Sharp McDonald Center
Community Health Needs Assessment
Fiscal Year 2019

Committed to Improving the Health and Well-Being of Our Community
Sharp McDonald Center 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 McDonald Center (SMC), base their community benefit and community health programs on both the findings of these needs assessments and the combination of expertise in programs and services offered and the knowledge of the populations and communities served by each Sharp hospital.

SMC 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”), and IRS Form 990, Schedule H for not-for-profit hospitals.¹

The Sharp McDonald Center 2019 Community Health Needs Assessment (CHNA) examines the health needs of the community members it serves in San Diego County (SDC). SMC’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 needs assessment. 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 SMC 2019 CHNA and was further supported by additional data analysis and community engagement activities specific to the community served by SMC. The findings of the SMC 2019 CHNA will be used to help guide current and future community health programs and services at SMC, particularly for high need community members. In addition, SMC will develop and make publicly available, its three-year implementation strategy to address the needs identified through the SMC 2019 CHNA process.

Under the Affordable Care Act enacted in March, 2010, IRS Code Section 501(r)(3) requires not-for-profit hospitals to conduct a triennial assessment of prioritized health needs for the communities served by its hospital facilities, as well as adopt an implementation plan — a written strategy to address the health needs identified as a result of the CHNA. 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, San Diego County 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/.

SMC is the only medically supervised substance abuse recovery center in SDC. As such, the community served by SMC includes SDC as a whole, including all six regions: central, east, north central, north coastal, north inland and south. Table 1 below presents the ZIP codes where the majority of SMC patients reside.

Table 1: Primary Communities Served by SMC

<table>
<thead>
<tr>
<th>ZIP Code</th>
<th>Community</th>
<th>ZIP Code</th>
<th>Community</th>
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<tbody>
<tr>
<td>91910</td>
<td>Chula Vista</td>
<td>92106</td>
<td>Point Loma</td>
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<td>91932</td>
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<td>La Mesa</td>
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<td>University City</td>
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<tr>
<td>92071</td>
<td>Santee</td>
<td>92126</td>
<td>Mira Mesa</td>
</tr>
<tr>
<td>92101</td>
<td>Downtown San Diego</td>
<td>92128</td>
<td>Carmel Mtn. Ranch</td>
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<tr>
<td>92103</td>
<td>Hillcrest</td>
<td>92129</td>
<td>Rancho Penasquitos</td>
</tr>
<tr>
<td>92105</td>
<td>City Heights</td>
<td>92131</td>
<td>Scripps Ranch</td>
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</table>

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, SMC’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 SMC that have especially high need based on their CNI score.

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<td>Linda Vista</td>
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Source: Dignity Health Community Need Index. 2018.

**Methodology**

The HASD&IC 2019 CHNA process and findings significantly informed the SMC 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: [https://hasdic.org/2019-chna/](https://hasdic.org/2019-chna/) 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
Quantitative/Secondary Data

Quantitative data were drawn from several public sources to support the HASD&IC and SMC 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 SMC inpatient data was also conducted in addition to the analyses described above.

Community Engagement

HASD&IC 2019 CHNA community engagement activities included focus groups, key informant interviews, and an online survey which targeted 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 a case study 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.
For SMC, the most directly relevant input focused on behavioral health and came from facilitated discussions with Sharp case managers and social workers, as well as from patients and community members that participate in SMC’s Aftercare program. The Aftercare program helps substance abuse/behavioral health patients maintain a sober lifestyle with support through the necessary transitions at home, work and in the community.

Lastly, the SMC 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 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 SMC 2019 CHNA community engagement:

Figure 3: SMC 2019 CHNA – Summary of Community Engagement Activities

2 Key Informant Interviews/Case Studies + 50 Focus Group Participants + 380 Survey Participants = 432 Community Participants
Figure 3: SMC 2019 CHNA – Summary of Community Engagement Activities

<table>
<thead>
<tr>
<th>Health Need/Population Served</th>
<th>Activity</th>
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</table>
| Aging Concerns               | - Sharp Senior Health Centers Staff Focus Group  
|                              | - Senior Community Member Focus Group    |
| Behavioral Health            | - Sharp McDonald Center Aftercare Support Group (community residents) |
| Cancer                       | - Sharp Cancer Patient Navigator & Social Worker Focus Group  
|                              | - Sharp Key Informant Interview  
|                              | - Sharp Case Study |
| Diabetes                     | - Sharp Diabetes Health Educator Focus Group |
| Maternal and Prenatal Care, Including High-Risk Pregnancy | - Sharp Mary Birch Hospital Case Manager & Social Worker Focus Group  
|                              | - Sharp Key Informant Interview  
|                              | - Sharp Case Study |
| Special Populations          | - Sharp Patient Family Advisory Council (PFAC - community residents)  
|                              | - Sharp Case Management Leadership Focus Group |
| Community Residents/Sharp Patients | Sharp Insight Community Survey (online) |
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 SMC, this prioritization process was replicated for the SMC 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 analysis and community engagement activities conducted as part of the SMC 2019 CHNA. In addition, Maternal and Prenatal Care, including High-Risk Pregnancy, was also identified as a community health need by the SMC 2019 CHNA.

However, as a specialty hospital providing substance use disorder programs and recovery services, many of these identified health needs – including cancer, cardiovascular disease, diabetes, obesity, unintentional injury, and maternal and prenatal care – fall outside the scope of services provided by SMC, and thus are not addressed through SMC’s programs or activities. However, considering these findings, SMC continues to explore partnerships and strategies that address the connection between behavioral health (including substance use) and physical health conditions, and has made some strides in this area. For details, please refer to SMC’s FY 2020 – FY 2023 Implementation Strategy at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

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, 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:
Figure 5: 2019 CHNA – Resources and Opportunities to Address Identified Health Needs

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 caries 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 social 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

SMC 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 SMC for several years. In addition, SMC leadership, Sharp Community Benefit and team members across Sharp are committed to an ongoing evaluation of the programs provided to address the needs of SMC’s community members. The SMC 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 SMC FY 2020 – FY 2023 Implementation Strategy are summarized in Table 3 below:

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

<table>
<thead>
<tr>
<th>SMC FY 2020 – FY 2023 IMPLEMENTATION STRATEGY SUMMARY, BY IDENTIFIED NEED</th>
</tr>
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<tbody>
<tr>
<td><strong>ACCESS TO CARE &amp; HEALTH INSURANCE</strong></td>
</tr>
<tr>
<td>• Participation 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</td>
</tr>
<tr>
<td><strong>BEHAVIORAL HEALTH, including SUBSTANCE USE</strong></td>
</tr>
<tr>
<td>• Provide a Medication Assisted Treatment (MAT) program, as a comprehensive treatment and support protocol for San Diego community members impacted by opioid use.</td>
</tr>
<tr>
<td>• Explore and evaluate opportunities for drug and alcohol screening in primary care settings (e.g., Sharp Rees-Steeley).</td>
</tr>
<tr>
<td>• Continue to provide and explore further community education, resources and screenings through awareness and resources events; both onsite and in the community</td>
</tr>
<tr>
<td>• Continue to provide education to community behavioral health care professionals through continuing education classes, speaking engagements, conference and trainings, and community collaboration</td>
</tr>
<tr>
<td>• Participate in community outreach activities across different Sharp entities to increase community awareness of behavioral health services (e.g., Sharp Chula Vista Medical Center Behavioral Health Resource Fair, etc.)</td>
</tr>
<tr>
<td>• Continue to lead the Aftercare support groups (e.g., SMC Mood Disorders support group, etc.) as well as the Substance Abuse Family Care Program to provide support to families of patients with substance use disorder issues post-discharge</td>
</tr>
<tr>
<td>• Collaborate with Sharp Mesa Vista to host community-based support groups</td>
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• Support community-based behavioral health and substance use organizations through continued participation in key mental health events and fundraising activities.
• Participation 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

AGING CONCERNS, CANCER, CARDIOVASCULAR, DIABETES, MATERNAL & PRENATAL CARE including HIGH-RISK PREGNANCY, OBESITY, UNINTENTIONAL INJURY & VIOLENCE

In general, as a specialty hospital providing treatment and services for behavioral health including substance use disorders, these additional identified community health needs do not fall within the scope of SMC’s services and resources. However, considering findings of Sharp’s recent CHNAs, SMC is considering incorporating primary health screening into behavioral health events, in order to address the issue of mind-body integration and effects of physical health on behavioral health and vice versa. Similarly, collaborations to provide nutrition education and resources at behavioral health events are also of interest, particularly in partnership with Sharp Mesa Vista.

Further, currently, SMC offers weekly nutrition classes for patients, as well as nutritional consultations as needed. Metabolic screening may be considered, contingent upon inpatient data post one year.

COMMUNITY & SOCIAL SUPPORT

• Continue to provide the SMC Aftercare support group.
• Provide support to families of patients with substance use disorder issues post-discharge through the Substance Abuse Family Care Program.
• Participation 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

ECONOMIC SECURITY

• Participation 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

EDUCATION

• Continue to support workforce development and provide student mentorship in various health care disciplines.
• Continue to provide education to community behavioral health care professionals through continuing education classes, speaking engagements, conference and trainings, and community collaboration.
• 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)
• Also refer to education items noted within the Behavioral Health section.

HOMELESSNESS & HOUSING INSTABILITY

• Participation 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

Next Steps

SMC is committed to the health and well-being of its community, and the findings of SMC’s 2019 CHNA will help inform the activities and services provided by SMC to improve the health of its community members. These programs are detailed in SMC’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. Phase 2 will focus on continued engagement of community partners to analyze and improve the CHNA process, as well as the hospital implementation strategies that address the 2019 CHNA findings. Thus, the CHNA process will evolve to meet the needs of our community members, and support the work of our community partners who also address those identified 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 SMC), 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 90,000 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 McDonald Center 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.