Sharp Chula Vista Medical Center
Community Health Needs Assessment – Implementation Plan
Fiscal 2017-2020

identified Community Health Need: Access to Care	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	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 stay when Medi-Cal Presumptive Eligibility rules apply.	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. 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.	Navigators Patient Access Service Representatives Patient Access Services Public Resource Specialist Patient Access Service Self-Pay Team Manager	Access to Care Education	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. PointCare has expanded its website to also provide linkage to Covered CA as appropriate. The tool interfaces patient screening information in the GE record. 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. 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. 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 Medi-Cal.

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					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, education and support to 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.	Financial Counselor	Access to care Financial assistance Provide education on patient financial services	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 for uninsured and underinsured patients, to offer support patients needing advanced guidance on available funding options.	Patient Access Services; Public Resource Specialist Patient Access Service Self-Pay Team Manager	Access to care Financial assistance Provide education on patient financial services	In 2015, a new position was created – the Public Resource Specialist – to support to patients needing extra guidance on available funding options. These individuals will 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. These positions were deployed in fiscal year 2016.
		c. Patient Assistance Team will continue to assist patients in need of assistance gain access to free	Supervisor, Patient Assistance	Access to care Provide education on patient financial	Cost savings for replacement drugs is monitored through pharmacy and supply chain. The patient accounting staff remove the charges from the patient

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		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.	Navigators Manager Patient Financial Services, Self-Pay Patients	services	statement. Sharp was the first hospital 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 population at our hospitals significantly. With the ending of the In-Person assistance program in July 2015, entity counselors will be transitioned to the Certified Application Assistance Program. 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.
		d. Continue to offer ClearBalance – a specialized loan program for patients facing high medical bills. Through this collaboration with San Diego-based CSI Financial Services, both insured and uninsured patients have the opportunity to secure small bank	Supervisor, Patient Assistance Navigators Manager Patient Financial Services, Self-Pay	Access to Care	To date in FY16, more than 1,830 Sharp patients have been assisted through the ClearBalance loan program.

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		loans in order to pay off their medical bills in low monthly payments.	Patients		
		e. Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.	SCVMC Chief Financial Officer	Access to Care	Project HELP funds are tracked though an internal database. From FY2010 to FY 2015, Project HELP funds totaled $150.3 K, an increase of ~42% over this time period.
	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 San Diego's chronically homeless community members.	Vice President, Sharp HealthCare (SHC) Government Relations	Access to Care Collaboration Care Management	This effort concluded in 2015, 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	This project concluded in 2016. 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.

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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 SGH in a safe space, in addition to psychiatric care, substance abuse counseling and other services through the San Diego Rescue Mission.	Care Transitions Program Manager	Access to Care Care Management Collaboration	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.	Care Transitions Program Manager	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.
		e. Continue to explore opportunities for collaboration with community	Vice President, SHC Government	Access to Care Collaboration	With the success of Sharp Grossmont Hospital's Care Transitions Intervention (CTI) pilot, Sharp is exploring

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		organizations to provide medical care, financial assistance, psychiatric and social services to high-risk, chronically ill, and/or chronically homeless patients	Relations Care Transitions Program Manager Program Manager, Community Benefits and Health Improvement	Care Management	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, including SCVMC. In progress.
	4. Increase understanding of health insurance - including access, use, etc. - to community members in SDC's south region.	a. Provide education on understanding and using health insurance to community members and community health workers (promotores) through Sharp's Conviva y Aprenda series.	Senior Specialist, SHC Multicultural Community Relations	Access to Care Understanding and Using Health Insurance	An initial educational session (Conviva y Aprenda) for promotores in SDC's south region on health insurance has been scheduled. This educational session will be conducted in Spanish in collaboration with Sharp Health Plan. The educational session was developed in response to findings from the 2016 CHNA that identified understanding and using health insurance as two of the top barriers within "Access to Care" for community members.

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	1. Reduce stigma and improve outcomes and experience for patients presenting behavioral health challenges and crises in the ED through staff education and training.	a. In collaboration with Mental Health America, San Diego, provide Mental Health First Aid training to SCVMC front-line staff in the ED.	SCVMC CEO Program Manager, Community and Multicultural Relations	Mental/Behavioral Health Access to Care Education Care Management	In FY 2016, Sharp Chula Vista Medical Center 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 was the first hospital/health system to participate in this training, currently funded by the County of San Diego. SCVMC is currently exploring opportunities to collaborate with Mental Health First Aid. Sharp Mesa Vista Hospital dispatches PET (Psychiatric Evaluation Team) staff to SCVMC's ED in order to identify patients that should be transferred to SMV. Although Behavioral Health is identified as a priority health need in the primary communities served by SCVMC, the facility does not have the resources to comprehensively address this priority. The behavioral health needs of communities served by SCVMC are addressed through the programs and services provided through Sharp Mesa Vista Hospital (SMV) and Sharp

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					McDonald Center (SMC) – the major providers of behavioral health and chemical dependency services in San Diego County.
	2. Improve behavioral health outcomes for safety net patients through early assessment, intervention and resource provision.	a. Provide assessment and early intervention of behavioral health issues for safety net patients presenting in the ED.	Manager, SCVMC Case Management/ Social Work SCVMC Social Services Staff	Mental/Behavioral Health Access to Care Education Care Management	In FY 2015, SCVMC provided comprehensive behavioral health services to safety net patients through the SCVMC social services staff. Individuals who presented in the ED with severe mental illness received a PET assessment and were provided mental health placement, information and resources as needed. In FY 2015, 2,961 social service interventions, including behavioral health interventions, were conducted throughout the ED. Of these interventions, more than 100 family conferences were conducted as well as approximately 45 psychosocial assessments, and more than 835 staff consultations. More than 355 patients were seen for counseling, more than 115 patients were evaluated for substance abuse and more than 450 individuals received information and referral resources. More than 350 individuals were also assessed due to suicidal or homicidal ideations. They were provided with outpatient resources or mental health treatment placement, which is an increase of 15 percent from the previous year. SCVMC also continued programming that

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					establishes outpatient treatment plans collaboratively with the safety net patients who frequent the ED.
	3. Provide behavioral health – including mental health and substance abuse – education and screenings to community members in the South Bay.	a. In collaboration with community partners – including the County of San Diego – provide a community screening, education and resource event around mental health in the South Bay.	Program Manager, Community and Multicultural Relations	Mental/Behavioral Health Stigma Collaboration Access to Care Education	In May 2016, SCVMC provided the first, community-wide behavioral health resource fair - "Changing Minds - Minds Matter" South County Behavioral Health Resource Fair - to South Bay community members. More than 100 community members attended the event as well as more than 40 community agencies that provide behavioral health services in the community, including: Mental Health Systems, Maria Sardinas Wellness Recovery Center and Sharp Mesa Vista Medical Center. As a result of the tremendous success of this event, SCVMC is currently planning another community behavioral health resource fair in FY 2017, and expects the event will be provided annually, pending continued positive community response and available resources.

Identified Community Health Need: Cancer	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. Improve navigation of the health care system for cancer patients in the South Bay through patient navigation services.	a. Continue to offer the cancer patient navigator program to SCVMC cancer patients.	SCVMC Cancer Patient Navigator Coordinator	Cancer Access to Care Patient Navigation Care Management	In FY 2015, more than 350 community members were assisted by SCVMC's two cancer patient navigators. Patients are tracked internally, and patients meet with the navigator on their initial visit. Navigation services provided to patients are closely tracked through internal databases. **Navigation Resources:** In FY 2016, there was a vacancy in Sharp's cancer navigator position. The individual hired to fill this position was a MSW/LCSW social worker to better address patient needs. The position was filled with in February, 2016. Later in 2016 with growing clinical needs, approval was secured to hire an RN to meet both Navigator and Radiation Oncology needs. That position was filled in August, 2016. This team will provide navigation services for adult patients with all cancer types. *Metric:* Navigation FTEs. **Identification and Prioritization of Needs:** Distress Screening to assess practical and emotional issues contributing to cancer patient distress has been conducted at Sharp Chula Vista Medical Center over the past few years. A recent effort was initiated by Sharp Cancer Outpatient social workers to develop a consistent tool across the Sharp system that would

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					evaluate these needs in greater detail in order to make them actionable and rate them by intensity so that they may be prioritized and addressed appropriately. *Metrics:* Routine reports including number of patients screened, information on the issues that are most challenging for patients and the percentage of patients rated in high distress will be provided to the Integrated Network Cancer Program and to individual entities. The information will drive efforts to target and provide additional support and resources to better meet our patient needs. **Navigation Communication:** Currently patient navigation is not consistently documented and easily accessible to all care team members. Often patients share valuable information with Navigators that can be useful to other team members for care coordination as well as identifying concerns about treatments and side effects that can be addressed by physicians and other staff for a more personalized approach to care and presenting options that may be more acceptable for cultural or personal beliefs. A project is planned for integrating Navigator care documentation in Cerner EMR to provide improved communication among all cancer team members. *Metric:* Implementation of Navigator documentation in

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					Cerner. **Timely Access to Care:** Navigators have identified that timely access to specialist appointments and imaging studies is a consistent issue among our cancer patients with delays that feed patient anxiety and is a clinical concern for impacting maximum effectiveness of cancer treatment. This will be a focus for our cancer navigators and the cancer program in identifying performance improvement initiatives to reduce the time from diagnosis to treatment for our cancer patients. *Metrics:* Calculation of the time from diagnosis to treatment for key sites that will capture the predominant issues and annual evaluation of the change in number of days to treatment at least annually. Also measured will metrics specific to focused projects on key processes identified that are contributing to delays in care.
		b. Continue to seek funding for the cancer patient navigator program and expand navigator services to all cancers.	SCVMC Patient Navigator	Access to Care Care Management	In FY 2015, Sharp Chula Vista Medical Center utilized grant funding from the Susan G. Komen Breast Cancer Foundation and National Breast Cancer Foundation to assist in funding the patient navigator program.

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	2. Increase cancer education and support for community members in the South Bay with cancer diagnoses.	a. Continue to offer a Meet the Pathologist lecture - educational presentations provided by a SCVMC pathologist that provide personal information about a woman's diagnosis by reviewing her pathology report and explaining it in layman's terms.	SCVMC Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY 2015, Meet the Pathologist presentations reached 40 community members. Currently, these informational and educational sessions are not tracked / evaluated. Also in FY 2015, Sharp Multicultural Services offered the Conviva y Aprenda (Share and Learn) educational series in the South Bay providing education and resources on prostate cancer to approximately 60 Spanish-speaking community members. Development of programs and services driven by Distress Screening (see action item "Cancer: a" above) and feedback from navigators, social workers and other staff will be ongoing. Expansion of Sharp partnership with the American Cancer Society to provide education and support materials and community support connections to ACS Patient Organizers. This will be in conjunction with Sharp information for patient education, services offered, information specific to care at SCVMC and additional connections to community and national organizations that provide assistance to cancer patients. A specific portion of Sharp's website (sharp.com) is planned for cancer patients to provide information and tools that will be helpful to patients

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					during the course of their cancer journey. **Metrics (forthcoming):** Number of Patient Organizers delivered (?); initiation of patient information website section; number of hits on the patient website indicating use.
		b. Continue to provide meeting space for Look Good… Feel Better classes to cancer patients with support from SCVMC auxiliary members.	SCVMC Cancer Patient Navigator Coordinator	Cancer Education Care Management Collaboration	This free program is offered by the ACS to teach women with cancer beauty techniques to help manage the side-effects related to cancer treatment. In FY 2015, six meetings were held, serving approximately 35 community members.
		c. Continue to provide ongoing support groups to members of the community diagnosed with cancer. This includes: general cancer support groups; breast cancer support groups in Spanish and English; prostate cancer support groups; Spanish caregiver support groups for individuals battling any type of cancer.	SCVMC Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY 2015, SCVMC conducted weekly breast cancer support groups in English and Spanish, a monthly men's cancer support group, a monthly support group for caregivers of individuals battling any type of cancer, and a monthly support group for individuals newly diagnosed with cancer. A New Normal support group is offered monthly for cancer patients ages of 19 - 45. Further, in collaboration with Las Damas de San Diego Foundation, a Las Damas support group met twice a month to provide psycho-social support for women undergoing cancer diagnosis and treatment for breast or cervical cancer. SCVMC's

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					support groups reached nearly 760 individuals in FY 2015.
		d. Continue to provide a wig and prosthesis bank to cancer patients.	SCVMC Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY15 SCVMC provided more than 120 cancer patients with ~310 donated wigs, prosthetic devices and other items at no cost.
	3. Increase community education on the signs and symptoms of cancer through education and screening events.	a. Continue to conduct comprehensive community cancer health seminars with health screenings in English and Spanish.	Program Manager, SCVMC Community and Multicultural Relations SCVMC Cancer Patient Navigator Coordinator Manager, SCVMC Marketing and Communications	Cancer Education Collaboration Screenings	Through June 2016, SCVMC has provided four cancer education and screening events, reaching more than 400 community members and screening more than 130. SCVMC continues its collaboration with Las Damas de San Diego International Nonprofit Organization (Las Damas de San Diego Foundation) and Clinica Medica de la Mora to provide three breast and cervical cancer screening events specifically low-income Hispanic women in the South Bay. SCVMC also partners with Las Damas de San Diego Foundation and Clinica Medica de la Mora to provide bimonthly cancer screening services for women through registration in Every Woman Counts, a state program that pays for their screenings and care. Cancer education and screening events offered by SCVMC are evaluated through participant surveys.

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					Surveys include point scores to measure the value of the program content, as well as opportunities for open-ended feedback from community members. These surveys exclude the Las Damas screenings, as SCVMC serves solely as a host for the events.

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	1. Increase community education around heart health to South Bay community members.	a. Continue to provide community members with Expos focused on cardiovascular care, targeting Spanish-speaking South Bay community members.	Manager, SCVMC Cardiac Services Manager, SCVMC Marketing and Communications Senior Specialist, SHC Multicultural Community Relations	Cardiovascular Health Education Care Management	Through June 2016, SCVMC has provided education and blood pressure screenings at multiple community events, including the Cycle Eastlake Health Fair. In FY 2017 SCVMC will collaborate with the Senior Specialist of SHC Multicultural Relations on the next Spanish Heart Expo. In FY 2015 SCVMC hosted two Heart Health Expos including a Spanish expo, reading nearly 100 community members. Events provided education on heart disease prevention, diagnosis and treatment, as well as resource booths on cardiac rehabilitation, nutrition, advanced care planning and the Mended Hearts community support group. The events also included screenings for blood pressure, cholesterol, BMI, glucose and bone density.
	2. Empower patients/community members with cardiovascular and cerebrovascular disease through education and support; promote accountability and behavioral	a. Continue to provide education and support to South Bay community members living with heart disease.	Senior Cardiac Specialist, SCVMC Cardiac Services	Cardiovascular Health Care Management Education	SCVMC provides twice weekly classes in both English and Spanish targeted to open heart patients. Classes cover methods to better manage heart disease at home as well as post-surgery care. Additionally, all heart patients are targeted for cardiac rehabilitation as an outpatient and are encouraged to

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	change through education on chronic disease self-management. Facilitate and improve post-care processes.				attend regardless of ability to pay. Topics include heart attack, heart disease, heart failure, its causes, signs and symptoms, medication, follow-up care and the patient's role in controlling heart disease. Fluid restriction, weight monitoring and the importance of a low sodium diet. All HF patients receive bedside education about managing HF including a "heart card" that contains key information about the disease for their follow-up appointment. Several articles have appeared on radio, television, newspaper and social media including the Union Tribune, authored by SCVMC cardiology physicians with editing and assistance from Marketing Department.

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	3. Increase access to cardiovascular and stroke health screenings for South Bay community members.	a. Continue to provide community member stroke, blood pressure and cholesterol screenings through community events in the South Bay.	Manager, SCVMC Cardiac Services Program Manager, SCVMC Community and Multicultural Relations	Cardiovascular Health Education Screening Access to Care	In FY 2015, SCVMC provided approximately 85 student athletes in the Sweetwater Union High School District (SUHSD) with heart health screenings including electrocardiograms (EKG) at Olympian High School. Fifteen abnormalities were found during the sudden cardiac arrest screening and, of those 15, two were required to follow up with a physician. Throughout the year, SCVMC provided a variety of stroke education and screening opportunities for community members in the South Bay. At the Chula Vista Chamber of Commerce Mixer, approximately 30 community members received blood pressure screenings and education regarding risk factors for stroke, warning signs, prevention and appropriate interventions. At the Sharp Women's Health Conference in March, Sharp's systemwide Stroke Program provided stroke screenings with pulse checks as well as stroke education, including types of stroke, risk factors, risk reduction, and stroke recognition, to more than 80 attendees. In addition, SCVMC provided nearly 30 health care professionals from the Veterans Home of California, Chula Vista, with education on stroke risks and prevention in January.

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	4. Collaborate with other health care organizations in San Diego on stroke education and prevention efforts.	a. Continue participation in San Diego County Stroke Consortium	Vice President, SHC Ortho/Neuro Service Line Program Manager, SCVMC Community and Multicultural Relations	Cardiovascular Health Collaboration	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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	1. Increase education of signs and symptoms of diabetes throughout the South Bay, particularly underserved and minority populations in the community.	a. Participate in educational forums, health fairs and events throughout San Diego County's (SDC) south region.	SHC Diabetes Leadership Team Program Manager, SCVMC Community and Multicultural Relations Program Manager, Community Benefits and Health Improvement	Diabetes Education Collaboration	Sharp's Diabetes Educators fulfill a set amount of community hours as part of their role, depending on their status (e.g., 1.0 FTEs provide 8hours, 0.6 FTE provides 6 hours, etc.). SHC Program Manager, Community Benefits and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. Programs planned/being explored for FY 2017 include continued Family Health Centers of San Diego (including the Chula Vista site) collaboration, and collaboration with clinics in Imperial Beach. At the Sharp Women's Health Conference (which serves community members across SDC, including the South Bay), the Sharp HealthCare (SHC) Diabetes Education Program provided resources on diabetes management and nutrition. Through fundraising and team participation, the SHC Diabetes Education Program also continued to support the ADA's Step Out: Walk to Stop Diabetes held in October at Mission Bay. Feedback is collected from community members on educational courses provided, in order to improve and

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					refine educational resources for community member needs. In addition, the SHC Diabetes Leadership Team meets annually to evaluate the programs over the previous year.
		b. Explore opportunities with new venues/ community groups, and community clinics to provide additional resources and education to vulnerable populations.	SHC Diabetes Leadership Team Program Manager, Community Benefits and Health Improvement Program Manager, SCVMC Community and Multicultural Relations	Diabetes Education Access to Care Collaboration	SHC Program Manager, Community Benefits and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. Programs planned/being explored for FY 2017 include continued Family Health Centers of San Diego (including the Chula Vista site) collaboration, and collaboration with clinics in Imperial Beach. In FY 15, SHC Diabetes Education Program continued collaboration with Family Health Centers of San Diego (FHCSD) to conduct outreach and education to vulnerable community members in the South Bay. Sharp Diabetes educators supported the expansion of FHCSD's Diabetes Management Care Coordination Project (DMCCP), which provides FHCSD patients with group diabetes education and encourages peer support and education from project "graduates" to current patients/project enrollees. The project monitors

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					enrollees' A1C levels, and has proven successful outcomes in lowering and maintaining these levels through education and peer support. In the South Bay, the SHC Diabetes Education Program provided a lecture in Spanish on the basics of diabetes and nutrition, to 70 community members at the FHCSD Chula Vista site. Outcomes data expected in early FY 2017. In FY15 the SHC Diabetes Education Program collaborated with La Maestra Community Health Centers to educate and advise underserved pregnant women and breastfeeding mothers with Type 1, Type 2 or gestational diabetes on how to manage blood sugar levels. In addition, the SHC Diabetes Education Program evaluated patients' management of their blood sugar levels and collaborated with La Maestra's obstetrician/gynecologist (OB/GYN) to prevent complications. At SCVMC, the SHC Diabetes Education Program collaborated with the hospital's OB/GYN to assist approximately 180 underserved pregnant women with diabetes over the course of 720 visits.

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		c. Utilize findings in the FY 2016 CHNA to assess existing community resources and explore areas where additional diabetes education and resources may be needed in SDC's south region.	SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and Health Improvement	Diabetes Education Access to Care Collaboration	Program Manager, Community Benefits and Health Improvement to meet with SHC Diabetes Leadership Team regularly to assess additional opportunities for outreach and education. Current discussions focus on clinic collaborations (Family Health Centers Partnership continuance) and exploring partnerships to address food insecurity as part of nutrition education, similar to Feeding America San Diego / UCSD Student-Run Clinic Partnership (see action item "Diabetes, d" below).
		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.	SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and Health Improvement	Uncontrolled 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 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

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					CalFresh outreach. Approximately 200 participants enrolled in the one-year Diabetes Wellness Project. Data forthcoming, results to be published in Fall, 2016. 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.

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	2. Improve identification of pre-diabetes and diabetes in South Bay 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 SDC's south region.	SHC Diabetes Leadership Team Program Manager, SCVMC Community and Multicultural Relations	Diabetes Screening Access to Care Collaboration	In FY 2015, the SCVMC Diabetes Education Program conducted two blood glucose screenings, screening nearly 100 community members. As a result of these screenings, 11 individuals were identified with elevated blood glucose levels and were referred to follow-up resources. Of those individuals with elevated blood glucose levels, seven did not have preexisting cases of diabetes. Screenings were held at the Cycle EastLake Run and the Las Damas de San Diego Health Fair at the Douglas & Nancy Barnhart Cancer Center at SCVMC. **Screenings Discontinued in 2016:** 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 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.

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					As a result, Sharp's Diabetes Education team has focused efforts on working in partnership with Feeding America and local community clinics (e.g., FHCSD) 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. **Regulation details:** • 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 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

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					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. • 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. Community members with elevated blood glucose levels are referred for follow-up to either PCP or 82-SHARP, and uninsured patients are referred to community clinics in the South Bay.
		b. Explore partnerships with community clinics to offer diabetes classes at clinic locations	SHC Diabetes Leadership Team	Access to Care Collaboration Community Clinics	This past year, the SHC Diabetes Education Program collaborated with Family Health Centers of San Diego (FHCSD) to conduct outreach and education to

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
			SHC Program Manager, Community Benefits and Health Improvement		vulnerable community members in SDC's south region, specifically the FHCSD site in Chula Vista. Sharp Diabetes educators supported the expansion of FHCSD's Diabetes Management Care Coordination Project (DMCCP), which provides FHCSD patients with group diabetes education and encourages peer support and education from project "graduates" to current patients/project enrollees. In FY 2015/2016 sessions held in Chula Vista reached 70 community members/clinic patients. Overall through the partnership, Sharp Diabetes Educators have provided 12 lectures from Jan through June 2016, including classes in English and Spanish. Classes have served 92 attendees at the Lemon Grove, North Park, Chula Vista and Logan Heights FHCSD sites. Classes briefly paused in June, 2016 and will resume in August, 2016. The project monitors enrollees' A1C levels, and has proven successful outcomes in lowering and maintaining these levels through education and peer support. The SHC Diabetes Education Program supports the project through the provision of diabetes lectures at multiple FHCSD sites. In SDC's east region, the SHC Diabetes Education Program provided a diabetes

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					lecture to nearly 15 attendees at the FHCSD Lemon Grove site. Topics included nutrition, physical activity, diabetes mellitus, self-management and goal setting. Outcomes data forthcoming. In Summer, 2016 Sharp Program Manager, Community Benefits and Health Improvement met with Diabetes Education Team to support FHCSD partnership. Team meetings with FHCSD are scheduled for FY 2017 to strengthen the collaboration. In addition, the SHC Diabetes Leadership team meets annually to evaluate the programs over the previous year.
		c. Create language-appropriate and culturally sensitive diabetes educational materials.	SHC Diabetes Education Leadership Team	Diabetes Education Care Management Collaboration	Materials have been updated for Type 1 and 2 Diabetes, as well as Gestational Diabetes Mellitus post-discharge. Materials are designed to assist mothers after delivery as well as to advise on how to manage blood sugars while breast feeding. Materials have also been completed for the Chaldean and Vietnamese populations in San Diego. Materials for Vietnamese populations include gestational diabetes, as well as a culturally-appropriate 7-day meal plan. Also exploring new opportunities for more effective

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					methods and resources for properly translated educational materials (e.g. multi-lingual interns, etc.).

Identified Community Health Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. Provide free biometric screenings for community members that address risk factors for obesity.	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 the South Bay include Parkway Community Center and Westfield Plaza in Bonita.	Sharp HealthCare Chief Experience Officer	Obesity Screening Education Collaboration	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. 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. The screening program concluded in early 2016. 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. Though Sharp's hospitals, including SCHHC provide

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Identified Community Health Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					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.
	2. Increase education and awareness of nutrition and healthy lifestyle options for South Bay community members.	a. Provide nutrition/healthy lifestyle educational resources to South Bay community members at community events throughout the year.	Program Manager, SCVMC Community and Multicultural Relations Senior Specialist, SHC Multicultural Community Relations	Obesity Access to Healthy Food Education Collaboration	In FY15 SCVMC provided community health education classes on a variety topics, many including nutrition/healthy lifestyle resource, to approximately 200 community members In addition, SCVMC provided ongoing educational sessions to promotores in the South Bay - titled “Conviva y Aprenda.” In October, this section focused on “Healthy Eating in a Fast-Food World.” The event reached 65 promotores. Each education and screening program provided by SCVMC and *on the SCVMC campus* is evaluated by participants through survey.

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Identified Community Health Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	3. Participate in and support South Bay community initiatives to address community health issues, specifically obesity and healthy lifestyles.	a. Collaborate with the City of Chula Vista on their Healthy Chula Vista Initiative.	Program Manager, SCVMC Community and Multicultural Relations Program Manager SHC Community Benefits and Health Improvement	Collaboration Obesity Education	In 2016 this initiative changed to “Healthy Chula Vista/Live Well San Diego.” Since its inception, the initiative created a strategic plan that was adopted by the City of Chula Vista. SCVMC’s Program Manager of Community and Multicultural Relations serves both as part of the Leadership Team of Live Well San Diego, South Region, as well as a Commissioner on the Healthy Chula Vista Advisory Commission. In addition, SHC’s Program Manager of Community Benefits and Health Improvement works with SCVMC’s Program Manager of Community and Multicultural Relations to support and grow collaboration with the Healthy Chula Vista / Live Well San Diego initiative.

Identified Community Health Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	4. Continue to provide care management in support of weight loss and healthy lifestyle choices for San Diego community members.	NA	NA	Obesity Education Care Management	In general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time. However, free, Healthier Living Workshops are provided to community members through Sharp HealthCare's medical group, Sharp Rees-Stealy, including in areas served by SCVMC. 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.

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Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. 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, and other resources to seniors.	a. Maintain active relationships with community organizations serving seniors in the South Bay, including senior centers.	Program Manager, SCVMC Community and Multicultural Relations	Senior Health Education Screening Collaboration	Presentations and collaborations with senior community groups continue. Through June, 2016, SCVMC has provided educational sessions at San Ysidro Senior Center and St. Paul's Assisted Living Community Center. Currently working with Westmont Assisted Living Facility to provide health education classes. Evaluation of community education programs varies with regard to the collaborating organizations.
		b. Continue to participate in community health fairs for seniors as requested and as opportunities arise.	Program Manager, SCVMC Community and Multicultural Relations	Senior Health Education Screening Collaboration	Presentations and collaborations with senior community groups continue. Through June, 2016, SCVMC has provided educational sessions at San Ysidro Senior Center and St. Paul's Assisted Living Community Center. Currently working with Westmont Assisted Living Facility to provide health education classes. Evaluation of community education programs varies with regard to the collaborating organizations.
	2. Provide coordinated care to patients with advancing progressive chronic disease,	a. Continue collaboration with Sharp HospiceCare to offer the Transitions program: a program	Vice President, Sharp HospiceCare	Senior Health Care Management	Patient and Family Satisfaction Surveys provided to all Transition participants at the end of the program's "Active Phase" (six weeks).

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	in order to improve the individual experience as they near end-of-life.	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.	Utilization Review, Sharp HospiceCare		Performance Target: 200 admissions across the system each year. In FY 2015, 300 admissions across the system; YTD FY 2016, 178 admissions. 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 Chula Vista Medical Center, and SCVMC staff collaborate with Sharp HospiceCare staff on these efforts.
	3. 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 and provide professional education on hospice-related topics to community agencies, health care facilities, colleges and universities on hospice and palliative care.	Medical Director, Sharp HospiceCare Business Development, Sharp HospiceCare Program Manager, SCVMC Community and Multicultural Relations	Senior Health Education Collaboration	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 Chula Vista Medical Center.

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		b. Provide Advance Care Planning (ACP) 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 Chula Vista Medical Center. 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.

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	4. 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	Track number of mailings annually through internal Access/Excel database. In FY 2015, ~1,300 community members received bereavement support newsletters. 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 Chula Vista Medical Center.
		b. Continue to provide community education and resource services throughout San Diego	Business Development Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of community education events through internal database. 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. 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

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					Sharp – including Sharp Chula Vista Medical 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 Chula Vista Medical 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

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					centers, homecare agencies, churches and seminars. 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 Chula Vista Medical Center.
	5. Collaborate with community, state and national organizations to develop and implement appropriate services for the needs of the aging population.	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.	Vice President, Sharp HospiceCare Medical Director, Sharp HospiceCare	Senior Health Education Collaboration	Sharp HospiceCare provides approximately six presentations each year in collaboration with state and national organizations. All community presentations provided through Sharp HospiceCare– including those to professional organizations – are evaluated through survey to evaluate effectiveness. 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 Chula Vista Medical Center.
		b. Continue to collaborate with a variety of local networking groups and community-oriented agencies	Business Development, Sharp	Senior Health Education Collaboration	Community presentations provided through Sharp HospiceCare– including those to professional organizations – are evaluated through survey to

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Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		to provide caregiver classes, end-of-life programs, advance care planning seminars and web presentations for consumers and health care professionals.	HospiceCare		evaluate effectiveness and revise program content
		c. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	Business Development Dept., Sharp HospiceCare	Senior Health Caregivers Collaboration	New community partnership: Lantern Crest in Santee; Elmcroft of San Diego (throughout the County as well as additional home care facilities. 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 Chula Vista Medical Center.