the clinic. In addition, FASD provides Diabetes Wellness Food Boxes to project participants, in conjunction with a monthly diabetes and nutrition education course. Provided by an SHC Diabetes Educator - as well as CalFresh outreach. Approximately 200 participants enrolled in the one-year Diabetes Wellness Project.</p> <p>Data forthcoming, results to be published in late FY16/early FY17. However initial results reveal correlation of food insecurity with increased depression and decreased fruit/vegetable intake, with program participants at baseline. In addition, statistically significant positive impacts on food insecurity, depression, and HbA1c levels of uncontrolled diabetics enrolled in the program were observed.</p>
	2. Improve identification of pre-diabetes and diabetes in community members through screening.	a. Collaborate with the Sharp HealthCare Diabetes Service Line Leadership Team to coordinate and implement blood glucose screenings at community and hospital sites in San Diego County.	Manager, SCHHC Patient and Administrative Relations SHC Diabetes	Diabetes Screening Access to Care Collaboration	<p><u>Screenings Discontinued in 2016:</u> Various regulatory and logistical challenges contributed to the discontinuance of screenings in FY 2016, which are detailed below. In summary, in light of the changes, Sharp’s Diabetes Leadership took a hard look at the benefits of providing screening events, and found that very few of the elevated BG levels were due to people</p>

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			<p>Leadership Team</p> <p>SHC Program Manager, Community Benefits and Health Improvement</p>		<p>who were unaware they had diabetes, rather they were diagnosed but wanted to get there BG checked; thus, it seemed we were not reaching our target audience. It was then decided to focus our efforts by providing education to the underserved who had no access to education due to lack of insurance or funding, and provide classes that would benefit and educate in a more meaningful manner.</p> <p>As a result, Sharp’s Diabetes Education team has focused efforts on working in partnership with Feeding America and local community clinics (e.g., FHCSO) providing classes in both Spanish and English to patients diagnosed with diabetes who would have no access to this service by usual means. This has been well received by the community and also Sharp Diabetes educators who feel that they are truly meeting the needs of the community and making a difference in the lives of those impacted by diabetes.</p> <p>Regulation details:</p> <ul style="list-style-type: none"> • In January 2014, the FDA issued the Draft Guidance entitled: Blood Glucose Monitoring Test Systems for Prescription Point-of-Care Use. Since its release, the uncertainty has been building among hospital laboratory management and point of care coordinators

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					<p>over the future of point of care glucose meter use. Because of the potential impact of the outcome of the decision on the clinical laboratory and point of care community, there was a lot of speculation as to what POCT meter we would be able to use for community screenings as current POCT meters are approved for home use by FDA, and If we use meters outside of manufacturers recommendations it is considered "Off Label". CLIA REG - 1253 b 2 requires establishment of performance specification (sensitivity and specificity) if we use meters "Off Label". During 2015 the controversy continued and we explored any POCT meters that were approved for multiple use that we could use at community events.</p> <ul style="list-style-type: none"> • In addition, in 2015 the Department of Health and Human Agency (DHHA) required a permit request 1 month prior to any requested screenings as well as staff names and competency. If a staff member became sick just prior to an event we were not able to substitute with another staff member as this had not been submitted to DHHA. Screening permits cost \$1,000 which in previous years was supported by Roche Diagnostics who is no longer able to provide financial support, nor can they provide the test strips free of charge for these community events.

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					<ul style="list-style-type: none"> • Another change in late 2015: AB 333 - LQHE discontinuation (Limited Quantity Hauler Exemption) and medical waste temporary events registration. Any BG screening operators are required to notify San Diego County department of Environmental Health (DEH) for each temporary event through Citizen Access Portal. Due to this change we were also required to print out the record number and send along with the permit request to the DHHA.
		<p>b. Conduct system-wide (across SHC) community-wide screening effort through at least 5,000 free community based individual biometric health screenings, including diabetes screening. Locations in Coronado included the Coronado Community Pharmacy.</p>	<p>Sharp HealthCare Chief Experience Officer</p>	<p>Obesity Screening Education Collaboration</p>	<p>In FY 2015, Sharp HealthCare hosted 75 community health screening events throughout SDC, screening more than 5,200 San Diegans and providing more than 110,000 hours in support of the effort.</p> <p>From the inception of the screenings Sharp HealthCare participated in nearly 200 community health screenings events across San Diego – ultimately screening more than 14,000 San Diegans.</p> <p>The screening program concluded in early 2016.</p> <p>Screenings provided personalized health information at no charge to community members over the age of 18. Participants were not asked to provide personal</p>

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					information, nor were they required to show proof of insurance or have any relationship with Sharp to be eligible for the screening. To encourage participation, identifying and follow-up information was not collected. Appointments were not required, and community members retained the only copy of their results. Community members also received personalized strategies to improve their overall health and well-being.
		c. Utilize findings from the FY 2016 CHNA to assess existing community resources and explore areas where additional diabetes screening and resources may be needed.	Manager, SCHHC Patient and Administrative Relations SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and Health Improvement	Diabetes Education Access to Care Collaboration	In Summer 2016, feedback from the IB community suggests stronger concern for diabetes development education and resource development. Currently diabetes screenings are provided in IB however SCHHC’s Manager of Patient and Administrative Relations and the SHC Diabetes Leadership Team are evaluating opportunities for complimentary partnerships to provide additional diabetes education and resources to the IB community. SHC Program Manager, Community Benefits and Health Improvement to meet with SHC Diabetes Leadership Team regularly to assess additional opportunities for outreach and education.

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	<p>1. Provide free biometric screenings for community members that address risk factors for obesity.</p>	<p>a. Conduct system-wide (across SHC) community-wide screening effort through at least 5,000 free community based individual biometric health screenings, including cholesterol, blood sugar, body mass index (BMI), and blood pressure. Locations in Coronado included the Coronado Community Pharmacy.</p>	<p>Sharp HealthCare Chief Experience Officer</p>	<p>Obesity Screening Education Collaboration</p>	<p>In FY 2015, Sharp HealthCare hosted 75 community health screening events throughout SDC, screening more than 5,200 San Diegans and providing more than 110,000 hours in support of the effort.</p> <p>From the inception of the screenings Sharp HealthCare participated in nearly 200 community health screenings events across San Diego – ultimately screening more than 14,000 San Diegans.</p> <p>The screening program concluded in early 2016.</p> <p>Screenings provided personalized health information at no charge to community members over the age of 18. Participants were not asked to provide personal information, nor were they required to show proof of insurance or have any relationship with Sharp to be eligible for the screening. To encourage participation, identifying and follow-up information was not collected. Appointments were not required, and community members retained the only copy of their results. Community members also received personalized strategies to improve their overall health and well-being.</p>

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Identified Community Health Need: <u>Obesity</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					<p>Though Sharp’s hospitals, including SCHHC provide various nutrition education opportunities for the community, in general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time.</p>
		<p>b. Coordinate and provide BMI and blood pressure screenings to community members at community events.</p>	<p>Manager, SCHHC Rehabilitation Services</p>	<p>Obesity Screening Education Collaboration</p>	<p>SCHHC provided a community wellness event in FY 16 as well as a booth at the Imperial Beach Health Fair in April 2016. At both events SCHHC provided measures of BMI, and education/resources on importance of healthy exercise and diet. More than 100 community members attended both events.</p> <p>SCHHC is currently exploring additional opportunities to collaborate with the Imperial Beach community to address nutrition, access to healthy food and wellness.</p>
		<p>Continue to offer health and wellness services in the new Sewall Healthy Living Center.</p>	<p>Manager, SCHHC Rehabilitation Services SCHHC Director of Ancillary Services</p>	<p>Obesity Screening Education Physical activity Healthy eating</p>	<p>Services available through the Sewall Healthy Living Center include:</p> <ul style="list-style-type: none"> • Memberships for general fitness center access • Personal training sessions for individualized fitness services • Fitness classes for all levels of mobility • Personalized nutrition counseling services

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Identified Community Health Need: <u>Obesity</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
			SCHHC Chief Financial Officer, VP of Clinical Services		<ul style="list-style-type: none"> • A menu of diagnostic health screenings <p>In general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time.</p> <p>However, free, Healthier Living Workshops are provided to community members through Sharp HealthCare’s medical group, Sharp Rees-Stealy, including in areas served by SCHHC. The six-week class teaches how to manage the challenges of living with a chronic disease, including diabetes, high blood pressure, asthma, arthritis and other conditions. Topics include: appropriate exercise for maintaining and improving strength, flexibility and endurance; appropriate use of medications; communicating effectively with family, friends and health professionals; nutrition to improve well-being; techniques to deal with frustration, fatigue, pain and isolation often associated with chronic disease. Family members or friends of someone with an ongoing health condition, as well as community members interested in becoming more physically and socially active, are welcome to attend.</p>

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Identified Community Health Need: Senior Health	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	<p>1. Continue to host a variety of senior health education and screening programs, in order to raise awareness, identify risk factors, and connect seniors to helpful resources.</p>	<p>a. Provide information on various senior issues such as senior mental health, memory loss, hospice, senior services, nutrition, healthy aging and balance and fall prevention</p>	<p>Manager, SCHHC Patient and Administrative Relations</p>	<p>Senior Health Education Collaboration</p>	<p>SCHHC’s provided a community health fair in FY 16 that addressed various senior health issues with education booths, literature handouts and interactive exhibits. In addition, SCHHC was a sponsor at Sharp Hospice’s Aging Conference and continue to partner in their AIM (Live Stronger Longer) events in FY 16. SCHHC continues to explore additional opportunities to provide education and resources to address senior health issues in its community.</p> <p>SCHHC continues to focus on hospital- sponsored free education via radio broadcasts, on local journals, online and in the newspaper. These efforts help to support event attendance. SCHHC will also be hosting a community health fair in October, 2015, which will provide a variety of health screening and education services to community members.</p> <p>Each education and screening program provided by SCHHC is evaluated by participants. Evaluations include point SCHHCs and average evaluation SCHHCs, as well as open-ended questions such as: what was the most important thing participants learned, what other programs seniors (participants) would like.</p>

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Identified Community Health Need: <u>Senior Health</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		b. Continue to participate in community health fairs for seniors	Manager, SCHHC Patient and Administrative Relations	Senior Health Education Screenings Collaboration Behavioral Health	<p>SCHHC has skin cancer screenings for seniors scheduled for Sept. 2016.</p> <p>In addition, senior behavioral health topics were addressed in the annual Aging Conference, and are scheduled for a community event in early FY 2017.</p> <p>SCHHC continues to explore opportunities to provide education and resources to community seniors.</p> <p>Currently exploring opportunities for community event participation – especially those serving older adults.</p>
		c. Coordinate an educational conference in collaboration with Sharp HospiceCare.	Manager, SCHHC Patient and Administrative Relations	Senior Health Education Screenings Collaboration	<p>SCHHC is currently in the planning stages for the Live Stronger Longer event in collaboration Sharp Hospice for early FY17.</p> <p>Each education and screening program provided by SCHHC is evaluated by participants. Evaluations include point SCHHCs and average evaluation SCHHCs, as well as open-ended questions such as: what was the most important thing participants learned, what other programs seniors (participants) would like.</p>

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Identified Community Health Need: <u>Senior Health</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		d. Continue to offer screenings tailored for seniors, including monthly blood pressure clinics, and four to eight types of health screenings annually.	Manager, SCHHC Patient and Administrative Relations	Senior Health Education Screenings Collaboration	SCHHC is planning future screenings to focus on skin cancer and behavioral health due to low attendance at blood pressure clinics. Each education and screening program provided by SCHHC is evaluated by participants. Evaluations include point SCHHCs and average evaluation SCHHCs, as well as open-ended questions such as: what was the most important thing participants learned, what other programs seniors (participants) would like.
	2. Engage and partner with local community organizations that address senior health issues in order to foster future opportunities for collaboration in provision of education, screening, food and other resources to seniors.	a. Maintain active relationships with community organizations serving seniors throughout San Diego, including Rotary, the Steering committee for the Coronado Senior Center, and Meals on Wheels, San Diego County (see Action item “b” below).	Manager, SCHHC Patient and Administrative Relations	Senior Health Education Screenings Collaboration	SCHHC is in the planning stages for a collaboration with Coronado CARES, as well as Sharp Mesa Vista Hospital due to community request for behavioral health event in conjunction with the annual flu clinic. Event planned for FY17 (October). Continued presence on Rotary and Steering Committee for the Coronado Senior Center.

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Identified Community Health Need: <u>Senior Health</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		b. Continue and strengthen partnership with Meals on Wheels San Diego County to serve homebound seniors and other vulnerable community members.	Manager, SCHHC Patient and Administrative Relations	Senior Health Food Insecurity Social Isolation Access to Care Collaboration	<p>SCHHC continues to partner with Meals on Wheels San Diego County, and in FY 2015 the hospital delivered nearly 5,000 meals to Coronado seniors in their homes.</p> <p>In addition to meal service delivery seven days a week, SCHHC’s partnership with Meals on Wheels San Diego County includes the provision of sliding scale payment programs, free pet food, daily wellness checks and more to men and women who are elderly, homebound, disabled, frail or at-risk. Meals on Wheels volunteers also observe the client’s environment for potential health and safety issues and are trained to obtain emergency response if needed. This partnership helps promote independence, reduce social isolation and improve the quality of life and health of participating community members.</p>
	3. Provide coordinated care to patients with advancing progressive chronic disease, in order to improve the individual experience as they near end-of-life.	a. Continue collaboration with Sharp HospiceCare to offer the Transitions program: a program designed to provide home-based palliative care and management for patients with advanced progressive chronic illness. The program is adapted to match each patient’s unique physical, emotional and spiritual needs.	Vice President, Sharp HospiceCare Utilization Review, Sharp HospiceCare	Senior Health Care Management	<p>Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However the Transitions Program is intended for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.</p> <p>Patient and Family Satisfaction Surveys provided to all Transition participants at the end of the program’s “Active Phase” (six weeks).</p>

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Identified Community Health Need: Senior Health	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					Performance Target: 200 admissions across the system each year. In FY 2015, 300 admissions across the system; YTD FY 2016, 178 admissions.
	4. Provide education and outreach to the San Diego community concerning hospice and palliative services within the care continuum, in order to raise awareness of the choices available towards the end of life and empower community members so that they and their family members may take an active role in their treatment.	a. Continue to conduct outreach activities on hospice and palliative care to community agencies, health care facilities, colleges and universities.	Medical Director, Sharp HospiceCare; Manager, SCHHC Patient and Administrative Relations Business Development, Sharp HospiceCare Advance Care Planning Coordinator	Senior Health Education Collaboration	SCHHC’s Patient and Administrative Relations Dept. will continue to support survey and measurement process. All community presentations provided in collaboration with and by Sharp HospiceCare– including those to professional organizations – are evaluated through survey and tracked through an internal Excel database. Survey and data tracking serve to evaluate effectiveness and to document activities for Sharp’s annual Community Benefits Plan and Report. Currently, these strategies are led primarily by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However, these services are provided to community members and patients across Sharp – including Sharp Coronado Hospital and Healthcare Center.
		b. Provide Advance Care Planning Training to physicians, case managers and other health care professionals.	Advance Care Planning Coordinator	Senior Health Education Collaboration	Currently, these strategies are led primarily by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However, these services are provided to community members and patients across Sharp – including Sharp

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					<p>Coronado Hospital and Healthcare Center.</p> <p>In FY 2015, HospiceCare educated more than 500 local, state and national health professionals on ACP and POLST, including, but not limited to case managers from the San Diego Care Transitions Partnership, Grossmont Post-Acute Care, Continuum Healthcare, Senior Care Action Network (SCAN) Health Plan, the Center to Advance Palliative Care (CAPC) National Conference, SDRHCC, Caregiver Coalition of San Diego, SDCCEOLC, San Diego Dementia Consortium, the Sharp HospiceCare Resource & Education Expo, Greater San Diego Business Association and the County of San Diego Ombudsmen Program. In collaboration with the Coalition for Compassionate Care of California (CCCC), the Sharp ACP team also offered a POLST Train-the-Trainer workshop to train community health care providers on POLST.</p>

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Identified Community Health Need: <u>Senior Health</u>	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	5. Increase the availability of education, resources and support to community members with life-limiting illness and their loved ones.	a. Provide 13 mailings of bereavement support newsletters	Bereavement Dept., Sharp HospiceCare	Senior Health Education Care Management	<p>Track number of mailings annually through internal Access/Excel database. In FY 2015, ~1,300 community members received bereavement support newsletters.</p> <p>Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare’s programs are intended for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.</p>
		b. Continue to provide community education and resource services throughout San Diego	Business Development Dept., Sharp HospiceCare	Senior Health Education Care Management	<p>Track number of community education events through internal database.</p> <p>In FY 2015, Sharp HospiceCare collaborated with community organizations to provide more than 2,400 community members with end-of-life education and outreach at a variety of churches, senior living centers, and community health agencies and organizations throughout SDC, as well as through participation in community health fairs and events.</p> <p>Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare’s programs are intended</p>

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					for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.
		c. Continue to offer individual and family bereavement counseling and support groups	Bereavement Dept., Sharp HospiceCare	Senior Health Care Management	Track number of individual and group counseling sessions through internal database. In FY 2015, the Healing After Loss and the Widow’s and Widower’s ongoing bereavement support groups served approximately 200 community members. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare’s programs are intended for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.
		d. Provide Advance Care Planning (ACP) for community groups as well as individual consultations	Advance Care Planning Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of sessions and individual consultations through Allscripts Business Unit, Excel spreadsheet and participant evaluations. Quarterly community presentations offered throughout San Diego County. In FY 2015, the program engaged approximately 2,500 community members in free ACP and POLST (Physician Orders for Life-Sustaining Treatment) education at a variety of community sites, including health fairs, senior

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					<p>centers, homecare agencies, churches and seminars.</p> <p>Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare’s programs are intended for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.</p>
	<p>6. Collaborate with community, state and national organizations to develop and implement appropriate services for the needs of the aging population.</p>	<p>a. Continue active involvement with and participation on state and national hospice organizations (California hospice and Palliative Care Association (CHAPCA) the NHPCO Leadership etc.) included presentations on understanding late-stage illness, changing our culture of care to one of partnership and a continuum of care perspective, advanced care planning, etc.</p>	<p>Vice President, Sharp HospiceCare</p> <p>Medical Director, Sharp HospiceCare</p> <p>Advance Care Planning Coordinator</p> <p>Business Development Dept., Sharp HospiceCare</p>	<p>Senior Health Education Collaboration</p>	<p>Sharp HospiceCare provides approximately six presentations each year in collaboration with state and national organizations.</p> <p>All community presentations provided through Sharp HospiceCare– including those to professional organizations – are evaluated through survey to evaluate effectiveness.</p> <p>Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare’s programs are intended for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.</p>

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Identified Community Health Need: Senior Health	Objectives/ Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		b. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	Business Development Dept., Sharp HospiceCare	Senior Health Caregivers Collaboration	<p>New community partnership: Lantern Crest in Santee; Elmcroft of San Diego (throughout the County as well as additional home care facilities).</p> <p>Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare’s programs are intended for community members and patients served across Sharp – including Sharp Coronado Hospital and Healthcare Center.</p>