Sharp Grossmont Hospital 2019 CHNA Executive Summary

Introduction and Background

Sharp HealthCare (Sharp) has been a long-time partner in the process of identifying and responding to the health needs of the San Diego community. This partnership includes a broad range of hospitals, health care organizations, and community agencies that have worked together to conduct triennial Community Health Needs Assessments (CHNAs) for more than 20 years. Previous collaborations among not-for-profit hospitals and other community partners have resulted in numerous well-regarded CHNA reports. Sharp hospitals, including Sharp Grossmont Hospital (SGH), base their community benefit and community health programs on the findings of these needs assessments as well as the combination of expertise in programs and services offered and the knowledge of the populations and communities served by each Sharp hospital.

The Sharp Grossmont Hospital 2019 Community Health Needs Assessment (CHNA) examines the health needs of the community members it serves in San Diego County (SDC). SGH prepared this CHNA for Fiscal Year 2019 (FY 2019) in accordance with the requirements of Section 501(r)(3) within Section 9007 of the Patient Protection and Affordable Care Act (“Affordable Care Act”) enacted in March 2010, and IRS Form 990, Schedule H for not-for-profit hospitals. SGH’s 2019 CHNA process and findings are based on the collaborative Hospital Association of San Diego and Imperial Counties (HASD&IC) 2019 Community Health Needs Assessment process and findings for SDC.

The HASD&IC 2019 CHNA is implemented and managed by a standing CHNA Committee comprised of representatives from seven hospitals and health systems. Sharp is an integral hospital partner in the HASD&IC 2019 CHNA. This Committee reports to the HASD&IC Board of Directors who provide policy direction and ensure that the interests of all member hospitals and health systems are met. HASD&IC contracts with the Institute for Public Health (IPH) at San Diego State University (SDSU) to perform the CHNA. The HASD&IC 2019 CHNA Committee includes representatives from the following San Diego hospitals and health care systems:

- Kaiser Foundation Hospital – San Diego
- Palomar Health
- Rady Children’s Hospital – San Diego
- Scripps Health (Chair)
- Sharp HealthCare (Vice Chair)
- Tri-City Medical Center
- University of California San Diego Health
The process and findings of the collaborative HASD&IC 2019 CHNA significantly informed the SGH 2019 CHNA, and was further supported by additional data analyses and community engagement activities specific to the community served by SGH. The findings of the SGH 2019 CHNA will be used to help guide current and future community health programs and services at SGH, particularly for high need community members. In addition, SGH will make publicly available its three-year implementation strategy — a federally-required written strategy to address the needs identified through the SGH 2019 CHNA process.

The CHNA is considered adopted once it has been made widely available to the public. In addition, the CHNA and the implementation strategy must be approved by an authorized governing body of the hospital facility.

2019 CHNA Objectives

The 2019 CHNA processes (HASD&IC and Sharp) built on the results of the 2016 CHNA and included three types of community engagement efforts: focus groups with residents, patients and their family members, community-based organizations, service providers, and health care leaders; key informant interviews with health care experts; and online surveys for residents, patients and stakeholders. In addition, the CHNA included extensive quantitative analysis of national and state-wide data sets, SDC emergency department and inpatient hospital discharge data, community clinic usage data, county mortality and morbidity data, and data related to social determinants of health (SDOH). These different approaches allowed for the capability to view community health needs from multiple perspectives.

Specific objectives of the 2019 CHNA process included:

- To identify, understand and prioritize the health-related needs of the people of SDC, especially those community members served by Sharp.
- Provide a deeper understanding of barriers to health improvement in SDC and to inform and guide local hospitals in the development of their programs and strategies that address identified community health needs.
- Build on and strengthen community partnerships established through the 2016 CHNA processes.
- Obtain deeper feedback from and about specific vulnerable populations in San Diego.
- Align with national best practices around CHNA development and implementation, including the integration of health conditions with SDOH.
Community Defined

For the purposes of the collaborative, HASD&IC 2019 CHNA, the study area is the entire County of San Diego due to a broad representation of hospitals in the area. More than three million people live in socially and ethnically diverse SDC. Information on key demographics, socioeconomic factors, access to care, health behaviors, and the physical environment can be found in the full HASD&IC 2019 CHNA report at: https://hasdic.org/2019-chna/.

The community served by SGH includes the entire east region of SDC, including the sub-regional areas of Jamul, Spring Valley, Lemon Grove, La Mesa, El Cajon, Santee, Lakeside, Harbison Canyon, Crest, Alpine, Laguna-Pine Valley and Mountain Empire. Approximately five percent of the population lives in remote or rural areas of this region. Table 1 below presents the ZIP codes where the majority of SGH patients reside. As SGH’s primary communities are in SDC’s east region, CHNA demographics provided at the regional level focus on SDC’s east region, for the most accurate reflection of the community served by SGH.

Table 1: Primary Communities Served by SGH

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<thead>
<tr>
<th>ZIP Code</th>
<th>Community</th>
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<tbody>
<tr>
<td>91941</td>
<td>La Mesa</td>
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<tr>
<td>91942</td>
<td>La Mesa</td>
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<tr>
<td>91945</td>
<td>Lemon Grove</td>
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<td>91977</td>
<td>Spring Valley</td>
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<td>92019</td>
<td>El Cajon</td>
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<td>92020</td>
<td>El Cajon</td>
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<tr>
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<td>El Cajon</td>
</tr>
<tr>
<td>92040</td>
<td>Lakeside</td>
</tr>
<tr>
<td>92071</td>
<td>Santee</td>
</tr>
<tr>
<td>92114</td>
<td>Encanto</td>
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Source: Centricity HPA via Merlin (internal data warehouse), Sharp HealthCare, FY 2018.

Recognizing that health needs differ across the region and that socioeconomic factors impact health outcomes, SGH’s 2019 CHNA process utilized the Dignity Health Community Need Index (CNI) to identify communities with the highest level of health disparities and needs. Table 2 below presents primary communities (by ZIP code) served by SGH that have especially high need based on their CNI score.
Table 2: High-Need Primary Communities Served by SGH, CNI Score > 4.0

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<tr>
<th>ZIP Code</th>
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<tr>
<td>91945</td>
<td>Lemon Grove</td>
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<td>91977</td>
<td>Spring Valley</td>
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<td>92020</td>
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<td>92021</td>
<td>El Cajon</td>
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<tr>
<td>92114</td>
<td>Encanto</td>
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</table>

Source: Dignity Health Community Need Index. 2018.

Methodology

The HASD&IC 2019 CHNA process and findings significantly informed the SGH 2019 CHNA process and as such are described as applicable throughout this report. For complete details on the HASD&IC 2019 CHNA process, please visit the HASD&IC website at: www.hasdic.org or contact Lindsey Wade at lwade@hasdic.org.

For the HASD&IC 2019 CHNA, quantitative analyses of publicly available data provided an overview of critical health issues across SDC, while qualitative analyses of feedback from the community provided an appreciation for the experiences and needs of San Diegans. The CHNA Committee reviewed these analyses and applied a pre-determined set of criteria to them to prioritize the top health needs in SDC. This process is represented in Figure 1 below.
Figure 1: HASD&IC 2019 CHNA – Process Map

2019 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) PROCESS MAP

Community Engagement Activities
- Identify and explore priority health needs, social determinants of health, barriers to care, community assets and resources

2016 CHNA FINDINGS
- Identify and explore priority health needs, social determinants of health, community health statistics

Electronic Survey
- Community residents, community-based organizations, Federally Qualified Health Centers, hospitals and health systems, local government agencies, philanthropic organizations, and San Diego County Public Health Services

Data Collection & Analysis
- Demographics
  - Sex, age and race/ethnicity
- Hospital & Clinic Utilization
  - ED discharges, hospitalizations, and community clinic visits

Focus Groups
- Community residents, students, parents, patients, community advisory members, health experts, service providers, and front-line staff at social service agencies

Hospital & Clinic Utilization

Key Informant Interviews
- Community leaders and health experts representing Federally Qualified Health Centers, schools, and social service organizations

Morbidity & Mortality
- Disease prevalence and leading causes of death

Public Health Department Input
- County of San Diego Public Health Department and Health and Human Services Agency

Social Determinants of Health & Health Behaviors
- Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes

Identification & Prioritization of Needs

2019 CHNA PHASE 1 REPORT
Quantitative/Secondary Data

Quantitative data were drawn from several public sources to support the HASD&IC and SGH 2019 CHNAs. Data from the Dignity Health CNI and the Public Health Alliance of Southern California’s Healthy Places Index (HPI) were used to identify geographic communities in SDC that were more likely to be experiencing health inequities, which guided the selection of communities/individuals for community engagement activities (described below), as well as the development of community engagement questions.

Hospital discharge data exported from SpeedTrack’s California Universal Patient Information Discovery, or CUPID application were used to identify current and three-year trends in primary diagnosis discharge categories and were stratified by age and race. This allowed for the identification of health disparities and the conditions having the greatest impact on hospitals and health systems in SDC.

Data from national and state-wide data sets were analyzed including SDC mortality and morbidity data, and data related to SDOH. In addition, Kaiser Permanente consolidated data from several national and state-wide data sets related to a variety of health conditions and SDOH in SDC and conducted a comprehensive statistical analysis to identify which SDOH were most predictive of negative health outcomes. Kaiser Permanente then created a web-based data platform (chna.org/kp) to post these analyses for use in the CHNA.

Analysis specific to SGH inpatient and emergency department (ED) data was also conducted in addition to the analyses described above. Further, Sharp Cancer Registry Data was also incorporated into the SGH 2019 CHNA quantitative analyses.

Community Engagement

HASD&IC 2019 CHNA community engagement activities included focus groups, key informant interviews, and an online survey designed to reach stakeholders from every region of SDC, all age groups, and numerous racial and ethnic groups. Collaboration with the County of San Diego Health & Human Services Agency, Public Health Services was vital to this process. A total of 579 individuals participated in the 2019 CHNA: 138 community residents and 441 leaders and experts. Please see Figure 2 below for details on the types of participants engaged.
In addition to an active role in the collaborative HASD&IC 2019 CHNA process, Sharp contracted separately with the IPH at SDSU to conduct a number of community engagement activities to collect input specifically from Sharp HealthCare providers as well as from patients and community members served by Sharp hospitals. This input focused on behavioral health, cancer, diabetes, maternal and prenatal care, senior health (now termed aging concerns), and the needs of highly vulnerable patients and community members. These additional efforts included focus groups and key informant interviews involving 50 Sharp providers and 14 patients/community members. Further, IPH created case studies with the intent of representing a “typical” patient experience within Sharp. The case studies focused specifically on breast cancer and high-risk pregnancy. Data collected during the community engagement activities and from literature reviews supported development of the case studies.

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Lastly, the SGH 2019 CHNA community engagement process included a robust online survey conducted through the Sharp Insight Community. The Sharp Insight Community is a private online environment for Sharp patients and their families, community members, Sharp employees, and Sharp-affiliated physicians. The 2019 CHNA Sharp Insight Community online survey sought to obtain feedback on the top health and social needs faced by SDC community members, as well as assess their awareness of community outreach programs offered by Sharp. The online survey also provided participants the opportunity to provide specific suggestions for Sharp to improve community health and well-being. A total of 380 community members completed the online survey. Figure 3 below summarizes SGH 2019 CHNA community engagement:
Prioritization of 2019 Health Needs

The CHNA Committee collectively reviewed the quantitative and qualitative data and findings. Several criteria were applied to the data to determine which health conditions were of the highest priority in SDC. These criteria included: the severity of the need; the magnitude/scale of the need; disparities or inequities; and change over time. Those health conditions and SDOH that met the largest number of criteria were then selected as top priority community health needs.

As the HASD&IC 2019 CHNA process included robust representation from the communities served by SGH, this prioritization process was replicated for the SGH 2019 CHNA.

Findings: Top 10 Community Health Needs

The 2019 CHNA Committee identified the following as the highest priority community health needs in SDC, (in alphabetical order by SDOH or health condition).

Figure 4: 2019 CHNA Top 10 Community Health Needs for San Diego County

Figure 4 above illustrates the interactive nature of SDOH and health conditions — each impacting the other. In addition, an underlying theme of stigma and the barriers it creates arose across 2019 CHNA community engagement activities. For instance, stigma impacts the way in which people access needed services that address SDOH, which consequentially impacts their ability to maintain and manage health conditions.
These same findings were supported through both the quantitative analyses and community engagement activities conducted as part of the SGH 2019 CHNA. In addition, Maternal and Prenatal Care, including High-Risk Pregnancy, was also identified as a community health need by the SGH 2019 CHNA.

**Description of Identified Needs**

**Access to health care.** Overcoming barriers to health care, such as lack of health insurance and insurance issues, economic insecurity, transportation, the shortage of culturally competent care, fears about immigration status, and the shortage of health care providers emerged as a high priority community need. In addition, specific services were identified as challenging to obtain, including behavioral health care, dental care, primary care, and specialty care.

**Aging concerns.** Conditions that predominantly affect people who are 65 and older — such as Alzheimer’s disease, Parkinson’s disease, dementia, falls, and limited mobility — were identified as a high priority health need. Community engagement participants most often described aging concerns in relation to the SDOH, including: transportation, access to fresh food, social isolation and inadequate family support, and economic insecurity.

**Behavioral health.** Greater access to behavioral health care was cited as a priority health need. Three types of behavioral health care were identified as challenging to access: urgent care services for crisis situations; inpatient psychiatric beds and substance abuse facilities; and transitional programs and services for post-acute care. In addition, several barriers to behavioral health care were named as priorities to address, including a lack of availability of needed services and appointments, insurance issues, logistical issues, such as transportation and time off work, and the inability to pay co-pays and deductibles.

**Cancer.** Health needs related to cancer were described in relation to the effects on well-being beyond physical health. These include financial, practical, and emotional impacts on individuals and families; these effects are exacerbated by barriers to cancer care.

**Chronic conditions.** Three chronic conditions were identified as priorities: cardiovascular disease, diabetes, and obesity. Key factors that individuals struggle with to prevent chronic diseases include access to fresh, healthy foods and safe places to exercise and play. In addition, economic issues, transportation to medical care, fears about immigration status, and a lack of knowledge about chronic conditions were named as particular challenges related to the management of chronic conditions.

**Community and social support.** A high priority for the well-being of San Diego residents is ensuring that individuals have adequate resources and substantial support within their neighborhood. Valuable neighborhood resources include federally qualified health centers (FQHCs) and those that are culturally and linguistically competent. Without adequate support from others, community engagement and community spirit are affected.
Economic security. Economic security was described as a vital social factor impacting every aspect of San Diegans’ daily lives. The health of the economically insecure is worsened by food insecurity, chronic stress and anxiety, and reduced capability to manage health needs. Economically insecure community members are at greater risk of poor mental health days, asthma, obesity, diabetes, stroke, cancer, smoking, pedestrian injury and visits to the emergency department for heart attacks. Low wages, housing and childcare costs were identified as contributors to economic insecurity.

Education. Receiving a high school diploma, having the opportunity to pursue higher or vocational education, being health literate, and having opportunities for non-academic continuing education were identified as important priorities for the health and well-being of San Diego residents. Family stress and a lack of school and community resources were identified as factors underlying low levels of educational attainment.

Homelessness and housing instability. Homelessness and housing instability were identified as critical factors affecting the health of San Diegans. Serious health impacts of these issues were cited, including increased exposure to infectious disease, substantial challenges in chronic disease and wound care management (e.g., asthma), and increased stress and anxiety.

Maternal and prenatal care, including high-risk pregnancy. Maternal and prenatal care were cited as critical components of health and well-being. Maternal health is often complicated by co-existing health conditions including diabetes, preterm pregnancies, substance use, postpartum depression, anxiety, and other mood disorders. In addition, a number of SDOH present obstacles to maternal and prenatal care, such as lack of access to mental health services (even for those patients with insurance), lack of transportation, and economic stress related to childcare and maternity leave.

Unintentional injury and violence. Exposure to violence and neighborhood safety were cited as priority health needs for San Diegans. Neighborhood safety was discussed as influencing residents’ ability to maintain good health, while exposure to violence was described as traumatic and impactful on mental health.
Community Assets & Recommendations

The 2019 CHNA identified many health resources in SDC, including those provided by community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. In addition, 2-1-1 San Diego is an important community resource and information hub that facilitates access to services. Through its 24/7 phone service and online database, as well as a host of innovative navigation and support programs, 2-1-1 San Diego helps connect individuals with community, health, and disaster services.

2-1-1 San Diego researched their database using relevant search terms for each identified need. The number of resources located for each need are listed below:

- Aging Concerns: 91
- Access to Care: 260
- Behavioral Health: 703
- Cancer: 129
- Cardiovascular Disease: 161
- Diabetes: 144
- Maternal and Prenatal Care, including High-Risk Pregnancy: 251
- Obesity: 298
- Social Determinants of Health: 5,836 (transportation, food access, etc.)

In addition to community input on health conditions and SDOH, a wealth of ideas emerged from community engagement participants about how hospitals and health systems could support additional resources and partner with organizations to help meet San Diego’s community health needs. Figure 5 below outlines types of resources identified by community engagement participants:
RESOURCES & OPPORTUNITIES
TO ADDRESS PRIORITY HEALTH NEEDS

Community engagement participants identified three means by which the identified health needs could be better addressed:

1. The implementation of overarching strategies to address the health needs,
2. The development or expansion of resources to meet the needs,
3. The creation of systemic, policy, and environmental changes to better support health outcomes.

All of these approaches, participants emphasized, would require collaboration between political, health care system, and community leaders, health care professionals, community organizations, and residents.

**STRATEGIES**

1. Increase community knowledge with educational campaigns that promote available services within the community, clinics, and hospitals
2. Address potential barriers to care such as insurance, translation, navigation services, transportation, and potential impacts on immigration status
3. Improve patient experience through culturally competent health navigators and case managers, care coordination, and community clinical linkages including language services

**RESOURCES**

1. Urgent care services that include expanded hours, availability to all populations, and mental health and substance use services
2. Preventative care programs that offer services such as immunizations (including the flu vaccine), HIV testing, and exercise programs
3. Dental services for preventive care and to address oral health issues such as cavities and gum disease
4. Onsite programs and mobile units that bring services to the community, including programs in senior housing complexes, school clinics, mobile screening, and mobile food distribution
5. Culturally competent programs for refugees, Native Americans, Latinos, Blacks, African Americans, LGBTQ individuals, non-citizens, and asylum seekers
6. Programs for the youth, especially community centers and programs for young men and for homeless youth
7. Homeless services and discharge support, including mobile showers, more shelters, and further options for post-acute recuperative care
8. Food insecurity navigation that includes reference guides for food system/service navigation of San Diego County, private, and non-profit organizations, and signage for healthy food options for CalFresh/Supplemental Nutrition Assistance Program (SNAP) users at stores and restaurants

**SYSTEMIC CHANGE**

1. Create universal and/or affordable health care
2. Increase minimum wage
3. Fund policies: increase applications for federal funding and allow more time to prove a return on investment (ROI) for funding

**COLLABORATION**

1. Form partnerships with community residents by engaging residents in advocacy
2. Share and disseminate information and data back into the communities from where the data came from
3. Work with communities to adapt programs and interventions to the unique needs of minority groups (go beyond collective impact approach)
4. More collaboration between social workers, law enforcement, and attorneys
5. Warm hand-offs between agencies and organizations
Further, as part of Sharp’s 2016 CHNA Phase 2 process, the Sharp CHNA Community Guide was developed and made publicly available on Sharp.com at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm. The Sharp CHNA Community Guide seeks to provide community members with a user-friendly resource to learn about Sharp’s CHNA process and findings, as well as the identified health and SDOH needs addressed through Sharp programs. The Sharp CHNA Community Guide also provides a direct link for community members to provide feedback on Sharp’s CHNA. An updated Sharp CHNA Community Guide will be publicly available on sharp.com during early- to mid- 2020.

Implementation Strategy

SGH developed its FY 2020 – FY 2023 Implementation Strategy to address the needs identified through the 2019 CHNA process for the community it serves. Many of the programs included in the implementation strategy have been in place at SGH for several years. SGH leadership, Sharp Community Benefit and team members across Sharp are committed to an ongoing evaluation of the programs provided to address the needs of SGH’s community members. The SGH FY 2020 – FY 2023 Implementation Strategy is submitted along with the IRS Form 990, Schedule H, and will be publicly available on Guidestar (http://www.guidestar.org/) in the coming months. Categories of programs and activities included in the SGH FY 2020 – FY 2023 Implementation Strategy are summarized in Table 3 below:

Table 3: SGH FY 2020 – FY 2023 Implementation Strategy Summary

<table>
<thead>
<tr>
<th>ACCESS TO CARE &amp; HEALTH INSURANCE</th>
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<tbody>
<tr>
<td>● Provide “Public Resource Specialist” position in Sharp Patient Access Services (PAS) to offer support for underinsured and uninsured patients needing advanced guidance on available funding options.</td>
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<tr>
<td>● Increase coverage for patients seen in the ED 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.</td>
</tr>
<tr>
<td>● Provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.</td>
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<tr>
<td>● Sharp Integrated Care Management (ICM) is working more aggressively with Sharp PFS to ensure patients are aware of all funding opportunities for which they may be eligible.</td>
</tr>
<tr>
<td>● Collaborate with 2-1-1 San Diego to provide the Care Transitions Intervention (CTI) program which proactively screens high-need patients for SDOH needs, and then proactively refers them to 2-1-1 San Diego’s Health Navigation program for connection to community resources.</td>
</tr>
<tr>
<td>● Participate in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs.</td>
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<thead>
<tr>
<th>AGING CONCERNS</th>
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<tr>
<td>● Provide seasonal flu vaccines to seniors with limited mobility and who lack transportation (SGH Senior Resource Center).</td>
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<tr>
<td>● Support the safety net for seniors living along in SDC’s east region through daily telephone reassurance calls (SGH Senior Resource Center).</td>
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- Host a variety of community senior health education and screening programs in order to raise health education/awareness, identify risk factors and connect seniors and caregivers to resources (SGH Senior Resource Center); collaborate with Sharp HospiceCare for annual community education events for caregivers.
- Maintain active relationships with community organizations serving seniors throughout SDC’s east region (board service, financial support, event management, etc.).
- Plan and provide community education events for seniors around SDOH (e.g., food insecurity, etc.).

**BEHAVIORAL HEALTH**

- Provide comprehensive behavioral health programs to adults and older adults in East County with acute or persistent psychiatric disorders. Includes: a dedicated psychiatric assessment team in the ED and acute care; hospital-based outpatient programs that serve adults with a variety of behavioral health issues (e.g., schizophrenia, depression, anxiety, etc.); and specialized inpatient treatment programs designed to address the specific needs and conditions of patients.
- Participate in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs.

**CANCER**

- Provide free education and support programs for community members with cancer diagnoses, and their families/loved ones.
- Provide ongoing social and psychosocial supports to community member with cancer diagnoses.
- Continue to conduct comprehensive community cancer health seminars with health screenings in English and Spanish.
- Participate in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs.

**CARDIOVASCULAR**

- Provide free bimonthly cardiac education classes, and monthly congestive heart failure education classes and support groups.
- Provide educational sessions on heart disease and cardiovascular health for SDC’s east region, as well as blood pressure screenings.
- Continued participation in the San Diego County Stroke Consortium.
- Through the City of San Diego partnership, provide stroke education and resources to City employees as well as community residents.
- Provide weekly support groups for stroke survivors and their families.

**COMMUNITY & SOCIAL SUPPORT**

- Participate in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs.

**DIABETES**

- Increase education of signs and symptoms of diabetes in SDC’s east region through participation in community educational forums and health fairs and events.
- Provide diabetes education to high-risk pregnant women with diabetes through affiliation with the CA Diabetes and Pregnancy Program’s “Sweet Success” Program and in collaboration with community clinics who serve underserved pregnant women with diabetes (in FY 2018, SGH served more than 200 women through this program).
- Collaborate with community clinics (i.e., Family Health Centers of San Diego) to provide diabetes education classes at clinic sites.
- Offer and create new (as needed) language-appropriate and culturally sensitive diabetes educational materials. To date this has included materials in Arabic, Somali, Tagalog, Vietnamese and Spanish.

**ECONOMIC SECURITY**
• Please see financial support activities listed under Access to Care.
• Participate in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs.
• Continue to connect high-risk, underfunded patients and community members to local resources and organizations for low-cost medical equipment and follow-up care. SGH case managers and social workers actively seek DME donations from the community and SGH Volunteer Services.

EDUCATION
• Collaborate with local schools to provide opportunities for students to explore and train for a variety of health care professions. Includes: undergraduate and graduate student internships, as well as career pathway programs for high school-age students and younger in SDC’s east region (e.g., Health Sciences High and Middle College; Health-Career Summer Institute; Healthcare Towne; I Inspire).
• Provide a variety of health and wellness education and services at events and sites throughout the community through the City of San Diego partnership (includes both City employees and residents).

HOMELESSNESS & HOUSING INSTABILITY
• In FY 2019, in conjunction with the passing and signing of SB 1152, Hospital Discharge Processes: Homeless Patients, Sharp HealthCare develop formalized processes, procedures, and protocols to improve care for patients experiencing homelessness. This work includes technology to track and measure care and utilization of individuals experiencing homelessness served within the SHC system.
• For FY 2020, Sharp Integrated Care Management (ICM) will use captured data to isolate trends and gaps in care related to homeless populations served. The SB1152 Task Force (formally Homeless Task Force) will use the data to identify action planning for go-forward.
• Participate in the one-year pilot/partnership with 2-1-1 San Diego Community Information Exchange (CIE) to increase assessment for social determinant of health needs (SDOH) and connection to community resources addressing those SDOH needs.

MATERNAL & PRENATAL CARE, INCLUDING HIGH-RISK PREGNANCY
• Provide education, outreach and support to help meet the unique needs of women, mothers and newborns throughout the community.
• Collaborate with community organizations to help raise awareness of women’s health issues and services, as well as to provide low-income and underserved women in the San Diego community with support and critical prenatal services.
• Continue to participate in and partner with community organizations and advisory boards for maternal and child health.

OBESITY
• Provide free education and screenings for community members that address risk factors for obesity; includes both community body mass index and blood pressure screenings.

UNINTENTIONAL INJURY & VIOLENCE
• Through the Sharp ThinkFirst/Sharp on Survival Program, offer talks and opportunities within SDC’s east region to Health and Science Pipeline Initiative (HASPI) high school students on injury, violence prevention and health care career readiness (as grant funding allows).
Next Steps

SGH is committed to the health and well-being of its community, and the findings of SGH’s 2019 CHNA will help inform the activities and services provided by SGH to improve the health of its community members. These programs are detailed in SGH’s FY 2020 – FY 2023 Implementation Strategy, which will be made available online to the community at: http://www.sharp.com/about/community/health-needs-assessments.cfm.

Sharp will continue to work with HASD&IC and IPH as part of the CHNA Committee to develop and implement Phase 2 of the 2019 CHNA. In addition, beginning with Phase 2, Grossmont Healthcare District will join the HASD&IC CHNA Committee. Phase 2 will focus on continued engagement of community partners to analyze and improve the CHNA process, as well as refine hospital implementation strategies. Thus, the CHNA process will evolve to meet the needs of San Diegans, and support the work of our community partners who also address identified community health needs. This will include a deeper dive into the impact of stigma on health, and an exploration of how hospitals may help address this impact.

In addition, in the first year of Sharp’s FY 2020 – FY 2023 Implementation Strategy, Sharp hospitals (including SGH), medical groups, and health plans are embarking on a new, innovative partnership with 2-1-1 San Diego’s Community Information Exchange (CIE). The CIE includes a longitudinal client record with community member history, access to and utilization of social programs (e.g., housing, food banks, community clinics, etc.), emergency transport data, and much more. The CIE also includes a direct-referral feature, which allows for documented, bi-directional, close-loop referrals between all CIE partners — including hospitals, clinics, and social service programs. Currently, there are more than 60 community partners (organizations) participating in CIE, and more than 100,000 community members enrolled, with approximately 4,500 new community members enrolled each month. Sharp HealthCare is the first integrated health system — including its hospitals, medical groups and health plan — to participate in the CIE as a health care system. By leveraging this technology, and expanding upon this capability for shared data, consistent tracking and robust reporting, the CIE partnership presents an exciting opportunity for Sharp to strengthen and evaluate the impact of clinical-community linkages for its patients and community members in need, particularly regarding SDOH. The data collected in this one-year partnership will inform the value case for continuing with the partnership after the pilot year (Summer 2020).

The complete Sharp Grossmont Hospital 2019 Community Health Needs Assessment will be available for public download by September 30, 2019 at: http://www.sharp.com/about/community/health-needs-assessments.cfm. The report is also available by contacting Sharp HealthCare Community Benefit at: communitybenefits@sharp.com.

Sharp extends our deepest thanks for the contributions made by all who participated in the 2019 CHNA process. Further, Sharp is committed to providing a CHNA that is valuable to all our community partners, and we look forward to strengthening that value and those community partnerships in the years to come.