SHARP Chula Vista Medical Center

Sharp Chula Vista Medical Center
Community Health Needs Assessment – Implementation Strategy
Fiscal 2018-2021

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 22,786 self-pay patients since October 01, 2015 through 07/31/2017. PointCare has expanded its website to also provide linkage to Covered CA as appropriate. The tool interfaces patient screening information in the GE record. In FY 2016, Sharp Healthcare's Patient Access Services department processed real-time Medi-Cal eligibility determinations under the Hospital Presumptive Eligibility Program for 1,990 unfunded patients in the ED. 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. 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.

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	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, positions were created within Sharp's Patient Financial Services department (system level) entitled Public Resource Specialists – to support patients at all Sharp hospitals (including SCHHC) needing extra guidance on available funding options. These Public Resource Specialists also perform what is traditionally called "field calls" (home visits) to patients who have left the hospital and require assistance in completing a process to facilitate coverage. Anticipate implementation of tracking tool in FY 2017.
		c. Provide specialized financial assistance and support program to families with children in a Sharp NICU.	Patient Access Services Public Resource Specialist Patient Access Service	Access to care Financial assistance	This program was expanded to Sharp Chula Vista Medical Center in 2017 -outcomes/case data forthcoming. **Background**: In Summer 2015, a pilot program was launched at Sharp Mary Birch Hospital for Women & Newborns in support of Sharp's NICU babies. This

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			Self-Pay Team Manager		process includes a meeting with families where a newborn that has been diagnosed with a devastating medical condition or extremely low birth weight is evaluated for eligibility for Supplemental Security Income (SSI).
		d. Patient Assistance Team will continue to assist patients in need of assistance gain access to free or low-cost medications. Patients are identified through usage reports, or referred through case management, nursing, physicians or even other patients. If eligible, uninsured patients are offered assistance, which can help decrease readmissions due to lack of medication access. The team members research all options available including programs offered by drug manufacturers, grant-based programs offered by foundations, copay assistance, low-cost alternatives, or research where the patient might find their medication at a lower cost.	Supervisor, Patient Assistance Navigators Manager Patient Financial Services, Self-Pay Patients	Access to care Provide education on patient financial services	Cost savings for replacement drugs is monitored through pharmacy and supply chain. The patient accounting staff remove the charges from the patient 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.

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		e. 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 loans in order to pay off their medical bills in low monthly payments.	Supervisor, Patient Assistance Navigators Manager Patient Financial Services, Self-Pay Patients	Access to Care	To date in FY17, 58 Sharp patients have been assisted through the ClearBalance loan program (nearly 2,000 patients since the program's inception).
		f. 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 2016, Project HELP funds totaled $165K.
	3. Improve access to health and social services for high-risk community members, particularly San Diego's	a. Continue to collaborate with the San Diego Rescue Mission to discharge chronically homeless patients to the Rescue Mission's	SHC VP Case Management Service Line	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

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	homeless population.	Recuperative Care Unit. These patients receive follow-up care through SHC in a safe space, in addition to psychiatric care, substance abuse counseling and other services through the San Diego Rescue Mission.			tracked via Sharp's Case Management Department's cost reports.
		b. Evaluate patients applying for Medi-Cal for CalFresh (Food Stamps) through on-site hospital Patient Financial Services and Hospital Outstation Program (collaboration with the County of San Diego). Facilitate enrollment of qualified patients in CalFresh.	Manager, Patient Financial Services, Self-Pay Patients	Access to Care Access to Healthy Food (Food Insecurity) Collaboration Care Management	Across Sharp HealthCare PFS: YTD metrics through April, 2017: 367 CalFresh applications submitted, 209 applications approved, 15 applications pending.
		c. 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.	SHC VP Case Management Service Line	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

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					measure any savings that Sharp might experience.
		d. Continue to explore opportunities for collaboration with community organizations to provide medical care, financial assistance, psychiatric and social services to high-risk, chronically ill, and/or chronically homeless patients	SCVMC Patient Support Services and Development SCVMC Program Manager, Community and Multicultural Relations SHC VP Case Management Service Line Care Transitions Program Manager Manager, Community Benefit and Health Improvement	Access to Care Collaboration Care Management	**NEW - Urban Street Angels event:** In October 2017, SCVMC will provide a community health event specifically for clients of Urban Street Angels, a non-profit organization aimed at addressing youth homelessness in San Diego. The event will be hosted at SCVMC specifically for Urban Street Angels Clients and is a collaboration with Family Health Centers, Feeding San Diego, Sharp Mesa Vista Hospital, SHC Occupational Health and others. Health/behavioral screenings, vaccinations, and community resources (food, HepA prevention) will be provided at the event. Expected attendance of 30 TAY (Transition Age Youth). Dependent upon the event's success, this service may be offered on an ongoing basis. In addition, in September 2017, SHC Occupational Health began providing free TB tests to clients of Urban Street Angels. **Care Transitions Intervention Program:** 1.The prior success of the CCTP program, as well as the program outcomes for Sharp Grossmont Hospital's specific CTI program (following termination of the Innovation Grant) distinguish this as an opportunity for

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					further exploration. The Integrated Care Management Plan includes reviewing program outcomes – past and current – reviewing opportunities for alternative funding, and then re-implementation of a redesigned program in FY 2019. Success will be measured through identified metrics for the target population, to include: decreased readmissions, decreased ALOS, and decreased inappropriate ED visits. 2. Integrated Care Management is currently working with leaders across the Sharp continuum (SHC, SMV, SRS, and SCMG) for alternative solutions for hard to place patients requiring long-term supportive housing, assisted living, and/or custodial care, who also live with chronic behavioral health disabilities. Leaders are formulating a plan that includes working with community health care partners to vet opportunities. Care Management seeks to have options in place for strategic planning FY 2019 – 2020. Measures of success will include quality of care improvements, with decreased costs of care for the target population. This may be realized by measuring change in ALOS, transitions to safe and sustainable home or home like settings, and demonstrating improved linkages to Behavioral Health Primary Care providers.

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	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 was 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. 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 2016, 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 2016, more than 29,000 social service interventions, including nearly 2,500 psychosocial assessments, were conducted throughout the ED. Of these interventions, more than 275 family conferences were conducted as well as approximately and nearly 6,700 staff consultations. Approximately 1,750 patients were seen for counseling, and more than 300 patients were evaluated for substance abuse. More nearly 300 individuals were also assessed for suicidal or homicidal ideations and were provided with outpatient resources or mental health treatment placement. In addition, 108 patients were treated strictly for issues related to homelessness, and other homeless patients were treated for drug and alcohol abuse. SCVMC also continued programming that establishes outpatient treatment plans collaboratively with the safety net patients who frequent the ED.

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	2. 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 2017, SCVMC provided its second-annual, community-wide behavioral health resource fair - “Changing Minds - Minds Matter” South County Behavioral Health Resource Fair - to South Bay community members. Approximately 125 community members attended the event, which included more than 50 community partners that provide behavioral health services in the South Bay, including: Mental Health Systems, Maria Sardinas Wellness Recovery Center and Sharp Mesa Vista Medical Center. The program provided eight workshops, covering: Adult Behavioral Health, Child/Adolescent Behavioral Health, Substance Use, Caregiving and Suicide Prevention. The event also offered “check your mood” depression screenings. As a result of the tremendous success of this event, SCVMC is currently planning another community behavioral health resource fair in FY 2018, 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 2016, more than 450 community members were assisted by SCVMC's 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 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, however became vacant again in early 2017. Due to the large budget variances Sharp HealthCare has experienced this fiscal year, it was decided to postpone filling this position until the start of FY18. *Metric (forthcoming):* Patients served. Currently implementing systemwide changes to Cerner that capture documentation and automate this reporting. **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

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					consistent tool across the Sharp system that would 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. **New**: A systemwide policy has been approved establishing the pivotal time to give each radiation and infusion patient at least one distress screening assessment. *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

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					integrating Navigator care documentation in Cerner EMR to provide improved communication among all cancer team members. *Metric:* Implementation of Navigator documentation in Cerner. Current status of this is on track; received first proof to review in August, 2017. **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. **Current status**: focused work has been done on breast and improvements noted; collected follow-up stats for 2016 data. Need to

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					review and complete assessment for other top sites before year end.
		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	Status: continued funding uncertain. SHC Foundation is attending a workshop in 2017 to research whether to submit an application for the new funding cycle. In FY 2016, 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.
	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 2016, Meet the Pathologist presentations reached approximately 20 community members. Currently, these informational and educational sessions are not tracked / evaluated. 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

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					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 during the course of their cancer journey. **Status**: On track. Patient focus group completed with feedback to direct initiative in a patient-focused manner; website section has been prepared; initial documents to upload in final review. **Metrics:** Number of Patient Organizers delivered for SCVMC (YTD 2017 = 243). Initiation of patient information website section.
		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 2016, six meetings were held, serving more than 40 community members.
		c. Continue to provide ongoing support groups to members of the community diagnosed with	SCVMC Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY 2016, SCVMC's Douglas & Nancy Barnhart Cancer Center (the Cancer Center) reached nearly 830 individuals through a variety of cancer support groups

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		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.			provided in response to community needs. This included 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.
		d. Continue to provide a wig and prosthesis bank to cancer patients.	SCVMC Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY16 the Cancer Center provided more than 120 cancer patients with ~160 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	Cancer Education Collaboration Screenings	YTD FY 2017, the Cancer Center has provided two cancer education and screening events, reaching more than 400 community members and screening more than 130. In FY 2016, the Cancer Center hosted more than 40 free cancer-related seminars and classes, where more than 700 community members received education and

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			Coordinator Manager, SCVMC Marketing and Communications		resources for awareness and prevention of various cancers, including colorectal, lung, cervical and breast as well as education on smoking cessation. Seminar topics included talking to the doctor about cancer; talking to children about cancer; intimacy, sexuality and cancer; advance directives; and cancer-related anxiety and depression. In addition, throughout FY16, the Cancer Center provided breast model demonstrations, education on the importance of clinical breast exams and annual mammograms, and other cancer education and resources — including genetic testing, nutrition information and navigation services — to nearly 1,300 individuals at community events SCVMC collaborates with Las Damas de San Diego Foundation, Clinica Medica de la Mora and La Maestra Community Health Centers to provide quarterly breast and cervical cancer screening events to nearly 350 community members - primarily low-income Hispanic women in the South Bay registered in Every Woman Counts, a state program that pays for cancer screenings and care for un/under-insured women. The events included free genetic testing; blood pressure, glucose, and bone density screenings; measurement of weight

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					and body fat; preventive health lectures on nutrition, oral health and the importance of breast self-examinations; education and resources on cancer, mammograms and clinical breast exams; live music; and mindful meditation. In FY 2016, these screening events provided more than 130 clinical breast exams or mammograms. Cancer education and screening events offered by SCVMC are evaluated through participant surveys. 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 Director, SCVMC Marketing and Communications Specialist, SHC Multicultural Community Relations	Cardiovascular Health Education Care Management	YTD Fiscal 2017 (July) August 2017, SCVMC has provided education and blood pressure screenings at multiple community events, including the Love Your Heart Expo, as well as at sites such as schools, churches, and Chamber of Commerce events. In FY 2017 SCVMC will host the annual Heart Health Expo in English and Spanish. SCVMC will also host a seminar on reducing the risk of AFib-related stroke. Further, cardiovascular physicians and other experts regularly appear in local English and Spanish media, coordinated by the Marketing Department, to educate community members on a variety of heart health topics.
	2. Empower patients/community members with cardiovascular and cerebrovascular disease through education and support; promote accountability and behavioral change through education on chronic disease self-management. Facilitate and	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 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

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	improve post-care processes.				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. To further support the clinical needs around heart health and cardiovascular care of this fast-growing community, SCVMC will also be expanding facilities in the way of OR space and hybrid procedure rooms. Completion anticipated in 2019.
	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	Throughout FY 2016, SCVMC provided a variety of stroke education and screening opportunities for community members in the South Bay. In February, SCVMC provided a presentation titled Care of the Patient/Resident with a Cerebrovascular Incident and Post-Stroke Dementia to more than 40 nurses and other health care professionals at the Veterans Home of California, Chula Vista. Topics included: how to provide care to stroke patients including assessments, brain anatomy, risks factors, emergency management treatments, patient education, and rehabilitation; and the most common types of dementia, care, and treatments including support groups and other

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					services. In August, SCVMC provided approximately 15 community members at St. Paul's Plaza with education on brain health including the basic anatomy of the brain, the definition and types of strokes, stroke risks, diagnostic tests, treatment, rehabilitation, nursing interventions, prevention and how to respond using FAST (Face, Arms, Speech, Time).
	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 will once again participate in the "Strike Out Stroke" event at the Padres in September 2017 (rescheduled from May due to rain), 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 Manager, Community Benefit and Health Improvement	Diabetes Education Collaboration	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 diabetes risk assessments using the ADA's Diabetes Risk Test questionnaire as well as offered resources on pre-diabetes, diabetes management and nutrition to approximately 1,000 attendees.. Through fundraising and team participation, the SHC Diabetes Education Program also continued to support the ADA's Step Out: Walk to Stop Diabetes in FY16. In addition, the SRS Diabetes Education Program provided: • Education on diabetes and a healthy diet to more than 70 seniors and caregivers at the Kimball Senior Center for the South County Action Network's Live Stronger Longer event. • Education on nutrition and a Mediterranean diet to more than 60 seniors at the San Ysidro Adult Day Center. Feedback is collected from community members on educational courses provided, in order to improve and refine educational resources for community member

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					needs. 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 Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. 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 to provide additional resources. E.g. churches, YMCA's and schools.	SHC Diabetes Leadership Team Manager, Community Benefit and Health Improvement Program Manager, SCVMC Community and	Diabetes Education Access to Care Collaboration	SHC Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. As a result of these discussions in FY17, the SHC Diabetes Team will be working with the Imperial Beach community to provide diabetes education and resources, in collaboration with the IB Healthy Grocery Initiative.

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			Multicultural Relations		
		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 Manager, Community Benefit and Health Improvement SHC Diabetes Leadership Team	Diabetes Food Insecurity Education Access to Care	SHC Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education based on the findings and relationships generated from the 2016 CHNA. Current efforts focus on: • *Clinic collaborations* (Family Health Centers Partnership continuance) • Exploring *partnerships to address food insecurity as part of nutrition education, and incorporating food insecurity screening* into patient diabetes education and counseling. • *CDC's National Diabetes Prevention Program* - a partnership of public and private organizations working to prevent or delay type 2 diabetes. Partners work to make it easier for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall

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					health. In Fall, 2017 the SHC Manager of Community Benefit and Health Improvement will be providing an in-service to Sharp's Diabetes Educators on the intersection of food insecurity and health, as well as providing tools for food insecurity screening and referrals/resource connection for patients/community members. In addition, SHC's Diabetes Education Team has become very involved with SuperFood Drive, a San Diego-based organization that focuses on improving the health of food insecure populations through outreach, education and encouragement of healthy, nutritious food donations. In partnership with SuperFood Drive, the SHC Diabetes Education Program (and specifically, the Diabetes Educator located at SCVMC) provided an educational post on how to eat healthy on a budget, management to the Superfood Drive Instagram account, as well as a "Wellness Wednesday" educational post on the nutritional value of specific foods every week. Also in support of SuperFood Drive, the SHC Diabetes Education Program (same SCVMC Diabetes Educator) participated in Feeding San Diego's 2016 Nutrition Symposium, which was designed to facilitate innovative solutions to serve the community

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
					with dignity and provide the opportunity to share expertise and passion for ending hunger in San Diego through nutritious food and education.
	2. Improve access to diabetes educational resources for underserved populations in SDC.	a. Explore potential partnerships with the community clinics in order to offer diabetes classes at their clinic locations	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Access to Care Collaboration Community Clinics	The SHC Diabetes Education Program continues to collaborate with Family Health Centers of San Diego (FHCSD) to conduct outreach and education to vulnerable community members in SDC. In the south region, this specifically includes 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. At FHCSD's Chula Vista site, the SHC diabetes educators provided a lecture in Spanish to more than 30 community members on the basics of ¬¬¬diabetes and nutrition, including healthy eating, diabetes self-management and goal setting. **Overall program findings, July 2016 - mid June, 2017**: • 211 unique participants completed >1 classes • 56 unique participants completed >3 classes • 27% compliance

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<table>
<tr><th>Identified Community Health Need: Diabetes</th><th>Objectives/Anticipated Impact</th><th>Strategy/Action Items</th><th>Responsible Party/ies</th><th>Identified Themes in 2016 CHNA</th><th>Evaluation Methods, Measurable Targets, and Other Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<u>A1C Changes:</u>
32% improvement of participants with an A1C >8.1%
<table>
<tr><th colspan="4">56 Participants</th></tr>
<tr><th>A1C</th><th>Initial</th><th>Final</th><th>Difference</th></tr>
<tr><td><7</td><td>20</td><td>23</td><td>3</td></tr>
<tr><td><7.5</td><td>8</td><td>8</td><td>0</td></tr>
<tr><td>7.6 to 8.0</td><td>6</td><td>10</td><td>4</td></tr>
<tr><td>>8.1</td><td>22</td><td>15</td><td>-7</td></tr>
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<u>Weight Changes</u>:
<table>
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<tr><td># Participant that gain weight</td><td>25</td></tr>
<tr><td># Participant that maintain weight</td><td>8</td></tr>
</table>
<u>Next steps</u>: Currently, the SHC Diabetes Leadership and Educators are exploring more engaging educational methods, beyond PowerPoints. Lessons learned from the FHC partnership included that attendees responded more positively to sessions that were more conversational rather than lecture-based. Consequently, before additional FHC sites are added,
</td></tr>
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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's Diabetes team will revise their current educational materials to reflect this preference (e.g., less reliance on PPT, more discussion, visuals, etc.). The project monitors enrollees' A1C levels, and has proven successful outcomes in lowering and maintaining these levels through education and peer support. In addition, in FY 16, the SHC Diabetes Education Program continued 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. The SHC Diabetes Education Program collaborated with community clinics to provide patients with a variety of education and resources. Clinic patients also received logbooks to track and manage blood sugar levels. In addition, the SHC Diabetes Education Program evaluated patients' management of their blood sugar levels and collaborated with community clinics' obstetrician/gynecologists (OB/GYN) to prevent complications. **Findings:** At SCVMC, the SHC Diabetes Education Program collaborated with the hospital's OB/GYN to assist nearly 400 underserved pregnant women with

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
					diabetes, over the course of more than 1,500 visits. SHC Manager, Community Benefit and Health Improvement continues to work with the Diabetes Education Team to support and facilitate the FHCSD partnership. In addition, the SHC Diabetes Leadership team meets annually to evaluate the programs over the previous year.
		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 Manager, Community Benefit and Health Improvement	Uncontrolled Diabetes Education Access to Care Collaboration Food Insecurity	**Background**: 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 CalFresh outreach. Approximately 200 participants

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
					enrolled in the one-year Diabetes Wellness Project. **Findings of study released in Spring, 2017:** Participants with diabetes who received healthy food at clinic-based food pantries demonstrated statistically significant improvements in: • Household food insecurity status • Fruit and vegetable intake • Diabetes distress • Depression • Blood sugar control (for patients with HbA1c levels >=7.5) • Weight and Body Mass Index (for patients with HbA1c >=7.5) • Patients who were referred to off-site food pantries had no improvements and 89.5% of them did not go to an off-site food pantry despite personalized referrals

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
	3. 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 2016, the SCVMC Diabetes Education Program conducted two blood glucose screenings, screening nearly 85 community members. As a result of these screenings, 15 individuals were identified with elevated blood glucose levels and were referred to follow-up resources. Of those individuals with elevated blood glucose levels, one did not have a preexisting case of diabetes. Screenings were held at the Chula Vista Chamber of Commerce Mixer Health Fair and the SCVMC Heart Health Expo. **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 Label". CLIA REG - 1253 b 2 requires establishment of

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
					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.
	4. Improve access to diabetes educational resources for underserved and minority populations in San Diego	a. Create language-appropriate and culturally sensitive diabetes educational materials.	SHC Diabetes Leadership Team	Diabetes Education Care Management Collaboration	In FY 2016, the SHC Diabetes Education Program continued to provide services and resources to meet the needs of San Diego's newly immigrated Iraqi Chaldean population. The program facilitated

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
	County.				translation as well as provided resources to better understand Chaldean cultural needs. Educational resources included How to Live Healthy With Diabetes; What You Need to Know About Diabetes; All About Blood Glucose for People With Type 2 Diabetes; All About Carbohydrate Counting; Getting the Very Best Care for Your Diabetes; All About Insulin Resistance; All About Physical Activity With Diabetes; Gestational Diabetes Mellitus Seven-Day Menu Plan; Food Groups; and Arabic language materials for pregnancy. Food diaries and logbooks were given out to the community. Handouts were provided in Arabic as well as Somali, Tagalog, Vietnamese and Spanish, and live interpreter services were available in more than 200 languages via the Stratus Video Interpreting iPad application. Education was also provided to Sharp team members regarding the different cultural needs of these communities. Also exploring new opportunities for more effective methods and resources for properly translated educational materials (e.g. multi-lingual interns, etc.).

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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
	1. 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 FY16 SCVMC provided community health education classes on a variety topics, many including nutrition/healthy lifestyle resources, to more than 200 community members In addition, SCVMC provides ongoing educational sessions to Promotores in the South Bay - titled "Conviva y Aprenda." Each education and screening program provided by SCVMC and *on the SCVMC campus* is evaluated by participants through survey.

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
	2. 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 Manager SHC Community Benefit and Health Improvement	Collaboration Obesity Education	SCVMC's Program Manager of Community and Multicultural Relations is integrally involved in this initiative and SHC's Manager of Community Benefit and Health Improvement works with SCVMC's Program Manager of Community and Multicultural Relations to support and grow this collaboration. Developments in 2017 have included an increased focus on food insecurity/access to healthy food as well as increased awareness of SCVMC's most recent community health needs assessment. This latter has resulted in new opportunities to collaborate with the City, again largely around access to healthy food. **Background**: 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.

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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. 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.

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. SCVMC has provided educational sessions at San Ysidro Senior Center and St. Paul's Assisted Living Community Center and new: Community Congregational Church. Also in conversations with St. Charles Church in Imperial Beach and a Chula Vista senior housing complex. 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. SCVMC has provided educational sessions at San Ysidro Senior Center and St. Paul's Assisted Living Community Center and new: Community Congregational Church. Also in conversations with St. Charles Church in Imperial Beach and a Chula Vista senior housing complex. 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 2016, 235 admissions across the system; YTD FY 2017, 229 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.

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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
		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. Throughout the year the Sharp HospiceCare ACP team educated more than 700 local, state and national health care professionals on ACP and POLST, including, but not limited to, attendees of the San Diego Partners in Advance Care Planning Palliative Care and End-of-Life Planning conference; Cape Cod Healthcare; Arbor Hills Nursing Center; Cottage Hospital; Mountain Health; East County Action Network; SoCAN; HPNA; San Diego Professional Palliative Care Conference; Rainbow Hospice and Palliative Care; Neighborhood House Association; County AIS; Grossmont Post-Acute Care, SDCCEOLC; Coalition for Compassionate Care of California (CCCC), Sharp HealthCare's Advanced Illness Management Conference; Greater San Diego Business Association; and the California Association of Marriage and Family Therapists. In addition, the ACP team collaborated with the CCCC to offer a two-day POLST Train-the-Trainer workshop which trained 50 community health care providers on identifying the target population for POLST completion, how to

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
					facilitate a POLST conversation, and how to document patient treatment wishes on the POLST form.
	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 2016, ~1,400 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.
		a. Support the unique advanced illness management and end-of-life care needs of military veterans and their families through participation in veteran-oriented community events and services.	Bereavement Dept., Sharp HospiceCare;	Senior Health Veterans Education	FY 2016 veteran-specific community work included: • In May, participated in the San Diego County HVP and the Caregiver Coalition of San Diego's Veterans Resource Fair at the War Memorial Building in Balboa Park. The free event provided ~ 40 veterans, family members and caregivers with presentations on available health care services, VA benefits enrollment and estate planning. • In June, Sharp HospiceCare participated in the Operation Engage America Resource Fair at Liberty Station, an event hosted by Operation

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					Engage America — a nonprofit organization that provides support, awareness, education and resources for veterans, community members and families living with PTSD and TBI. Nearly 200 veterans, transitioning service members, first responders, families and other members of the community attended the free event which included education and resources from community organizations. • In August, Sharp HospiceCare participated in the VASDHS 2016 Community Mental Health Summit. The event brought together key community stakeholders in active dialogue around improving access to mental health services and addressing the mental health care needs of San Diego veterans and their family members. • In November, Sharp HospiceCare participated in Finding the Balance in Caregiving: Caring for Veterans, an educational seminar presented by the Caregiver Coalition of San Diego and the City of La Mesa. Held at the La Mesa Community Center, a free event provided approximately 100 attendees with education and resources on caring for veterans and their caregivers.

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					• Sharp HospiceCare also honored the nation's veterans at various community ceremonies and events in FY 2016. • Since 2010, member of the San Diego County Hospice Veterans Partnership - a coalition of VA facilities and community hospices working together to ensure excellent end-of-life care for veterans and their families. • Participation on the advisory board for the SCRC's Operation Family Caregiver. • Currently a Level 2 Partner, working towards Level 3 (4 levels available) in We Honor Veterans (WHV), a national program developed by the NHPCO in collaboration with the U.S. Department of Veterans Affairs (VA) to empower hospice professionals to meet the unique end-of-life needs of veterans and their families. As WHV partners, hospice organizations can achieve up to four levels of commitment in serving veterans. Level 2 partners have built the organizational capacity needed to provide quality care for veterans and their families. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital.

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
					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 2016, Sharp HospiceCare collaborated with community organizations to provide more than 2,500 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 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 2016, the Healing After Loss and the Widow's and Widower's ongoing bereavement support groups served approximately 200 community members.

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					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 2016, the program engaged approximately 2,000 community members in free ACP and POLST (Physician Orders for Life-Sustaining Treatment) education at a variety of community sites, including health fairs, senior 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.

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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
	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 to provide caregiver classes, end-of-life programs, advance care planning seminars and web presentations for consumers and health care professionals.	Business Development, Sharp HospiceCare	Senior Health Education Collaboration	Community presentations provided through Sharp HospiceCare– including those to professional organizations – are evaluated through survey to evaluate effectiveness and revise program content. Currently, this strategy is addressed by staff for Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However, these services are provided to community members and patients across Sharp – including Sharp Memorial Hospital.

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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
		c. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	Business Development Dept., Sharp HospiceCare	Senior Health Caregivers Collaboration	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.