# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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.<br><br>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<br>Patient Access Service<br><br>Representatives<br>Patient Access Services<br><br>Public Resource Specialist<br>Patient Access Service<br><br>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.<br><br>PointCare has expanded its website to also provide linkage to Covered CA as appropriate. The tool interfaces patient screening information in the GE record.<br><br>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.<br><br>Continued unknowns in understanding the efficacy of these 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.<br><br>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. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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 |
|---|---|---|---|---|---|
| | 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<br>Financial assistance<br>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;<br><br>Public Resource Specialist<br>Patient Access Service<br><br>Self-Pay Team Manager | Access to care<br>Financial assistance<br>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<br><br>Public Resource | Access to care<br>Financial assistance | This program was expanded to Sharp Grossmont in 2017 - outcomes/case data forthcoming.<br><br>This is a benefit to the family in that they not only get |

| 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 |
|---|---|---|---|---|---|
| | | | Specialist Patient Access Service<br><br>Self-Pay Team Manager | | support for their hospital stay, but many other services outside of the hospital to assist with the cost of care for their newborn. It is assistance not only for unfunded patients, but for insured families.<br><br>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 | Supervisor, Patient Assistance Navigators<br><br>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.<br><br>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 |

| 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 |
|---|---|---|---|---|---|
| | | 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. | | | Assistance Program.<br><br>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. |
| | | 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<br><br>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 | Sharp Grossmont Hospital (SGH) Chief Financial | Access to Care | Project HELP funds are tracked though an internal database. From FY10-FY16, Project HELP funds totaled > $964K, and increased 103.5%. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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 |
|---|---|---|---|---|---|
| | | disadvantaged patients. | Officer | | |
| | 3. Improve access and health outcomes for high-risk community members, particularly San Diego's homeless population. | a. Continue to collaborate with the San Diego Rescue Mission to discharge chronically homeless patients to the Rescue Mission's Recuperative Care Unit. These patients receive follow-up care through SGH in a safe space, in addition to psychiatric care, substance abuse counseling and other services through the San Diego Rescue Mission. | SHC VP Case Management Service Line | Access to Care<br>Care Management<br>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. |
| | | b. 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<br>Collaboration<br>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.<br><br>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. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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 |
|---|---|---|---|---|---|
| | | c. 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<br><br>Access to Healthy Food (Food Insecurity)<br><br>Collaboration<br><br>Care Management | Across Sharp HealthCare PFS:<br>YTD metrics through April, 2017: 367 CalFresh applications submitted, 209 applications approved, 15 applications pending. |
| | | 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 | SHC VP Case Management Service Line<br><br>Care Transitions Program Manager<br><br>Manager, Community Benefit and Health Improvement | Access to Care<br>Collaboration<br>Care Management | 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 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.<br><br>2. Integrated Care Management is currently working with leaders across the Sharp continuum (SHC, SMV, SRS, SCMG) for alternative solutions for hard to place patients |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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. |
| | | e. 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) | SHC VP Case Management Service Line<br><br>Care Transitions Program Manager<br><br>Manager, Community Benefits and | Access to Care Care Management Collaboration | **CY 2016 Results**:<br>• 526 patients enrolled in CTI<br>• 13% (69) identified as food insecure and provided food bags/referred to Feeding San Diego<br>• Avg. readmission rate for CY 2016 =~9%, compared to nearly 20% for those patients who qualify for but do not accept CTI services<br>• Readmission rate for patients identified **only** with food insecurity = 7.2%<br>• Of those that received food boxes, 75% (38) kept their PCP appointments, which is a higher rate |

| 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 |
|---|---|---|---|---|---|
| | | model pilot. | Health Improvement | | • than the general group (63%)<br>• 12% of CTI patients (62) referred to 2-1-1 Health Navigation Program; 31 referred completed the program<br>• 95% of those patients that completed 2-1-1 Health Navigation Program decreased vulnerability in one or more of the following areas: Housing, Food/Nutrition, Social/Community, Income/Benefits, Legal, Physical/Behavioral Health, Transportation, Employment, Utility, Clothing, Education, ADLs<br>• Readmission rate for patients that completed the 2-1-1 Health Navigation Program = 9.6%<br>• 94% of patients that completed the 2-1-1 Health Navigation Program believed there care was well coordinated<br>• 95% of patients that completed the 2-1-1 Health Navigation Program were confident in their current plan to maintain their health<br><br>Future steps: Looking to re-apply for Grossmont Hospital Foundation funds to continue support of the CTI program; specifically the partnerships with Feeding San Diego and 2-1-1 San Diego. |

| 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 |
|---|---|---|---|---|---|
| | | | | | **Background**: 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.<br><br>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. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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<br><br>Chief Medical Officer, SHC Behavioral Health | Behavioral Health<br>Screening<br>Access to Care<br>Co-occurring disorders<br>Senior Health | SGH is the only hospital in East County to provide this assessment to patients in the ED. Average daily census of psych patients in ED is 20 patients per day. This is ~6.4% of the total patient population seen in the ED. 95% of psych admissions are from the ED. Psychiatric consultations in the ED have increased approximately 117% from 2007 (294 consults) to mid-2016 (637 consults).<br><br>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, | Director, SGH Behavioral Health Services<br><br>Chief Medical | Behavioral Health<br>Screening<br>Access to Care<br>Co-occurring | 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 |

| 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 |
|---|---|---|---|---|---|
| | | depression and bipolar or anxiety disorders. | Officer, SHC Behavioral Health | disorders<br>Senior Health | 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 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<br><br>Chief Medical Officer, SHC Behavioral Health | Behavioral Health<br>Screening<br>Access to Care<br>Co-occurring disorders<br>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. |

| 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<br>Care Management | In FY 2016, the Breast CPN facilitated access to care for 217 breast cancer patients in need — many with late-stage cancer diagnoses — through the provision of referrals to various community and national organizations.<br><br>**Navigation Resources:**<br>*Metric (forthcoming):* Patients served. Currently implementing systemwide changes to Cerner that capture documentation and automate this reporting.<br><br>**Identification and Prioritization of Needs:** Distress Screening to assess practical and emotional issues contributing to cancer patient distress has been conducted at Sharp Grossmont Hospital 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 and addressed appropriately.<br>*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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | additional support and resources to better meet our patient needs. New in 2017: a policy has been approved establishing the pivotal time to give each radiation and infusion patient at least one distress screening assessment.<br><br>**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. 2017 update: this is on track; received first proof to review in August, 2017.<br><br>**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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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.<br>*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. 2017 Update: focused work has been done on breast and improvements noted. I have follow-up stats for 2016 data. Need to review and complete assessment for other top sites before year end.<br><br>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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | treatment. The Breast CPN also identifies patients who may benefit from the Breast and Cervical Cancer 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.<br>**2017:** Other outreach services include Cancer Detection Program, CancerCare Transportation Grant, Mama's Kitchen, and Breast Cancer Angels.<br><br>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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | the side effects of radiation therapy. A unique team of experts work with the head and neck patients to prevent malnourishment and hospitalization. This team consists of the CPN, LCSW, Licensed Dietitian, and Speech Pathologist. The CPN has assisted nearly 250 patients and their families since the inception of the program. |
| | | b. Seek funding for the cancer patient navigator program and expand navigator services to all cancers. | SGH Patient Navigator | Access to Care<br>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<br>Care Management | In FY 2016 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 monthly Lunch and Learn, and weekly Art and Chat support group. A new support group was added call Knit & Crochet which provides cancer patients, survivors, and their loved ones to knit and crochet hats and blankets for patients to increase tactile function, creativity, self- confidence and personal well-being. The Man Cave was also started to provide an atmosphere for males to chat amongst each other about treatments, side effects, life lessons, and their |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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.<br><br>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.<br><br>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.<br><br>*Metrics:* Number of Patient Organizers delivered for SGH (YTD 2017 = 66). Initiation of patient information website section. |

| 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 |
|---|---|---|---|---|---|
| | | 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 2016, 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. |
| | | 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 2016, 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.<br><br>The LCSW served 312 patients and family members in FY 2016, and an additional 30 community members contacted the LCSW for consultation regarding support groups and other SGH Cancer Center services and community resources. |

| 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 |
|---|---|---|---|---|---|
| | 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. Target underserved populations. | Manager, SGH Radiation Oncology HBO/WHC<br><br>SGH Cancer Patient Navigator Coordinator | Cancer Education Collaboration Screenings | In FY 2016, the SGH Cancer Center provided breast self-examinations and cancer education and resources from the ACS and National Cancer Institute (NCI) to more than 700 individuals at community events, including the YMCA Spring into Healthy Living, Nutrition for Breast Cancer, East County Senior Service Providers 17th annual Senior Health Fair in Santee Advances San Diego Film Festival, Sharp's annual Women's Health Conference, Women's Fitness World Health Fair and the Waterford Terrace Retirement Community Health Fair. In addition, SGH Cancer Center staff walked alongside cancer patients and families in the Free to Breathe Lung Cancer Walk in August and the ACS Making Strides Against Breast Cancer Walk in October.<br><br>The SGH Cancer Center also hosted educational classes at no cost for patients and community members facing cancer. The SGH Cancer Center also offered a 12-month Survivorship Lunch and Learn series in FY 2016, reaching approximately 12 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. |

| 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 |
|---|---|---|---|---|---|
| | | | | | In-services were also provided to the Chaldean Collaborative Outreach Committee and Borrego Health Clinics to educate the staff on our processes and programs as well as understanding their needs and concerns in the healthcare system. A presentation was provided to physicians in the advances and controversies in melanoma and other skin cancers. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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<br><br>Director, SGH Cardiac/ Vascular Services<br><br>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 280 individuals in FY 2016.<br><br>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<br><br>Director, SGH Cardiac/ Vascular Services<br><br>Director, SGH Marketing and Communication | Cardiovascular Disease Education | In FY16, a free, monthly CHF class and support group provided approximately 70 individuals with a supportive environment to discuss various topics about living well with CHF., covering topics such as exercise, nutrition, treatment plans and symptoms.<br><br>SGH educational programs are evaluated by participants through survey. |

| 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 |
|---|---|---|---|---|---|
| | | c. Educational sessions focused on cardiovascular disease and cerebrovascular health for the east region communities. | Manager, SGH 5 West, Cardiac Rehabilitation<br><br>Director, SGH Cardiac/ Vascular Services<br><br>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.<br><br>In FY 2016, SGH's Cardiac Training Center and Cardiac Rehabilitation Departments participated in a variety of community events throughout San Diego in FY 2016. Together, they offered community members free blood pressure screenings, cardiopulmonary resuscitation (CPR) demonstrations, and education and resources on cardiac health, including prevention, symptom recognition, evaluation and treatment. Events included: the annual Sharp Women's Health Conference, the Sharp Disaster Preparedness Expo, SGH's 2016 Heart Health Expo and the AHA Heart & Stroke Walk. The Cardiac Rehabilitation team also provided free flu shots to more than 20 community seniors during a flu clinic held at the hospital in October.<br><br>The team also collaborated with the SGH Senior Resource Center to educate 15 seniors at the Herrick Community Health Care Library about the importance of exercise and nutrition to maintain a healthy heart. |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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 2016, 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). |
| | | e. Continue to provide preventative cardiovascular screenings to community members in San Diego's east region. | Director, SGH Cardiac/ Vascular Services<br><br>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.<br><br>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 1,115 individuals since 2008. |
| | | f. Continue to participate in stroke screening & education events in San Diego, including events targeting seniors & high-risk adults as well as individuals with | Vice President, SHC Ortho/Neuro Service Line | Cardiovascular Disease Education Screening Collaboration | In FY 2016, the SGH Stroke Center conducted 11 education and screening events in SDC's east region, providing more than 500 community members with information about stroke risk factors, warning signs, and appropriate interventions including arrival at the hospital within early |

| 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 risk factors. | Program Coordinator, Sharp Senior Resource Center | | onset of symptoms. Events were held at various community sites, including but not limited to: Point Loma Presbyterian Church; Heartland Fire & Rescue in El Cajon; McGrath Family YMCA; ECSSP's 17th annual East County Senior Health Fair at Sunrise Community Church; and a host of others. The SGH Stroke Center identified risk factors during the stroke screenings, provided education, and advised behavior modification — including smoking cessation, weight loss and stress reduction at all events.<br><br>In collaboration with the SGH Senior Resource Center, the SGH Stroke Center and a Sharp interventional neuroradiologist presented on the recent advances in emergency treatment for stroke and provided resources to more than 30 community members at the Dr. William C. Herrick Community Health Care Library in May. The SGH Stroke Center also conducted personal health interviews, blood pressure and pulse checks, and provided education on emergency treatment for stroke, prevention and warning signs, and how to respond using FAST.<br>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. |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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 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. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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 2016, the SGH Diabetes Education Program reached more than 80 community members in the east region through educational lectures hospital and off-site locations, including Lemon Grove Family Health Center.<br><br>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. |
| | | b. Explore opportunities with new venues/ community groups to provide additional resources. E.g. churches, YMCA's and schools. | SHC Diabetes Leadership Team<br><br>SHC Manager, Community Benefit and Health Improvement | 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.<br><br>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. |

| 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 |
|---|---|---|---|---|---|
| | | 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 Manager, Community Benefit and Health Improvement<br><br>SHC Diabetes Leadership Team | Diabetes<br>Food Insecurity<br>Education<br>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.<br><br>Current efforts focus on:<br>• *Clinic collaborations* (Family Health Centers Partnership continuance)<br>• Exploring *partnerships to address food insecurity as part of nutrition education, and incorporating food insecurity screening* into patient diabetes education and counseling.<br>• *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 health.<br><br>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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | insecurity screening and referrals/resource connection for patients/community members.<br><br>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 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 participated in Feeding San Diego's 2016 Nutrition Symposium, which was designed to facilitate innovative solutions to serve the community with dignity and provide the opportunity to share expertise and passion for ending hunger in San Diego through nutritious food and education. |
| | | d. Provide diabetes education to food-insecure adults enrolled in Feeding San Diego's Diabetes Wellness Project – a collaboration | SHC Diabetes Leadership Team | Uncontrolled Diabetes Education Access to Care | **Background**: In 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 |

| 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 |
|---|---|---|---|---|---|
| | | including UCSD's Student Run Health Clinic. | SHC Manager, Community Benefit and Health Improvement | Collaboration Food Insecurity | 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.<br><br>**Findings of study released in Spring, 2017:**<br>Participants with diabetes who received healthy food at clinic-based food pantries demonstrated statistically significant improvements in:<br>• Household food insecurity status<br>• Fruit and vegetable intake<br>• Diabetes distress<br>• Depression<br>• Blood sugar control (for patients with HbA1c levels >=7.5) |

| 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 |
|---|---|---|---|---|---|
| | | | | | • Weight and Body Mass Index (for patients with HbA1c >=7.5)<br>• 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<br><br>**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.<br>**Findings**: At SGH, the SHC Diabetes Education Program collaborated with the hospital's OB/GYN to assist more than 400 underserved pregnant women with diabetes over the course of nearly 1,950 visits. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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 |
|---|---|---|---|---|---|
| | 2. Reduce incidence of Type 2 diabetes through education and resources provided to individuals in SDC's east region with prediabetes. | a. Provide free prediabetes classes to community members in SDC's east region. | SHC Diabetes Leadership Team | Diabetes<br>Uncontrolled Diabetes<br>Education<br>Care Management | In FY16, the SGH Diabetes team offered four on-site (at the hospital) prediabetes classes, teaching more than 30 community members about risk factors, and nutrition and lifestyle tools for prevention. As turnout for these classes was relatively low, future classes have been postponed while more effective options/avenues to provide this education are explored. Participation of SHC's Diabetes Service Line in the CDC's Diabetes Prevention Program currently supports/addresses this gap.<br><br>Sharp Manager, Community Benefit and Health Improvement to work with Diabetes Education Team on expanding prediabetes classes out to community organizations and clinics. In addition, work within the CDC's National Diabetes Prevention Program may also help to address prediabetes. |
| | | b. Explore potential partnerships with the community clinics in order to offer diabetes classes at their clinic locations | SHC Diabetes Leadership Team<br><br>SHC Manager, Community Benefit and Health | Access to Care<br>Collaboration<br>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'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 |

<table>
<tr><th>Identified Community Health Need: Diabetes</th><th>Objectives/Anticipated Impact</th><th>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>Improvement</td><td></td><td>and encourages peer support and education from project “graduates” to current patients/project enrollees.<br><br>In SDC’s east region, in FY16, the SHC Diabetes Education Program provided a diabetes lecture to 50 community members at the FHCSD Lemon Grove site. Topics included nutrition, physical activity, diabetes mellitus, self-management and goal setting.<br><br><u>Overall program findings, July 2016 - mid June, 2017</u>:<ul><li>211 unique participants completed >1 classes</li><li>56 unique participants completed >3 classes</li><li>27% compliance</li></ul><u>A1C Changes:</u><br>32% improvement of participants with an A1C >8.1%<br><br>
<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>
</table>
</td></tr>
</table>

| 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 |
|---|---|---|---|---|---|
| | | | | | **Weight Changes**:<br><br>**# Participant that lost weight** 23<br>**# Participant that gain weight** 25<br>**# Participant that maintain weight** 8<br><br>**Next steps**: 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, SHC's Diabetes team will revise their current educational materials to reflect this preference (e.g., less reliance on PPT, more discussion, visuals, etc.).<br><br>The project monitors enrollees' A1C levels, and has proven successful outcomes in lowering and maintaining these levels through education and peer support.<br><br>Sharp Manager, Community Benefit and Health Improvement continues to work with the 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 |
|---|---|---|---|---|---|
| | | | | | 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. |
| | 4. Improve access to diabetes educational resources for underserved populations in SDC's east region. | 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 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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | communities.<br><br>Also exploring new opportunities for more effective methods and resources for properly translated educational materials (e.g. multi-lingual interns, etc.). |

| 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 education and screenings for community members that address risk factors for obesity. | a. Coordinate and provide various health screenings, including BMI and blood pressure screenings at community events. | Manager, SGH Community Relations | Screenings Collaboration | In FY 2016 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.<br><br>Manager of SGH Community Relations is also currently working with the SHC Manager of Community Benefit and Health Improvement to explore opportunities to provide education and resources on nutrition, heart health, medication management, and other health issues to Chaldean and Middle-Eastern Social Services (a division of San Ysidro Health Centers) in El Cajon.<br><br>Education and programs provided by SGH are evaluated by participants through survey. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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<br>Cardiovascular<br>Hypertension<br>Diabetes<br>Chronic Disease<br>Care<br>Management | In general, resource limitations restrict growth beyond current programs and services provided at Sharp Grossmont Hospital that specifically address obesity at this time.<br><br>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. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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<br>Access to Care<br>Transportation | YTD in FY 2017 (July, 2017), the SGH Senior Resource Center provided 514 flu shots to seniors and high-risk adults at 12 different sites, including senior centers, the Salvation Army and 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 and high risk adults.<br><br>For FY18: 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<br>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.<br><br>The flu clinic sites assisted in distributing flu clinic information and encouraged their clients to get vaccinated. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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. Encouraged community partners who work with seniors to remind staff and clients of the importance of vaccinations. |
| | 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 2017, through June 2017, 3,702 calls were made through the daily telephone reassurance call program with 45 alerts. This included 2 new clients.<br><br>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 order to raise awareness, identify risk factors, and connect seniors to helpful | a. Provide information on various senior issues such as senior mental health, memory loss, hospice, senior services, nutrition, healthy aging and balance and fall prevention. | Program Coordinator, SGH Senior Resource Center | Senior Health Education Screenings Collaboration | In FY 2017 through July 2017, the SGH Senior Resource Center provided 59 free health education programs to nearly 1,400 community members. Six screening events were provided in FY 2017 through July 2017 to 131 seniors and as a result 7 attendees were referred to physicians for follow-up on their screening results. |

| 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 |
|---|---|---|---|---|---|
| | resources. | | | | 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.<br><br>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. |
| | | b. Continue to participate in community health fairs for seniors | Program Coordinator, SGH Senior Resource Center | Senior Health Education Collaboration | In FY 2017 through July 2017, the SGH Senior Resource Center participated in 25 health fairs throughout the east region, including El, Lakeside, Santee, La Mesa, Lemon Grove, the College Area and San Diego. Populations served at these fairs included seniors and caregivers; Parkinson's |

| 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 |
|---|---|---|---|---|---|
| | | | | | patients and caregivers, Dementia patients and caregivers, veterans and those caring for veterans, and Lesbian, Gay, Bisexual and Transgender (LGBT) seniors.<br><br>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 1,658 SGH employees and east region community members through July 2017. |
| | | 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 conferences for San Diego's Asian community and caregivers of community members with mental illness. Conferences provided education on emotional issues, resources available in the community and legal issues.<br><br>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 Care Needs through the Years. Held at the La Mesa Community Center the conference reached nearly 100 community members and provided education on: Miscommunications in Health Care, Quality of Life |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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.<br><br>In FY2017, the SGH Senior Resource Center attended meetings for East County Senior Service Providers, Meals on Wheels San Diego County, East County Advisory Board, Caregiver Coalition, and the Caregiver Education Committee throughout the year. In addition, the Program Coordinator serves on the Sharp Equality Alliance, an internal committee that provides outreach to various community organizations. |
| | 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 progressive chronic illness. The program is adapted to match each patient's unique physical, | Vice President, Sharp HospiceCare;<br><br>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).<br><br>Performance Target: 200 admissions across the system each year. In FY 2016, 235 admissions across the system; YTD FY 2017, 229 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 |
|---|---|---|---|---|---|
| | | 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 2016**, approximately, 1400 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. | Bereavement Dept., Sharp HospiceCare; | Senior Health Veterans Education | FY 2016 veteran-specific community work included:<br>• 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.<br>• In June, Sharp HospiceCare participated in the Operation Engage America Resource Fair at Liberty Station, an event hosted by Operation 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 |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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.<br>• 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.<br>• 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.<br>• Sharp HospiceCare also honored the nation's veterans at various community ceremonies and events in FY 2016.<br>• Since 2010, member of the San Diego County Hospice Veterans Partnership - a coalition of VA |

| 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 |
|---|---|---|---|---|---|
| | | | | | facilities and community hospices working together to ensure excellent end-of-life care for veterans and their families.<br>• Participation on the advisory board for the SCRC's Operation Family Caregiver.<br>• 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. |
| | | 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.<br><br>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, |

| 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 |
|---|---|---|---|---|---|
| | | | | | 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.<br><br>In FY 2016, 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.<br><br>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. |
| | | f. Continue to conduct outreach activities and provide professional education on hospice-related topics to community agencies, health care facilities, colleges and | Medical Director, Sharp HospiceCare<br><br>Business | 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. |

| 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 |
|---|---|---|---|---|---|
| | | universities on hospice and palliative care. | Development, Sharp HospiceCare<br><br>Program Coordinator, Sharp Senior Resource Center | | In FY 2016, Sharp HospiceCare provided:<br>• The ACP team provided introductory education on ACP, POLST, hospice, bioethics and goals of care to more than 400 students, including nursing students from Azusa Pacific University, SDSU, and California State University San Marcos (CSUSM); social work students from University of Southern California; San Diego Mesa College students; and Advanced Placement Psychology students at Valhalla High School.<br>• Education, training and outreach to local, state and national health professionals throughout the year. Audiences included Cape Cod Healthcare Quality of Life Management Summit; CHAPCA; Delaware Valley Accountable Care Organization conference; BIT third annual World Congress of Geriatrics and Gerontology; Rainbow Hospice Care; Outcome Resources pharmacy benefit management solutions; the Annual Assembly of the American Academy of Hospice and Palliative Medicine and HPNA; Winneshiek Medical Center Palliative Care Conference; CCCC Annual Summit; CSUSM Institute for Palliative Care and SDCCC Palliative Care Across the Continuum conference; Harvard Law School; and Caregiver Coalition of |

| 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 |
|---|---|---|---|---|---|
| | | | | | San Diego. Presentation topics included palliative care economics, advanced illness management, geriatric frailty, prognostication, delirium and treatments, ACP and POLST.<br>• Lectures on spiritual care in hospice to ~ 50 students in the Certified Hospice and Palliative Nursing Assistant training program through the HPNA.<br>• A POLST Train-the-Trainer workshop to community health care providers<br>• Participated in Sharp's continuing education conference titled Advanced Illness Management: An Integrated Approach across the Continuum of Care. The free conference educated approximately 100 physicians, nurses, social workers, chaplains, bereavement counselors, other interested health care providers and community members on AIM, tools to facilitate improved care coordination and planning, and communication strategies to help guide difficult conversations. |

| 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 | The Sharp 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.<br><br>Also participated in Sharp's continuing education conference titled Advanced Illness Management: An Integrated Approach Across the Continuum of Care. Free conference; served ~100 physicians, nurses, social workers, chaplains, bereavement counselors, other health care providers and community members on AIM, tools to facilitate improved care coordination and planning, and communication strategies to help guide difficult conversations. |
| | | b. Continue active involvement with | Vice President, | Senior Health | Sharp HospiceCare provides approximately six |

| 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 |
|---|---|---|---|---|---|
| | | 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. | Sharp HospiceCare<br><br>Medical Director, Sharp HospiceCare | Education Collaboration | presentations provided each year in collaboration with state and national organizations.<br><br>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.<br><br>Community presentations provided through Sharp 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 | No new community partners; efforts ongoing. |
| | | 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 | Business Development, Sharp HospiceCare | Senior Health Education Collaboration | No new updates; efforts ongoing. |

# Sharp Grossmont Hospital
# Community Health Needs Assessment – Implementation Strategy
# Fiscal Year 2018-2021

| 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 |
|---|---|---|---|---|---|
| | | Planning seminars and web presentations for consumers and health care professionals | | | |