Sharp Grossmont Hospital
Community Health Needs Assessment – Implementation Plan
Fiscal Year 2017-2020

Identified Community Health Need: Access to Care	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	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 and support high-risk, uninsured, underinsured, and patients admitted to hospital facilities with an inability to pay their financial responsibility after health insurance.	a. Provide the Maximum Out of Pocket Program to patients who express an inability to pay their financial responsibility after health insurance.	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.

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		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 Self-Pay Team Manager	Access to care Financial assistance	In Summer 2015, a pilot program was launched at Sharp Mary Birch Hospital for Women & Newborns in support of Sharp's NICU babies. This 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,	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

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		grant-based programs offered by foundations, copay assistance, low-cost alternatives, or research where the patient might find their medication at a lower cost.			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.
		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 FY16, more than 1,830 Sharp patients been assisted through the ClearBalance loan program.
		f. Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.	Sharp Grossmont Hospital (SGH) Chief Financial Officer	Access to Care	Project HELP funds are tracked though an internal database. From FY10-FY15, Project HELP funds totaled ~$792.8 K, and increased 58.4%.

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	3. Improve access and health outcomes 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.
		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	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.

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		other services through the San Diego Rescue Mission.			
		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 organizations to provide medical care, financial assistance, psychiatric and social services to high-risk, chronically ill, and/or	Vice President, SHC Government Relations Care Transitions	Access to Care Collaboration Care Management	With the success of Sharp Grossmont Hospital's Care Transitions Intervention (CTI) pilot (see line item below), Sharp is exploring the concept of expanding this model of care (connection to resources for food insecurity, transportation, and other social supports) to other high-risk patient populations at Sharp's hospital entities. In

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		chronically homeless patients	Program Manager Program Manager, Community Benefits and Health Improvement		progress.
		f. Continue to offer high-risk, vulnerable SGH patients (Self-Pay, Medi-Cal, Medi-Cal Presumptive, with complex chronic health conditions and limited social support) health coaching and resources (through multiple community partnerships) upon discharge to help ensure safe transition from hospital to home, and improve their quality of life; a Care Transitions Intervention (CTI) model pilot.	Care Transitions Program Manager Program Manager, Community Benefits and Health Improvement	Access to Care Care Management Collaboration	The CTI© program focuses on transitioning patient home safely by reviewing Medications, early recognition of symptoms, establishing a Medical Home, providing Advanced Care Planning choices and ensuring the patient has a plan for managing their care across the care continuum. Part of this is accomplished by connecting to patients to community resources (e.g., the San Diego Food Bank, 2-1-1 San Diego, Feeding America) that help them maintain their health and safety, including: food (directly), hunger relief organizations, transportation resources, access to a primary care physician for follow up care, medical equipment, and other social supports. In FY 2015, connections with Feeding America, San Diego and 211 San Diego were established with success.

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					With support for SGH Foundation, Wal Mart, SDGE and individual donors, the program has been able to support these patients with food, blood pressure cuffs, diabetes kits, pulse oximeters and pill boxes. The program is also able to assist with co-pays for medications should the need arise.
					
					Metrics since the inception of CTI (June, 2014):
					• 950 patients served
					• 457 (48%) required social support
					• 82 required food support (since Sept., 2014)
					• 55 received emergency food boxes (since March, 2015)
					• 25 received diabetes kits (since 2015)
					• 92 assist with PCP appt
					  o 75% patients made appts.
					  o 85% kept PCP appt.
					• 74 community clinic referrals
					• 83 Pharmacy support
					• 351 community resource information
					• 30 referral to 2-1-1
					• Readmission rates (30-day):
					  o Inpatient: 13.4 % average
					  o ED, post-discharge: 10.02%

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					o IP for those referred to 2-1-1: 4.7% For 2-1-1 partnership, also collecting metrics on social determinants of health and self-efficacy. Data forthcoming. A goal for the program is to integrate more Behavioral Health support as these are the patients that so often cannot be coached and need a specific Care Pathway.

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Identified Community Health Need: Behavioral Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. Provide comprehensive behavioral health programs to adults and older adults in East County with acute or persistent psychiatric disorders. Programs will help individuals in crisis regain their optimal level of functioning and achieve a renewed sense of emotional stability and wellness.	a. Continue to provide a dedicated psychiatric assessment team in the Emergency Department (ED) and acute care.	Director, SGH Behavioral Health Services Chief Medical Officer, SHC Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders Senior Health	SGH is the only hospital in East County to provide this assessment to patients in the ED. Psychiatric consultations in the ED have increased approximately 117% from 2007 (294 consults) to mid-2016 (637 consults). Although Behavioral Health is identified as a health need in the communities served by SGH, beyond clinical services, the facility does not have the resources to comprehensively address the elements of community education and support around this health need. Consequently, the community education and support elements of behavioral health care are addressed through the programs/services provided through Sharp Mesa Vista Hospital and Sharp McDonald Center, which are the major providers of behavioral health and chemical dependency services in San Diego County.
		b. Continue to provide hospital-based outpatient programs that serve individuals dealing with a variety of behavioral health issues, including schizophrenia, depression and bipolar or anxiety disorders.	Director, SGH Behavioral Health Services Chief Medical Officer, SHC Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders Senior Health	Current outpatient programs include: Adult Mental Health Program for adults with acute and chronic disorders such as schizophrenia and bipolar disease; Bridges Program, based on the Recovery Model for adults diagnosed with schizophrenia and bipolar disorder; Dual Recovery Program, for adults with co-existing mental illness and chemical-use/addictive behavior disorder; Older Adults (Senior) Mental Health Program, for adults age 60 and

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					older experiencing anxiety, depression and other behavioral health issues often associated with challenging, age-related life transitions; Outpatient Electroconvulsive Therapy (ECT) Program.
		c. Continue to offer specialized inpatient treatment programs designed to address the specific needs and conditions of patients.	Director, SGH Behavioral Health Services Chief Medical Officer, SHC Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders Senior Health	Current inpatient programs include: FOCUS program for adults suffering from psychiatric illness such as psychosis, delusions, depression, grief, anxiety, panic, obsessive-compulsive disorder, and traumatic stress syndromes; Intensive treatment programs for short-term crisis intervention, rapid recovery and return home; Medical Psychiatric Program and an Older Adult Program specifically for individuals age 60 and over.
		d. Explore collaboration with MHA's Mental Health First Aid Training to provide training to front-line SGH staff for improved management	SGH Chief Nursing Officer Program Manager, Community Benefits and Health Improvement	Behavioral Health Education Stigma Reduction Workforce Development	In Fall 2015, Sharp Grossmont Hospital staff attended a Sharp-hosted training with Mental Health First Aid– an internationally-renowned program that teaches front-line staff the signs and impacts of addiction and mental illness, including a 5-step action plan to assess and de-escalate situations, and local resources. This is a peer-reviewed, proven-effective program and is listed in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices. Sharp HealthCare is the first hospital/health system to participate in this training, currently funded by

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					the County of San Diego.

Identified Community Health Need: Cancer	Objectives/Anticipated Impact	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 San Diego's east region through patient navigation services.	a. Continue to offer the cancer patient navigator program to SGH cancer patients; facilitate connection to community resources via the navigator program.	SGH Cancer Patient Navigator Coordinator	Access to Care Care Management	In FY 2015, the Breast CPN facilitated access to care for more than 180 breast cancer patients in need — many with late-stage cancer diagnoses — through the provision of referrals to various community and national organizations. **Navigation Resources:** In FY 2016, due to a vacancy in Sharp's cancer navigator position, it was decided to replace the position with a navigator who was a social worker to better address patient needs. The position was filled with an LCSW in January, 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 will start in August, 2016. This team will cover all cancer sites, but will focus on those patients receiving radiation therapy. *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 evaluate these needs in greater detail in order to make them actionable and rate them by intensity so that they may be prioritized

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					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 Cerner. **Timely Access to Care:** Navigators have identified that timely access to specialist appointments and imaging

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					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. The Breast CPN is an RN certified in breast health who personally assists breast cancer patients and their families in their navigation of the health care system. The Breast CPN offers support, guidance, financial assistance referrals and connection to community resources. Through collaboration with community clinics — including FHCSD, Neighborhood Healthcare and Borrego Health — the Breast CPN refers unfunded or underfunded women for a covered diagnostic mammogram or immediate Medi-Cal insurance should their biopsy prove positive and require treatment. The Breast CPN also identifies patients who may benefit from the Breast and Cervical Cancer

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					Treatment Program, a program offered through the California Department of Health Care Services to provide urgently needed cancer treatment coverage, including referring patients to local clinics who help complete the enrollment process. Patients needing psychosocial support may be referred to various local or national support groups, the Jewish Family Service of San Diego's Breast Cancer Case Management program or the SGH Cancer Center Radiation Oncology Department's LCSW. Since 2014, a CPN at SGH has been designated for patients with cancers other than breast. The CPN primarily serves patients with head and neck cancers and lung cancer, but also assists those with anal and esophageal cancers as well as any cancer patient with complex care needs. The CPN supports patients and their family members through care coordination and connection to needed resources, including transportation, translation needs, financial assistance, speech therapy, nutritional support, feeding tube support, social work services and more. In addition, the CPN offers psychosocial support and education about the side effects of radiation therapy. The CPN has assisted nearly 160 patients and their families since the inception of the program.

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		b. Seek funding for the cancer patient navigator program and expand navigator services to all cancers.	SGH Patient Navigator	Access to Care Care Management	No current updates.
	2. Increase cancer education and support for community members in the east region with cancer diagnoses.	a. Continue to provide free support programs for community members with cancer diagnoses.	SGH Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY 2015, a variety of free support groups reached approximately 1,000 community members In SDC's east region impacted by cancer, including: bi-monthly breast cancer support group; monthly lung cancer support group; monthly brain cancer support group. In addition, beginning in the spring of 2015, the weekly Art and Chat support group offered cancer patients, survivors and their loved ones a combination of chat and relaxing drawing methods to increase focus, creativity, self-confidence and personal well-being. The SGH Cancer Center also offered the weekly chaplain-led Sacred Circle: Spirituality and Cancer support group, through which cancer patients used a mixture of expressive arts modalities, prayer, and discussion of personal and spiritual topics to restore their spirits. 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.

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					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 SGH 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. **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 Look Good… Feel Better classes to community members with cancer diagnoses.	SGH Cancer Patient Navigator Coordinator	Cancer Education Care Management Collaboration	In FY 2015, six Look Good…Feel Better classes taught approximately 30 women techniques to manage appearance-related side effects of cancer treatment and boost self-confidence. Offered through the ACS, the Look Good…Feel Better classes included a complimentary makeup kit for attendees and instruction from a licensed beauty professional on makeup application, skin care, and wearing wigs and headwear.

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		c. Continue to provide ongoing social and psychosocial supports to community member with cancer diagnoses.	SGH Cancer Licensed Clinical Social Worker	Cancer Education Care Management	In FY 2015, SGH's Cancer LCSW offered psychosocial services (assessments, crisis intervention, counseling and stress management), support group leadership, and advocacy and resources for transportation, palliative care and hospice, food and financial assistance. In FY 2015 this included improving patient and family connections to community services such as ACS, San Diego Brain Tumor Foundation, Leukemia and Lymphoma Society, Lung Cancer Alliance, Mama's Kitchen, 2-1-1 San Diego, Feeding America San Diego, SDFB and Jewish Family Service of San Diego's Breast Cancer Case Management program, and other food and financial assistance programs. The LCSW served approximately 230 patients and family members in FY 2015, and an additional 25 community members contacted the LCSW for consultation regarding support groups and other SGH Cancer Center services and community resources.
	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 screenings.	Manager, SGH Radiation Oncology HBO/WHC SGH Cancer	Cancer Education Collaboration Screenings	In FY 2015, the SGH Cancer Center provided breast self-examinations and cancer education and resources from the ACS and National Cancer Institute (NCI) to more than 500 individuals at community events, including the Cuyamaca College Health & Wellness Fair, East County Senior Service Providers 16th annual Senior Health Fair at Santee Trolley Square, the Southern Indian Health Council,

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			Patient Navigator Coordinator		Inc. Women's Wellness Health Fair, Sharp's annual Women's Health Conference, Sharp HospiceCare Resource & Education Expo and the Waterford Terrace Retirement Community Health Fair. In addition, SGH Cancer Center staff walked alongside cancer patients and families in the ACS Making Strides Against Breast Cancer Walk in October. The SGH Cancer Center also hosted educational classes at no cost for patients and community members facing cancer. Offered monthly between June and September, the Chair Yoga and Relaxation class taught individuals in all stages of cancer yoga postures, breathing and meditation techniques to help lower stress and calm the nervous system. The SGH Cancer Center also offered a 12-month Survivorship Lunch and Learn series in FY 2015, reaching approximately 10 individuals per session. Once a month, community members, patients and families were invited to hear local experts speak about a unique cancer-related topic — such as coping with the holidays, approaching survivorship with confidence, and complementary therapies – and participate in a Q&A session.

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Identified Community Health Need: Cardiovascular Disease	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. Empower community members with cardiovascular and cerebrovascular disease through education, screening and support; promote accountability and behavioral change through education on chronic disease self-management.	a. Continue to provide free bimonthly cardiac education classes.	Manager, SGH 5 West, Cardiac Rehabilitation Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication	Cardiovascular Disease Education	A free Heart and Vascular Risk Factors Education class was offered twice a month to individuals who were hospitalized within the last six months due to select heart conditions, reaching nearly 180 individuals in FY 2015. SGH educational programs are evaluated by participants through survey.
		b. Continue to provide free congestive heart failure education classes and support groups.	Manager, SGH 5 West, Cardiac Rehabilitation Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication	Cardiovascular Disease Education	In FY15, a free, monthly CHF class and support group, held at the Grossmont Healthcare District Herrick Community Health Care Library, provided approximately 45 community members with a supportive environment to discuss various topics about living well with CHF, covering topics such as exercise, nutrition, treatment plans and symptoms. SGH educational programs are evaluated by participants through survey.

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		c. Educational sessions focused on heart disease and cardiovascular health for the east region communities.	Manager, SGH 5 West, Cardiac Rehabilitation Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication	Cardiovascular Disease Education	Target is at least one to two community events per year – including health fairs and lectures. Past event have included: December Nights, Sharp Women's Health Conference and Celebrando. SGH educational programs are evaluated by participants through survey. In FY 2015, SGH's Cardiac Training and Cardiac Rehabilitation Departments provided education and free cardiovascular screenings at various community events throughout San Diego. Events included cardiopulmonary resuscitation (CPR) demonstrations and education and resources on cardiac health, including prevention, evaluation and treatment. Locations included the Summer Healthcare Saturday Health Fair at Grossmont Center, the SGH Women's Heart Health Expo, Celebrando Latinas Conference at the Hilton San Diego Bayfront, December Nights, the Sharp Women's Health Conference, and the American Heart Association (AHA) Heart & Stroke Walk. The team also collaborated with the SGH Senior Resource Center to educate 20 seniors at the Herrick Community Health Care Library about the importance of exercise and nutrition to maintain a healthy heart.

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					SGH educational programs are evaluated by participants through survey.
		d. Continue to provide educational resources on cardiac health at community events throughout San Diego.	Director, SGH Cardiac/ Vascular Services	Cardiovascular Disease Education	In FY 2014, SGH's Cardiac Training and Cardiac Rehabilitation Departments provided education and free cardiovascular screenings at various community events throughout San Diego (see item 1c above). Preventive cardiovascular screenings (fee-based) are comprehensive, include ultrasound, lab tests, and offer a calcium scoring option as well as assessing and educating the patient on his or her risk of a heart attack or stroke. SGH has screened approximately 900 individuals to date.
		e. Continue to provide preventative cardiovascular screenings to community members in San Diego's east region.	Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communications	Cardiovascular Disease Screenings	Preventive cardiovascular screenings (fee-based) are comprehensive, include ultrasound, lab tests, and calcium scoring as well as assessing and educating the patient on his or her risk of a heart attack or stroke. From FY 2008 to FY 2012, 634 individuals received these vascular screenings and 92 were referred for follow-up care, resulting in 869 outpatient visits.

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		f. Continue to participate in stroke screening & education events in San Diego, including events targeting seniors & high-risk adults as well as individuals with identified risk factors.	Vice President, SHC Ortho/Neuro Service Line Program Coordinator, Sharp Senior Resource Center	Cardiovascular Disease Education Screening Collaboration	Educational events conducted in collaboration with the Sharp Senior Resource Center collect evaluation forms to assess the quality of education/screening events. Feedback from these evaluations is incorporated for future planning. In addition, Sharp's Senior Resource Centers track attendance for each educational event and screening. Metrics on community members referred for follow-up are also tracked, and often participant's name and phone number are collected in order to facilitate follow-up. Often the community member talks to the department directly, or their provider (if a Sharp provider) is forwarded the information directly. Community members receive their results and feedback to take to their doctor on their own time.
	2. 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	Cardiovascular Disease Education 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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Identified Community Health Need: Cardiovascular Disease	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. Increase education of signs and symptoms of diabetes in East County.	a. Participate in educational forums, health fairs and events in San Diego's east region.	SHC Diabetes Leadership Team	Diabetes Education Collaboration	In FY 2015, the SGH Diabetes Education Program reached more than 1,770 community members through educational lectures and blood glucose screenings at hospital and off-site locations. Diabetes lectures were held at libraries, community centers, educational institutions and national conferences. Blood glucose screenings were provided at six community events including the Health & Wellness Fair at College Avenue Center, the Santee Cameron Family Health Fair at the Cameron Family YMCA, the Healthy Food Choices & Diabetes screening and lecture at the Dr. William C. Herrick Community Health Care Library, the Cuyamaca College Health Fair, the Waterford Terrace Health Fair and the 16th annual Senior Health Fair at the Santee Trolley Square. Collect feedback from community members on educational courses provided, in order to improve and refine educational resources tailored to community member needs. In addition, the SHC Diabetes Leadership team meets annually to evaluate the programs over the previous year.

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		b. Explore opportunities with new venues/ community groups to provide additional resources. E.g. churches, YMCA's and schools.	SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and Health Improvement	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.
		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 east region.	SHC Program Manager, Community Benefits and Health Improvement SHC Diabetes Leadership Team	Diabetes Food Insecurity Education Access to Care	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. 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 Partnership (see action item "Diabetes, d" below).
		d. Provide diabetes education to food-insecure adults enrolled in Feeding America San Diego's	SHC Diabetes Leadership Team	Uncontrolled Diabetes Education	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

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		Diabetes Wellness Project – a collaboration including UCSD's Student Run Health Clinic.	SHC Program Manager, Community Benefits and Health Improvement	Access to Care Collaboration Food Insecurity	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 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.
	2. Reduce incidence of Type 2 diabetes through education	a. Provide free prediabetes classes to community members in SDC's	SHC Diabetes Leadership	Diabetes Uncontrolled	New in August, 2016, the SGH Diabetes team began offering prediabetes classes to patients and community

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	and resources provided to individuals in SDC's east region with prediabetes.	east region.	Team	Diabetes Education Care Management	members in the east region who are either diagnosed with or at-risk for prediabetes. Metrics forthcoming. Sharp Program Manager, Community Benefits and Health Improvement to work with Diabetes Education Team on expanding prediabetes classes out to community organizations and clinics.
	3. Improve identification of pre-diabetes and diabetes in community members through screening.	a. Continue to coordinate and implement blood glucose screenings at community and hospital sites in SDC's east region.	SHC Diabetes Leadership Team	Uncontrolled Diabetes Screening Access to Care	In FY 2015, the SGH Diabetes Education Program reached more than 1,770 community members through educational lectures and blood glucose screenings at hospital and off-site locations. More than 250 community members were screened during these events and, as a result, more than 30 community members were identified with elevated blood glucose levels and were provided with follow-up resources. Of these individuals, more than 50 did not have a preexisting diagnosis of diabetes. **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

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					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. 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

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					potential impact of the outcome of the decision on the clinical laboratory and point of care community, there was a lot of speculation as to what POCT meter we would be able to use for community screenings as current POCT meters are approved for home use by FDA, and If we use meters outside of manufacturers recommendations it is considered “Off Label”. CLIA REG - 1253 b 2 requires establishment of performance specification (sensitivity and specificity) if we use meters “Off Label”. During 2015 the controversy continued and we explored any POCT meters that were approved for multiple use that we could use at community events. • 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. • Another change in late 2015: AB 333 - LQHE

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					discontinuation (Limited Quantity Hauler Exemption) and medical waste temporary events registration. Any BG screening operators are required to notify San Diego County department of Environmental Health (DEH) for each temporary event through Citizen Access Portal. Due to this change we were also required to print out the record number and send along with the permit request to the DHHA.
		b. Explore potential partnerships with the community clinics in order to offer diabetes classes at their clinic locations	SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and Health Improvement	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 vulnerable community members in SDC's east region, specifically the FHCSD site in Lemon Grove. 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 2016: • 4 sessions held in Lemon Grove • 61 attendees Overall through the partnership, Sharp Diabetes Educators

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					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 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 to work with Diabetes Education Team to support FHCSD partnership. In addition, the SHC Diabetes Leadership team meets annually to evaluate the programs over the previous year.
	4. Improve access to diabetes educational resources for	a. Create language-appropriate and culturally sensitive diabetes	SHC Diabetes Leadership	Diabetes Education	Materials have been updated for both Type 1 and 2 Diabetes, as well as Gestational Diabetes Mellitus post-

Identified Community Health Need: Diabetes	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	underserved populations in SDC's east region.	educational materials.	Team	Care Management Collaboration	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 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	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. In 2013, Sharp HealthCare began a community-wide effort to increase the early identification of health issues in the San Diego community through the provision of free health screenings for: cholesterol, blood sugar, body mass index (BMI), blood pressure and tobacco use. Locations in San Diego's east region included: El Cajon Jamboree, East County YMCA, Grossmont College Health Fair, East county Chamber Health Fair, Hatfield Park (Spring Valley), Santee Library, and the Westfield Parkway Shopping Center (El Cajon).	Sharp HealthCare Chief Experience Officer	Obesity Screening Education Collaboration	In FY 2015, Sharp HealthCare hosted 75 community health screening events throughout SDC, including the east region, 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 Sharp Grossmont

Identified Community Health Need: Obesity	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					provide various nutrition education opportunities for the community, i general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time.
		b. Coordinate and provide various health screenings, including BMI and blood pressure screenings at community events.	Manager, SGH Community Relations	Screenings Collaboration	In FY 2015 SGH participated in a variety of community events and provided education and health screenings for diabetes, stroke and heart health. Education and screenings include nutrition, and exercise education, as well as emphasis on maintaining a healthy weight and lifestyle. SGH also provides educational resources on risk factors for obesity and resulting chronic diseases. Education and programs provided by SGH are evaluated by participants through survey. Community screening participants receive their screening results, however additional follow-up, feedback and tracking is not conducted at this time.

Identified Community Health Need: Obesity	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	2. Provide care management in support of weight loss and healthy life style choices for San Diego community members.	a. NA	NA	Obesity Cardiovascular Hypertension Diabetes Chronic Disease Care Management	In general, resource limitations restrict growth beyond current programs and services provided at Sharp Grossmont Hospital 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 sites in SDC's east region. 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	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	1. Increase access for seniors and other high-risk populations to flu vaccines.	a. Continue to provide seasonal flu vaccinations at community sites for seniors with limited mobility and access to transportation, as well as for high-risk adults, including low-income, minority, chronically ill and refugee populations.	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care Transportation	In FY 2016, the SGH Senior Resource Center (SRC) provided 588 flu shots to seniors and high risk adults at 11 different sites including senior centers and three food banks. Because of increased availability of flu vaccine at grocery stores and pharmacies, numbers served by the SRC have decreased. However, the SRC is investing additional effort to reach the uninsured. For FY17: provide flu vaccinations to at least ten community sites. Provide flu clinics to at least three food bank sites. Track and evaluate trends in flu clinic attendance.
		b. Continue to coordinate the notification of seniors regarding the availability of seasonal flu vaccines and the provision of flu vaccines to high-risk individuals in selected community settings. Publicize flu clinics through media and community partners.	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care	Seniors were alerted through activity reminders, collaborative outreach conducted by the flu clinic site, Sharp.com and both paper and electronic newspaper notices. The flu clinic sites assisted in distributing flu clinic information and encouraged their clients to get vaccinated.

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		c. Continue to direct seniors and other chronically ill adults to available seasonal flu clinics, including physicians' offices, pharmacies and public health centers.	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care	Provided reminders to seniors who attend the SRC programs that flu vaccination is important for themselves and their families.
	2. Support the safety net for seniors living alone in East County.	a. Maintain daily contact through phone calls with East County individuals (often elderly and home-bound) in rural and suburban settings who are at risk for injury or illness, and continue supporting telephone reassurance call services for East County residents.	Program Coordinator, Sharp Senior Resource Center	Senior Health Care Management Access to Care	For FY 2016, through July 2016, 4,246 calls were made through the daily telephone reassurance call program with 42 alerts. In FY2016, 2 seniors were found on the floor and paramedics transferred them to area hospitals. One had fallen and the other fainted after not managing her diabetes well. Telephone reassurance call data are tracked internally by the Program Coordinator for the Sharp Senior Resource Center.
	3. Continue to host a variety of senior health education and screening programs, in	a. Provide information on various senior issues such as senior mental health, memory loss,	Program Coordinator, SGH Senior	Senior Health Education Screenings	In FY 2016 through July 2016, the SGH Senior Resource Center provided 45 free health education programs to nearly 988 community members. Nine screening events

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	order to raise awareness, identify risk factors, and connect seniors to helpful resources.	hospice, senior services, nutrition, healthy aging and balance and fall prevention.	Resource Center	Collaboration	were provided in FY 2016 through July 2016 to 153 seniors and as a result 14 attendees were referred to physicians for follow-up on their screening results. Each education program provided by or in collaboration with the Senior Resource Center is evaluated by participants. Evaluations include point scores and average evaluation scores, as well as open-ended questions such as: what was the most important thing participants learned, what other programs seniors (participants) would like. This feedback is provided to speakers so that they may refine future educational offerings. In addition, Sharp's Senior Resource Centers track attendance and for each educational event, flu vaccination event and screening held throughout the year. Metrics on community members referred for follow-up are also tracked, and often participants' names and phone numbers are collected in order to facilitate follow-up. Often the community member talks to the department directly, or their provider (if a Sharp provider) is forwarded the information directly. In addition, community members receive their results and feedback to take to their doctor on their own time.

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		b. Continue to participate in community health fairs for seniors	Program Coordinator, SGH Senior Resource Center	Senior Health Education Collaboration	In FY 2016 through July 2016, the SGH Senior Resource Center participated in health fairs in El Cajon, Rancho San Diego, Lakeside, Santee, La Mesa, Lemon Grove, the College Area and San Diego. Populations served at these fairs included seniors and caregivers; Parkinson's patients and caregivers, Dementia patients and caregivers, veterans and those caring for veterans, and Lesbian, Gay, Bisexual and Transgender (LGBT) seniors. In addition, the SGH Senior Resource Center event provided blood pressure screenings as well as educational resources on senior and caregiver services. Through participation in these events, the SGH Senior Resource Center provided education and resources to more than 1,813 community members through July 2016.
		c. Coordinate two conferences – one dedicated to family caregiver issues in collaboration with the Caregiver Coalition of San Diego and one focused on chronic care and advanced illness management in collaboration with Sharp HospiceCare.	Program Coordinator, SGH Senior Resource Center	Senior Health Education Collaboration	In collaboration with the Caregiver Coalition of San Diego, the SGH Senior Resource Center provided two conferences to more than 100 family caregivers: one focused on caring for veterans; and the other focused on caring for dementia. Conferences provided education on emotional issues, resources available in the community and legal issues. The SGH Senior Resource Center also partnered with Sharp HospiceCare and provided a conference to seniors and their families titled Life's Transitions: Changing Health

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					Care Needs through the Years. Held at the La Mesa Community Center the conference reached more than 80 community members and provided education on: Miscommunications in Health Care, Quality of Life Conversations, Legacy Planning and Coping with Life's Challenges.
	4. 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 and high-risk populations.	a. Maintain active relationships with community organizations serving seniors throughout San Diego. Organizations include: East County Senior Service Providers, Meals on Wheels, Caregiver Coalition, and the Caregiver Education Committee.	Program Coordinator, SGH Senior Resource Center	Senior Health Collaboration	As the Senior Resource Center increases the number of community partners it collaborates with, it is expected that additional opportunities will arise. In FY2016, the SGH Senior Resource Center attended meetings for East County Senior Service Providers, Aging Disability Resource Connection (ADRC) Advisory Board, Project CARE, Meals on Wheels Greater San Diego East County Advisory Board, Caregiver Coalition, and the Caregiver Education Committee throughout the year.
	5. Provide coordinated care to patients with advancing progressive chronic disease, in order to improve the individual experience as they near end-of-life.	a. Continue collaboration with Sharp HospiceCare to offer Sharp patients the Transitions program: a "pre-hospice" program designed to provide home-based palliative care and management for patients with advanced	Vice President, Sharp HospiceCare; Utilization Review, 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). Performance Target: 200 admissions across the system each year. In FY 2015, 300 admissions across the system; YTD FY 2016, 178 admissions.

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		progressive chronic illness. The program is adapted to match each patient's unique physical, emotional and spiritual needs.			
	6. 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	Track number of mailings annually through internal Access/Excel database. **In FY 2015**, approximately 1,300 community members received bereavement support newsletters.
		b. 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, and	Bereavement Dept., Sharp HospiceCare;	Senior Health Veterans Education	• In June, participated in the Operation Engage America Resource Fair, hosted by Operation Engage America, at Liberty Station, providing resources to nearly 200 veterans, families, caregivers and other community members. • Provided end-of-life care resources to ~ 100 attendees at the SCRC's Operation Family Caregiver conference at Camp Pendleton in October. • In August and October, provided education and resources at the Veterans, Military and Families Expos at the War Memorial Building at Balboa Park, to ~ 240 community members. • In November, provided education on ACP and

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					integrative therapies to ~ 50 veterans /families members at the VA San Diego Healthcare System's health fair • 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 1 Partner (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 1 partners are equipped to provide veteran-centric education to its staff and volunteers, including training them to identify patients with military experience.

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Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		c. Continue to provide community education and resource services throughout San Diego	Business Development, Sharp HospiceCare	Senior Health Education Collaboration	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.
		d. 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.
		e. 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

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					variety of community sites, including health fairs, senior centers, homecare agencies, churches and seminars.
		f. 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 Coordinator, Sharp Senior Resource Center	Senior Health Education Collaboration	Presentations provided to the health care community 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 Benefit Plan and Report. In FY 2015, Sharp HospiceCare provided: • Introductory education on hospice, bioethics and ACP to 36 advanced psychology students at Valhalla High School • Lectures on hospice, bioethics, ACP and advance directives to ~ 180 nursing students from Azusa Pacific University • Lectures on spiritual care in hospice to ~ 50 students in the Certified Hospice and Palliative Nursing Assistant training program through the HPNA. • Education to ~ 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, Senior Care Action Network (SCAN) Health Plan, the Center to

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					Advance Palliative Care (CAPC) National Conference, Caregiver Coalition of San Diego, etc. • A POLST Train-the-Trainer workshop to community health care providers • Educational outreach to local and national organizations (e.g., Good Samaritan Medical Center, Saddleback Memorial Medical Center, Highmark Health, Baylor Scott and White Health, Family Medicine Education Consortium, American Hospital Association (AHA) Leadership Summit, West Health Institute, etc.). Topics ranged from successful aging to ACP. • Sixth annual Resource and Education Expo titled Advanced Illness Management: Preserving Quality of Life for ~200 community health professionals.

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Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
	7. Provide education and outreach to the San Diego health care 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. Provide Advance Care Planning (ACP) Training to physicians, case managers and other health care professionals	Advance Care Planning Coordinator	Senior Health Education	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.
		b. 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	Vice President, Sharp HospiceCare Medical Director, Sharp HospiceCare	Senior Health Education Collaboration	Sharp HospiceCare provides approximately six presentations provided each year in collaboration with state and national organizations. Sharp HospiceCare leadership continues to serve as part of the CHCF Palliative Care Action Community, as well as the board, and as a state hospice representative, for NHPCO and CHAPCA. Community presentations provided through Sharp

Identified Community Health Need: Senior Health	Objectives/Anticipated Impact	Action Items	Responsible Party/ies	Identified Themes in 2016 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
		Care perspective, advanced Care planning, etc.			HospiceCare– including those to professional organizations – are evaluated through survey to evaluate effectiveness and revise program content.
	8. Collaborate with community, state and national organizations to develop and implement appropriate services for the needs of the aging population.	a. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	Business Development Dept., Sharp HospiceCare	Senior Health Collaboration	New community partnership: Lantern Crest in Santee; Elmcroft of San Diego (throughout the County as well as additional home care facilities.
		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	