Sharp Memorial Hospital and Sharp Mary Birch Hospital for Women & Newborns
Community Health Needs Assessment – Implementation Plan
Fiscal 2017-2020

Identified Community Need: Access to Care	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	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 hospital 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. Utilize 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.	Supervisor, Patient Assistance Navigators	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

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					exchange and the transition of qualified unfunded patients directly to Medi-Cal. Sharp has initiated a process of trending straight self-pay collections separate from balance after insurance collections in an effort to closely monitor these two distinct populations.
	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.	All Revenue Cycle Staff	Access to care Education	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 Financial Services (system- level) Public Resource Specialists	Access to care Education	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.

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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). Public Resource Specialists have assisted more than 60 families through the process of applying for SSI. This is a benefit to the family in that they not only get 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.
		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	Supervisor, Patient Assistance Navigators Manager Patient Financial Services, Self-Pay Patients	Access to care Education	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 health system in San Diego to gain Certification through the Covered CA program, training over 20 employees to become Certified Enrollment Counselors for CoveredCA.

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		assistance, which can help decrease readmissions due to lack of medication access. The team members research all options available including programs offered by drug manufacturers, grant-based programs offered by foundations, copay assistance, low-cost alternatives, or research where the patient might find their medication at a lower cost.			This, along with Hospital Presumptive Eligibility, has reduced the unfunded population at our hospitals significantly. 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 Manager Patient Financial Services, Self-Pay Patients	Access to care Education	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	Sharp Memorial Hospital (SMH) Chief Financial	Access to Care	Project HELP funds are tracked though an internal database. From FY10 – FY1F4, funds for SMH Project HELP totaled ~$634K.

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		other needs for economically disadvantaged patients.	Officer		
	3. Improve access to health and social services for high-risk community members, particularly San Diego's homeless population.	a. Provide data to St. Vincent de Paul for Permanent Supportive Housing Cost Effectiveness Study– which provides housing and social services to San Diego's chronically homeless community members.	Vice President, Sharp HealthCare (SHC) Government Relations	Access to Care Collaboration Care Management	This effort concluded in FY15, 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 SMH in a safe space, in	SHC, VP of Case Management Service Line	Access to Care Care Management Collaboration	Program tracks the number of referrals made to the Rescue Mission as well as cost data for patients for whom Sharp covers the cost of post-discharge treatment (at a Sharp facility). Data for the latter are tracked via Sharp's Case Management Department's cost reports.

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		addition to psychiatric care, substance abuse counseling and 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.	SHC, VP of Case Management Service Line	Access to Care Collaboration Care Management	Eligibility for Project SOAR's programming is incorporated into Sharp's current eligibility review process for all patients; patient files are assessed for Project SOAR eligibility and then referrals are conducted for qualified patients. Currently there are no mechanisms in place to track cost or volume on this program, as it is a cooperative with no direct costs for Sharp. Thus, it is difficult to 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 chronically homeless patients	Care Transitions Program Manager Program Manager, Community Benefits and Health Improvement	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 progress.

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			Vice President, SHC Government Relations		
	4. Increase health literacy for patients and community members through education and outreach.	a. Continue to partner with local, national and international organizations to increase health literacy in the community and increase referrals and connections to community resources.	Consumer Health Librarian, Community Health Library at the Cushman Wellness Center	Education Collaboration	Community organization membership/collaboration includes: CHIP Health Literacy Taskforce, San Diego Volunteer Lawyers Program, Jewish Family Services, various Sharp departments and others. Connection to community resources includes American Cancer Society, Alzheimer's Association, and the Caregiver Coalition, among others. Three community presentations completed thus far in 2016, including San Diego Center for the Blind, SDSU Nursing Students, Connections Housing. In addition, the consumer health librarian also shared health literacy best practices with the larger health care community through contribution of articles to the Journal of Hospital Librarianship and The San Diego Union-Tribune,.

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		b. Continue to grow the Health Information Ambassador Program to increase health literacy for hospital patients and their family members. The program is a partnership of the Community Health Library and Volunteer Department to provide patient education directly to the patient bedside – the most preferred method of information/education delivery by the patient.	Consumer Health Librarian, Community Health Library at the Cushman Wellness Center	Education Care Management	Health Information Ambassador Program statistics are tracked monthly through an internal database, and include the following metrics: Rooms Visited, Requests Filled, and Volunteer Hours. YTD for 2016 (July, 2016), the Health Information Ambassador Program has filled 465 requests, a slight increase from YTD 2015 (435 requests).
		c. Explore opportunities to expand health literacy education to underserved and marginalized populations.	Consumer Health Librarian, Community Health Library at the Cushman Wellness Center	Education Collaboration Care Management Access to Care	Community organization membership/collaboration includes: CHIP Health Literacy Taskforce, San Diego Volunteer Lawyers Program, Jewish Family Services, various Sharp departments and others. Connection to community resources includes American Cancer Society, Alzheimer's Association, and the Caregiver Coalition, among others.

Identified Community Need: Behavioral Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	1. Not applicable	a. Not applicable	NA	Behavioral Health Education Stigma	In Fall 2015, Sharp Memorial Hospital staff participated in Mental Health First Aid - an internationally-renowned program that teaches front-line staff the signs and impacts of addiction and mental illness, including a 5-step action plan to assess and de-escalate situations, and local resources. This is a peer-reviewed, proven-effective program and is listed in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices. Sharp HealthCare is the first hospital/health system to participate in this training, currently funded by the County of San Diego. The training for Sharp Memorial Hospital staff will be held on October 26, 2015. Although Behavioral Health is identified as a health need in SMH's patient community, the facility does not have the resources to comprehensively address this priority. The behavioral health needs of SMH's patient community 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. In addition, SMH's Clinical Social Workers provide patients with support, education and resources to help address behavioral/emotional health issues that often accompany many health conditions (e.g., cancer, post-

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					partum depression, physical rehabilitation, etc.).

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	1. Improve navigation of the health care system for cancer patients through patient navigation services.	a. Continue to offer the cancer patient navigator program to SMH cancer patients.	SMH Clinical Case Manager, Oncology Administration	Cancer Access to Care Patient Navigation Care Management	The Laurel Amtower Cancer Institute at SMH includes the Breast Health Center and the Neuro-Oncology Center, with four oncology patient navigators, two designated licensed clinical social workers (LCSW), a dietician, and a genetics counselor to guide and support patients and their families from the time of diagnosis through the course of treatment The patient navigators are assigned to a group of specific cancer diagnoses, including breast cancer; brain tumors; leukemia and lymphomas; head and neck, and lung cancers; and colon, rectal, renal, prostate, gynecological and all other cancers. The patient navigators provide ongoing guidance for patients and families, including facilitation of appointment scheduling; explanation of procedures and test results; provision of education and support during diagnosis and treatments; and provision of financial resources and referrals to community agencies. In FY 2015, LCSWs served more than 2,000 individuals through free psychosocial and emotional support, education and referrals for patients and their family members, while the

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					dietician received nearly 300 new patient referrals for nutrition counseling. Serving SMH, SGH and SCVMC, the genetics counselor provides risk assessment, counseling, genetics testing for personal and family history of cancer and referrals for high-risk patients. In FY 2015, the genetics counselor reached approximately 250 oncology patients and family members and dedicated nearly 450 hours to genetics counseling across each entity. Patients are tracked internally, and patients meet with the navigator on their initial visit. Navigation services provided to patients are closely tracked through internal databases. **Navigation Resources:** In FY 2016, there was a vacancy in Sharp's cancer navigator position. The individual hired to fill this position was a MSW/LCSW social worker to better address patient needs. The position was filled with in February, 2016. Later in 2016 with growing clinical needs, approval was secured to hire an RN to meet both Navigator and Radiation Oncology needs. That position was filled in August, 2016. This team will provide navigation

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					services for adult patients with all cancer types. *Metric:* Navigation FTEs. **Identification and Prioritization of Needs:** Distress Screening to assess practical and emotional issues contributing to cancer patient distress has been conducted at Sharp Chula Vista Medical Center over the past few years. A recent effort was initiated by Sharp Cancer Outpatient social workers to develop a consistent tool across the Sharp system that would evaluate these needs in greater detail in order to make them actionable and rate them by intensity so that they may be prioritized and addressed appropriately. *Metrics:* Routine reports including number of patients screened, information on the issues that are most challenging for patients and the percentage of patients rated in high distress will be provided to the Integrated Network Cancer Program and to individual entities. The information will drive efforts to target and provide additional support and resources to better meet our patient needs. **Navigation Communication:** Currently patient navigation is not consistently documented and easily accessible to all care team members.

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					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 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

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					to treatment for key sites that will capture the predominant issues and annual evaluation of the change in number of days to treatment at least annually. Also measured will metrics specific to focused projects on key processes identified that are contributing to delays in care.
		b. Continue to seek funding for the cancer patient navigator program and expand navigator services to all cancers.		Cancer Access to Care Care Management	No metrics to date.
	2. Increase cancer education and support for community members with cancer diagnoses.	a. Offer physician-led lectures/ educational presentations to provide personal information about cancer diagnoses by reviewing pathology reports and explaining in layman's terms.	SMH Clinical Case Manager, Oncology Administration	Cancer Education Care Management	In April, a free physician-led Breast Cancer Education Forum was held for individuals with a recent breast cancer diagnosis. Attendees learned about the pathological wording and staging of their particular cancer type as well as various treatment options. Development of programs and services driven by Distress Screening (see action item "Cancer: a" above) and feedback from navigators, social workers and other staff will be ongoing. Expansion of Sharp partnership with the American Cancer Society to provide education

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					and support materials and community support connections to ACS Patient Organizers. This will be in conjunction with Sharp information for patient education, services offered, information specific to care at SCVMC and additional connections to community and national organizations that provide assistance to cancer patients. A specific portion of Sharp's website (sharp.com) is planned for cancer patients to provide information and tools that will be helpful to patients during the course of their cancer journey. **Metrics (forthcoming):** Number of Patient Organizers delivered (?); initiation of patient information website section; number of hits on the patient website indicating use.
		b. Continue to provide meeting space for Look Good… Feel Better classes to cancer patients.	SMH Clinical Case Manager, Oncology Administration	Cancer Education Care Management Collaboration	This free program is offered by the ACS to teach women with cancer beauty techniques to help manage the side-effects related to cancer treatment.
		c. Continue to provide ongoing support groups to members of the community diagnosed with	SMH Medical Social Worker, Oncology Administration	Cancer Education Care Management	Monthly and bimonthly cancer support groups reached as many as 10 to 20 attendees per session in FY 2015. Support groups included Women's Cancer, Life After Cancer, Living with

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		cancer.	SMH Clinical Case Manager, Oncology Administration		Advanced Cancer, Care Partner — a support group specifically for friends and family members of cancer patients, and the Young Patient's support group — the only support group in San Diego for young adult men and women with cancer.
	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 a special focus on nutrition.	SMH Clinical Case Manager, Oncology Administration	Cancer Education Collaboration Screenings	Educational classes reached nearly 250 individuals impacted by cancer. Utilizing resources and guidelines from the National Cancer Institute (NCI), American Institute for Cancer Research, ACS, and the Environmental Working Group, free nutrition classes educated participants on maintaining optimal nutrition and basic nutrition and dietary recommendations during and after breast cancer treatment. A six-week Food for Life cooking series educated participants about the power of food for cancer prevention and survival. Instructed by the Cancer Project — a program of the Physicians Committee for Responsible Medicine (PCRM) — the series included nutrition lectures, live cooking demonstrations and food tastings to help participants learn how to prepare simple and healthy meals at home. An Exercise and

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					Stress Management class was also offered, which taught relaxation methods to allow the body to heal and easy strategies for exercising without going to the gym. Cancer education and screening events offered by SCVMC are evaluated through participant surveys. Surveys include point scores to measure the value of the program content, as well as opportunities for open-ended feedback from community members. These surveys exclude the Las Damas screenings, as SCVMC serves solely as a host for the events.
		b. Provide cancer education and resources to community members through participation in community events.	SMH Clinical Case Manager, Oncology Administration	Cancer Education Collaboration	Throughout FY 2015, the Laurel Amtower Cancer Institute staff provided cancer education and resources to hundreds of community members at a variety of community events, including the San Diego State University (SDSU) 2015 Health Expo — The Road to Wellness; the 30th annual Linda Vista Multicultural Fair & Parade; Fiesta del Sol family festival; and the Sharp Women's Health Conference. In observance of National Cancer Survivors Day, the Laurel Amtower Cancer Institute staff held a celebratory event for three days in June to recognize cancer survivors, support cancer patients and educate

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					the community, including a Survivorship Education class held later that month.

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	1. Empower community members with cardiovascular and cerebrovascular disease through education and support; promote behavioral change to improve their care management.	a. Continue to provide heart disease and stroke support groups to community members; support groups are hosted on the Sharp Memorial Hospital campus.	SHC Manager of Rehab Services Supervisor, SMH Cardiac Rehab/Health Promotion, Cushman Wellness Center Director, SMH Cardiovascular Service Line	Cardiovascular Disease Education Care Management	Current cardiac/stroke-related support groups include: Women With Heart Disease, Congestive Heart Failure, and Heart Transplant/Family Support Group. In addition, throughout FY 2015, the SMH Rehabilitation Center provided meeting space for Young Enthusiastic Stroke Survivors (YESS), a free weekly support group for survivors of stroke and head injuries and their loved ones, as well as professionals and educators. Education topics included coping skills; adjustment; family and intimacy; work and school re-entry; and support. The SMH Cardiac Rehabilitation program provides exercise therapy, education and support (staff to patient & peer to peer), to community members either with or at risk for heart disease. Program goals are to increase exercise tolerance and reduce associated risk factors for both primary & secondary prevention of heart disease. Measureable outcomes include increased exercise tolerance, decreased resting BP, body weight, %body fat, & pre-exercise blood sugar and improved SF 36 (Quality of Life Survey) scores post participation.

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					The YESS Program will explore participant satisfaction surveys/evaluation tools for recommendations to implement for the upcoming fiscal year.
		b. Continue to provide cardiac education at community events throughout San Diego, including the provision of information on blood pressure and body composition and providing information on reducing stroke and heart attack risk.	Supervisor, SMH Cardiac Rehab/Health Promotion, Cushman Wellness Center	Cardiovascular Disease Education Collaboration	SMH Cardiac Rehab and Cushman Wellness Center repeatedly participate in Sharp's annual Women's Health Conference, as well as the San Diego Crew Classic and worksite health fairs. The teams have also provided presentations at senior centers in San Diego, and monthly "lunch & learn" presentations sponsored by the Cushman Center at the Outpatient Pavillion focus on wellness and integrative medicine modalities to improve health.
		c. Continue to participate in stroke education events in San Diego, including events targeting seniors & high-risk adults as well as individuals with identified risk factors.	SHC Vice President of Ortho/Neuro Service Line Program Coordinator, SMH Senior Resource Center (SRC)	Cardiovascular Disease Education Collaboration	In FY 2015, the SMH Stroke Program collaborated with the SMH Senior Resource Center to provide a presentation and screening at Point Loma Community Presbyterian Church to 40 community members titled Stroke Is a Brain Attack. During the event, a neurologist discussed stroke prevention and warning signs, and stroke screenings were provided to ~20 community members.

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					Collaborations with the Senior Resource Center conduct and collect evaluation forms to assess the quality of education/screening events and incorporate feedback from community members 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. In addition, community members receive their results and feedback to take to their doctor on their own time.
	2. Increase access to cardiovascular and stroke health screenings to the San Diego community.	a. Continue to provide the Heart Attack and Stroke Screening Program (HASP) to community members.	Director, SMH Outpatient Pavilion Supervisor, SMH Cardiac Rehab/Health	Cardiovascular Disease Education Screening	SMH collects feedback from patients participating in the Heart Attack and Stroke Program (HASP) through survey (after their results are complete). Questions document communication with patient, and evaluate patient satisfaction, as well as any behavioral changes as a result of their screening. Data from

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			Promotion, Cushman Wellness Center Clinical Nurse, Lead RN for HASP Screenings, SMH-OPP Center for Health Assessment and Promotion		the follow up tool indicate continued excellent patient satisfaction and exercise & nutritional lifestyle changes as a result of participation in the screening. The Cushman Wellness Center continues to offer the Heart Attack and Stroke Screening program utilizing two advanced technologies, the CardioHealth Station and the SphygmoCor XCEL. The CardioHealth Station, using ultrasound technology, screens for carotid artery plaque and measures carotid artery wall thickness which has been shown to be an early indicator for atherosclerotic disease. The SphygmoCor XCEL non-invasively measures standard and central blood pressure (blood pressure at the heart) and provides important information about artery health and risk for heart disease, stroke, kidney disease and dementia, as well as information helpful in managing hypertension. All participants receive a thorough results review and education regarding making positive lifestyle changes to reduce risk of heart disease and stroke. Since the start of the program in May 2012, the program has screened more than 700 participants.

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					The Cushman Wellness Center will begin to offer "stand alone" advanced blood pressure screening & advanced body composition assessment with recommendations for decreasing risk for heart disease & stroke starting Oct. 1 2016.
		b. Continue to participate in stroke screening events in San Diego, including events targeting seniors & high-risk adults as well as individuals with identified risk factors.	SHC Vice President of Ortho/Neuro Service Line Program Coordinator, SHC Resource Center	Cardiovascular Disease Screenings Access to Care	In FY 2015, the SMH Stroke Program collaborated with the SMH Senior Resource Center to provide a presentation and stroke screenings at Point Loma Community Presbyterian Church to 40 community members titled Stroke Is a Brain Attack. ~20 seniors received stroke screenings. In addition, Sharp provided stroke screenings with pulse checks and risk education to more than 80 attendees at the Sharp Women's Health Conference held at the Sheraton San Diego Hotel and Marina. Topics included different types of strokes, how to identify risk factors for stroke, strategies for risk reduction and stroke recognition. Events conducted in collaboration with Sharp's

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					Senior Resource Center collect evaluation forms to assess the quality of education/screening events. Feedback from these evaluations is incorporated for future planning. Further, 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. In addition, community members receive their results and feedback to take to their doctor on their own time.
	3. Collaborate with other health care organizations in San Diego on stroke education and prevention efforts.	a. Continue participation in San Diego County Stroke Consortium	SHC Vice President of 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 April 2016. Stroke education, including warning signs and how to respond, was displayed on the JumboTron throughout the evening to a crowd of more than 44,400 community members

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	1. Increase education of signs and symptoms of diabetes.	a. Participate in educational forums, health fairs and events throughout San Diego.	SHC Diabetes Leadership Team	Diabetes Education Collaboration	In FY15, the SMH Diabetes Education Team provided diabetes education (often in combination with screenings) to more than 750 community members through several health fairs and events with a special focus on seniors, renal patients, Pre-Diabetes, and others. The SMH Diabetes Education Program screened nearly 50 people through these events and identified 16 attendees with elevated blood glucose levels. Of these identified individuals, 10 did not have a preexisting diagnosis of diabetes. At the Sharp Women's Health Conference (which serves community members across SDC), the SHC Diabetes Education Program provided resources on diabetes management and nutrition. Through fundraising and team participation, the SHC Diabetes Education Program also continued to support the ADA's Step Out: Walk to Stop Diabetes held in October at Mission Bay. Sharp's Diabetes Educators fulfill a set amount of community hours as part of their role, depending on their status (e.g., 1.0 FTEs provide 8hours, 0.6 FTE provides 6 hours, etc.).

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					SHC Program Manager, Community Benefits and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. Programs planned/being explored for FY 2017 include continued Family Health Centers of San Diego partnership. Feedback is collected from community members on educational courses provided, in order to improve and refine educational resources for community member needs. In addition, the SHC Diabetes Leadership Team meets annually to evaluate the programs over the previous year.
		b. Explore opportunities with new venues/ community groups 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	In FY 15, SHC Diabetes Education Program continued collaboration with Family Health Centers of San Diego (FHCSD) to conduct outreach and education to vulnerable community members in the South Bay. Sharp Diabetes educators supported the expansion of FHCSD's Diabetes Management Care Coordination Project (DMCCP), which provides FHCSD patients with group diabetes education and encourages peer support and education from project "graduates" to current

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					patients/project enrollees. The project monitors enrollees' A1C levels, and has proven successful outcomes in lowering and maintaining these levels through education and peer support. In the South Bay, the SHC Diabetes Education Program provided a lecture in Spanish on the basics of diabetes and nutrition, to 40 community members at the FHCSD Logan Heights site. Outcomes data expected in early FY 2017. In FY15 the SHC Diabetes Education Program collaborated with La Maestra Community Health Centers to educate and advise underserved pregnant women and breastfeeding mothers with Type 1, Type 2 or gestational diabetes on how to manage blood sugar levels. In addition, the SHC Diabetes Education Program evaluated patients' management of their blood sugar levels and collaborated with La Maestra's obstetrician/gynecologist (OB/GYN) to prevent complications. At SMH, the SHC Diabetes Education Program collaborated with the hospital's OB/GYN to assist more than 150 underserved pregnant women with diabetes, over the course of more than 620 visits.

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					SHC Program Manager, Community Benefits and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. Programs planned/being explored for FY 2017 include continued Family Health Centers of San Diego (including the Chula Vista site) collaboration, and collaboration with clinics in Imperial Beach. Program Manager, Community Benefits and Health Improvement to meet with SHC Diabetes Leadership Team regularly to assess additional opportunities for outreach and education. Current discussions focus on clinic collaborations (Family Health Centers Partnership continuance) and exploring partnerships to address food insecurity as part of nutrition education, similar to Feeding America San Diego / UCSD Student-Run Clinic Partnership (see action item "Diabetes, d" below).
		c. Utilize findings in the FY 2016 CHNA to assess existing community resources and explore areas where additional diabetes	SHC Diabetes Leadership Team SHC Program	Diabetes Education Access to Care Collaboration	Program Manager, Community Benefits and Health Improvement to meet with SHC Diabetes Leadership Team regularly to assess additional opportunities for outreach and education.

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		education and resources may be needed.	Manager, Community Benefits and Health Improvement		Current discussions focus on clinic collaborations (Family Health Centers Partnership continuance) and exploring partnerships to address food insecurity as part of nutrition education, similar to Feeding America San Diego / UCSD Student-Run Clinic Partnership (see action item "Diabetes, d" below).
		d. Provide diabetes education to food-insecure adults enrolled in Feeding America San Diego's Diabetes Wellness Project – a collaboration including UCSD's Student Run Health Clinic.	SHC Diabetes Leadership Team SHC Program Manager, Community Benefits and Health Improvement	Uncontrolled Diabetes Education Access to Care Collaboration Food Insecurity	New in FY15-FY16, the SHC Diabetes Education Program provided diabetes education to food insecure adults enrolled in Feeding America San Diego's (FASD) Diabetes Wellness Project, a randomized, controlled trial and collaboration between UCSD's Student-Run Free Clinic Project, the Third Avenue Charitable Organization (TACO) and Baker Elementary School in Southeast San Diego. The Diabetes Wellness Project screens adult clinic patients with Type 2 diabetes for food insecurity, and provides them with ongoing medical treatment and diabetes management through the clinic. In addition, FASD provides Diabetes Wellness Food Boxes to project participants, in conjunction with a monthly diabetes and nutrition education course. Provided by an SHC Diabetes Educator - as well as CalFresh outreach. Approximately 200 participants enrolled in the one-year Diabetes

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					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. 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 San Diego County.	SHC Diabetes Leadership Team Program Manager, SCVMC Community and Multicultural Relations	Diabetes Screening Access to Care Collaboration	In FY 2015, the SMH Diabetes Education Program conducted multiple blood glucose screenings in the community, screening nearly 50 people through these events and identified 16 attendees with elevated blood glucose levels. Of these identified individuals, 10 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

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					found that very few of the elevated BG levels were due to people who were unaware they had diabetes, rather they were diagnosed but wanted to get there BG checked; thus, it seemed we were not reaching our target audience. It was then decided to focus our efforts by providing education to the underserved who had no access to education due to lack of insurance or funding, and provide classes that would benefit and educate in a more meaningful manner. 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

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					Test Systems for Prescription Point-of-Care Use. Since its release, the uncertainty has been building among hospital laboratory management and point of care coordinators over the future of point of care glucose meter use. Because of the potential impact of the outcome of the decision on the clinical laboratory and point of care community, there was a lot of speculation as to what POCT meter we would be able to use for community screenings as current POCT meters are approved for home use by FDA, and If we use meters outside of manufacturers recommendations it is considered “Off Label”. CLIA REG - 1253 b 2 requires establishment of 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

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					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.blood glucose levels. Community members with elevated blood glucose levels are referred for follow-up to either PCP or 82-SHARP, and uninsured patients are referred to community clinics in the South Bay.
	3. Improve access to diabetes educational resources for underserved and minority populations in San Diego County.	a. Create language-appropriate and culturally sensitive diabetes educational materials.	SHC Diabetes Education Leadership Team	Diabetes Education Care Management Collaboration	Materials have been updated for Type 1 and 2 Diabetes, as well as Gestational Diabetes Mellitus post- discharge. Materials are designed to assist mothers after delivery as well as to advise on how to manage blood sugars while breast feeding. Materials have also been completed for the Chaldean and Vietnamese populations in San Diego. Materials for Vietnamese populations include gestational diabetes, as well as a culturally-appropriate 7-day meal plan. Also exploring new opportunities for more

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

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	1. Improve outcomes for expectant mothers experiencing high-risk pregnancy, as well as their babies, through research initiatives and provision of specialized care for premature and/or other complicated births.	a. Continue to meet the need for high-risk pregnancy services through the, 84-bed Level III NICU – the largest in San Diego and one of the largest in Southern California.	Chief Executive Officer, Sharp Mary Birch Hospital for Women & Newborns (SMBHWN) Director, SMBHWN Women's and Neonatal Services	High Risk Pregnancy Access to Care	The hospital's 84-bed NICU features a 15-bed area with private rooms designed specifically for families who are transitioning their babies from hospital care to home. Specialized, private rooms allow families to spend the night and begin to care for their babies more independently with the care and support of the nursing staff. Additionally, nine more private rooms offer intensive care for a total of 24 private rooms for infants who are at risk for or who have experienced brain injury in the Neurologic Intensive Care Unit within the NICU.
		b. Provide a Perinatal Special Care Unit	Chief Executive Officer, SMBHWN Director, SMBHWN Perioperative & Obstetric Services Manager of PSCU & ADC	High Risk Pregnancy Access to Care	One of the few units of its kind in the country, a highly-skilled team including nurses and perinatologists, care for the high-risk antepartum patient on this specially designed 36-bed unit. Patients with preterm labor, complicated with diabetes and/or hypertension, and cardiac complications, comprise the majority of the patient population. Patients are admitted for observation due to obstetrical complications and managing fetal conditions or placenta abnormalities such as placenta previa or placenta accrete. As the length of stay ranges from a few days to several months, the care

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					team members are challenged to meet the entire spectrum of needs for the PSCU patient and her family.
		c. Neonatal Research Institute (NRI)	Chief Executive Officer, SMBHWN Director, SMBHWN Women's and Neonatal Services	High Risk Pregnancy Access to Care	The second edition of the NRI Newsletter was released Oct 2015 and the third volume was released to community physicians and allied health professionals in June 2016. The purpose of this newsletter is to keep the local medical community updated on the studies and current activities of the NRI. The first edition was released in February, 2015. The NRI was established to identify and disseminate the latest scientific evidence on newborn care. The NRI includes the Parent Advisory Board (NRI-PAB) consisting of parents and grandparents of infants who have been in the NICU. Among other input, the NRI-PAB provides feedback on proposed and current clinical trials to ensure other parents will understand and feel comfortable participating in them. Current clinical trials aimed at improving outcomes for at-risk newborns include: delayed umbilical cord clamping; premature infant resuscitation with oxygen or air; sustained lung inflation in the delivery room; and treatment of

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					ductus arteriosus, an opening between the two major blood vessels leading from the baby's heart, which should close shortly after birth but can mistakenly remain open.
	2. Increase access to perinatal care for underserved populations	a. Provide education about high risk pregnancy services and other women's services offered at SMBHWN to consumers and community physicians	SMBHWN Business Development/ Service Line Specialist	High Risk Pregnancy Access to Care	In March 2016, the second annual CME conference was held for community physicians/clinicians. Physicians attended from as far away as Stanford, Loma Linda, Orange County, Yukapia, El Centro and many local practitioners. Several physicians from the local Community Clinics were able to attend this year. In response to a seminar held in 2014 on women's pelvic health, a second free, public community seminar was held on Nov. 10, 2015 for women with incontinence, pelvic pain or other pelvic health concerns. Once again, the seminar was well attended; some coming as far as North County San Diego.
		b. Coordinate services with community clinics	SMBHWN Business Development/ Service Line Specialist	High Risk Pregnancy Access to Care	Initial meeting with Medical Director of San Diego Family Care and Director of Nursing to ensure a seamless delivery of care for their patients receiving care at Sharp Mary Birch Hospital for Women & Newborns.

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		c. Implement Maternal (Perinatal) Transport Program	SMBHWN Business Development/ Service Line Specialist	High Risk Pregnancy Access to Care	This program is currently (Summer, 2015) on hold. As of Summer, 2014, the Phase I of the Program is complete and will be rolled out to the community pending final Administration approval.
		d. Identify incoming high-risk mothers and complex newborns transferred to SMBHWN from local hospitals; ensure communication between facilities/providers for optimum continuing of care.	SMBHWN Business Development/ Service Line Specialist	High Risk Pregnancy Care Management	Monthly analysis and review of patients transferred to SMBHWN is ongoing; data available for review upon request. Electronic tracking system implemented July, 2014.
	3. Reduce the incidence of neonatal morbidity and mortality associated with preterm delivery through outreach, education and support to new mothers and their families around preterm birth and prenatal health in San Diego. Target outreach	1. Continue to offer free monthly preterm birth prevention classes on the warning signs of preterm labor and preventing preterm births.	Director, SMBHWN Maternal Infant Services and Support Programs Manager, SMBHWN Women's Support Programs	High Risk Pregnancy Education	Sharp Mary Birch collects evaluations from participants in all of its educational offerings, in order to assess quality and incorporate feedback for improvement of future classes. Annual metric: • Prenatal education: 5,500 hours

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	to teenage mothers in San Diego.				
		b. Continue to provide a variety of educational programs and workshops for new mothers and their families covering various aspects of prenatal care (e.g., preparing for birth, medication choices, newborn characteristics, etc.)	Director, SMBHWN Maternal Infant Services and Support Programs Manager, SMBHWN Women's Support Programs	High Risk Pregnancy Education Care Management	Sharp Mary Birch collects evaluations from participants in all of its educational offerings, in order to assess quality and incorporate feedback for improvement of future classes. Annual metrics: • Prenatal education: 5,500 hours • Perinatal Special Care Unit Education (inpatient): 48 hours
		c. Continue to provide Teen Child Birth Preparation courses to pregnant teens in San Diego.	Director, SMBHWN Maternal Infant Services and Support Programs Manager, SMBHWN Women's Support Programs	High Risk Pregnancy Education	Sharp Mary Birch collects evaluations from participants in all of its educational offerings, in order to assess quality and incorporate feedback for improvement of future classes. • Annual metrics: 48 hours of education for Teen Child Birth Preparation.
	4. Provide support and education to new mothers and their families on postpartum care, in order to improve outcomes for both new mothers and their	a. Continue to provide breastfeeding support groups, post-partum support groups, and multiple loss support groups to community members	Director, SMBHWN Maternal Infant Services and Support Programs Manager, SMBHWN Women's Support	High Risk Pregnancy Education Care Management	Sharp Mary Birch does not collect evaluations on their support groups. • Breastfeeding support groups: 300 hours (in FY14: ~1,900 mothers) • Post-partum support groups: 150 hours (in FY14: ~ 800 mothers)

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	babies.		Programs		• *Baby and Me Time support group: 72 hours (in FY15: 400 new parents)
		b. Continue to provide a variety of educational courses to new mothers and their families on postpartum care through Family Home Care classes for patients and community classes (e.g., breastfeeding, car seat safety, postpartum depression and anxiety, infant nutrition, positive parenting techniques, etc.).	Director, SMBHWN Maternal Infant Services and Support Programs Manager, SMBHWN Women's Support Programs	High Risk Pregnancy Education Care Management	Sharp Mary Birch collects evaluations from participants in all of its educational offerings, in order to assess quality and incorporate feedback for improvement of future classes. Family Home Care classes are provided daily at no cost to patients, and imparts vital information on topics such as car seat safety, breastfeeding, signs and symptoms of illness, sleep strategies, Sharp postpartum resources and more. The program has seen an increase in attendance over recent years. Patient feedback on the education and educator has been overwhelmingly positive. Annually provides 360 hours of education.

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		c. Demonstrate best practices in breastfeeding and maternity care, and provide education and support to new mothers on the importance of breastfeeding. Achieve Baby-Friendly USA Designation by Spring, 2015 through the implementation of evidence-based maternity care practices and participation in the NICHQ Best Fed Beginnings Learning Collaborative.	Director, SMBHWN Maternal Infant Services and Support Programs	High Risk Pregnancy Education Care Management	SMBHWN received Baby-Friendly USA Designation in November of 2015. Designation was earned through participation in the NICHQ Best Fed Beginnings Learning Collaborative and through the implementation of evidence-based maternity care practices. Since 2011, the program has shown increases in the rate of exclusive breastfeeding at discharge, which is up to 62 percent on average throughout the year, compared to a baseline average of 47 percent throughout the year. Requirements for Baby-Friendly USA Designation include but are not limited to: providing education to pregnant women on the benefits of breastfeeding; demonstrating how to breastfeed and maintain lactation to new mothers; and referring mothers to breastfeeding support groups following discharge from the hospital.
	5. Facilitate care management and support for families with children in the NICU, provide NICU-specific support services to new mothers and their	a. Continue to provide the NICU Navigator Program – former parents who have experienced having a baby in the NICU pair with current families to provide additional support and guidance.	Director, SMBHWN Maternal Infant Services and Support Programs Program	High Risk Pregnancy Education Care Management	In FY 2015, the NICU Navigator Program provided education, encouragement and emotional support to more than 100 families with NICU newborns at SMBHWN.

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	families. In addition, provide PSCU-specific support services to new mothers and their families.		Coordinator, SMBHWN NICU Navigator		
		b. Continue to provide educational "Parent Hour" to new mothers and families with babies in the NICU.	Director, SMBHWN Maternal Infant Services and Support Programs Program Coordinator, SMBHWN NICU Navigator	High Risk Pregnancy Education Care Management	In FY 2015 15, Parent Hour sessions were offered free to more than 100 families with a baby in the NICU and focused on an assortment of topics, including premature growth and development, parenting a NICU infant, nutrition, feeding mechanics and discharge preparations. Sharp Mary Birch collects evaluations from participants in order to assess quality and incorporate feedback for improvement of future programming.
		c. Continue to provide a weekly NICU breastfeeding support group –open to all members of the community.	Director, SMBHWN Maternal Infant Services and Support Programs Program Coordinator, SMBHWN NICU Navigator	High Risk Pregnancy Education Care Management	SMBHWN continues to provide its weekly NICU Breastfeeding Support Group – the Mother's Milk Club – for all mothers in the community with a baby who spent any length of time in the NICU In FY 2015, approximately 100 mothers from the community received support and counseling for topics of concern including milk supply, latching, sleeping, the stress of having a baby who is experiencing problems and any other concerns of the group.

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					No evaluations collected.
		d. Continue to provide the PSCU Navigator Program – former PSCU parents who have experienced having a baby in the NICU pair with current families to provide additional support and guidance.	Perinatal Special Care Unit Manager Program Coordinator, SMBHWN PSCU Navigator	High Risk Pregnancy Education Care Management	The PSCU Navigator Program launched in FY16 to provide education, encouragement and emotional support to high-risk antepartum patients at SMBHWN during a critical time. The PSCU Navigator program is an in-hospital service aimed at providing patients with emotional and informational support during their hospital stay.
	6. Collaborate with and support community organizations that provide support and financial assistance to mothers and families San Diego.	a. Continue to support the Miracle Babies foundation in San Diego.	Chief Executive Officer, SMBHWN	High Risk Pregnancy Collaboration	In FY 2015, Sharp Mary Birch fundraised nearly $8,800 for Miracle Babies. Miracle Babies provides support and financial assistance to families with critically ill newborns in the NICU and also enhances the well-being of women, children and their families through education, prevention and medical care.
		b. Continue to support March of Dimes through active membership on annual major fundraising event.		High Risk Pregnancy Collaboration	Supported in FY 2014, 2015 and 2016

Identified Community Need: High Risk Pregnancy	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		c. Host annual Little Grad Reunion.	Director of Women's and Neonatal Services Manager of NICU	High Risk Pregnancy Education Collaboration	FY 2016 will be an annual event for parents and graduate infants – 700 attendees for FY 2016 and project over that for FY 2017.

Identified Community Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	1. Provide educational classes for community members that address factors that contribute to obesity.	a. The Sharp Memorial Outpatient Pavilion (the Pavilion) and various departments of SMH will continue to host and/or conduct a broad spectrum of community health education classes. Many classes are offered for free to the community. Topics relevant to obesity included (but were not limited to): integrative therapies and holistic healing (meditation, stress reduction, etc.), diabetes, nutrition, cooking classes, high blood pressure.	Supervisor, SMH Cardiac Rehab/Health Promotion, Cushman Wellness Center	Obesity Education	The Pavilion collects evaluations from all educational offering in order to assess quality and efficacy of programs and to incorporate feedback to further improve future courses. In general, SMH provides a variety of educational offerings to community members that target contributing factors to obesity, however at this time, resource limitations restrict further growth in this area.
	2. Provide free biometric screenings to community members that include 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.	Sharp HealthCare Chief Experience Officer	Obesity Screening Education Collaboration	In FY 2015, Sharp HealthCare hosted 75 community health screening events throughout SDC, screening more than 5,200 San Diegans and providing more than 110,000 hours in support of the effort. From the inception of the screenings Sharp HealthCare participated in nearly 200 community health screenings events across San Diego – ultimately screening more than 14,000

Identified Community Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		Screenings were held throughout San Diego. A small sample of locations/events included: the Friars Road and Toby Wells YMCA, San Diego Blood Bank, December Nights, Tour de Cure Expo, Vital Aging Conference, and the Rock Church.			San Diegans. The screening program concluded in early 2016. Screenings provided personalized health information at no charge to community members over the age of 18. Participants were not asked to provide personal information, nor were they required to show proof of insurance or have any relationship with Sharp to be eligible for the screening. To encourage participation, identifying and follow-up information was not collected. Appointments were not required, and community members retained the only copy of their results. Community members also received personalized strategies to improve their overall health and well-being. Though Sharp's hospitals, including SCHHC provide various nutrition education opportunities for the community, in general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time.
		b. The Pavilion and various departments of SMH will	Supervisor, SMH Cardiac	Obesity Screenings	All of the screening programs offered through the Pavilion evaluate for obesity and make

Identified Community Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		continue to provide numerous health screenings including contributing factors to obesity such as blood pressure and body mass index (BMI) at community events throughout the year.	Rehab/Health Promotion, Cushman Wellness Center	Education Collaboration	recommendations regarding behavior changes needed to reduce health risk. In general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time.
	3. Continue to provide care management in support of weight loss and healthy life style choices for San Diego community members.	NA	NA	Obesity Care Management Education	In general, resource limitations restrict growth beyond current programs and services that specifically address obesity at this time. However, free, Healthier Living Workshops are provided to community members through Sharp HealthCare's medical group, Sharp Rees-Stealy, including in areas served by SMH. 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

Identified Community Need: Obesity	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					members or friends of someone with an ongoing health condition, as well as community members interested in becoming more physically and socially active, are welcome to attend.

Identified Community Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	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, SMH Senior Resource Center (SRC)	Senior Health Access to Care Collaboration	Provide flu vaccinations to at least eight community clinics. For FY 2016: the SRC provided three flu shot clinics for seniors and high risk adults, including a clinic at a local food bank that reaches out to homeless individuals. The SRC provided 247 shots in FY2016, with reduced numbers a result of the increased availability of flu vaccine at readily accessible locations such as grocers and pharmacies. The SRC continues to focus efforts on low income seniors and high risk adults. 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	Program Coordinator, SMH Senior Resource Center (SRC)	Senior Health Access to Care Collaboration	The SMH Senior Resource Center coordinated notification of the availability and provision of seasonal flu vaccines for seniors and high-risk adults in a variety of community settings through activity reminders, collaborative outreach conducted by the flu clinic site, both paper and electronic newspaper notices and via Sharp.com. Communications reminded seniors

Identified Community Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
		media and community partners.			who attend SRC programs that flu vaccination is important for themselves and their families.
		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, SMH Senior Resource Center (SRC)	Senior Health Access to Care Collaboration	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 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. In addition, community members receive their results and feedback to take to their doctor on their own time.
	2. 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 resources.	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, SMH Senior Resource Center Manager, Sharp Senior Health Centers	Senior Health Education Screenings Access to Care Collaboration	In FY2016, through July 2016 the SMH Senior Resource Center provided 24 free health education programs to nearly 351 senior community members. Programs were presented by physical therapists, speech therapists, a psychologist, a physician, an audiologist, dietician, registered nurse, social worker and an attorney, as well as experts from community organizations. Health education

Identified Community Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					topics included pain management, peripheral artery disease, heart disease, diabetes, fall prevention, nutrition, Parkinson's disease, Alzheimer's disease, financial issues, caregiver resources, maintaining a healthy voice, brain health, Medicare, addressing behavior issues, stress management, hearing loss, advance care planning, avoiding scams, grief and loss. Locations included the Peninsula Family YMCA, Point Loma/Hervey Branch Library, Point Loma Community Presbyterian Church, All Souls Episcopal Church, Sharp Health Plan, and the Sharp Senior Health Center in Clairemont. In addition, Sharp Senior Health Centers provided more than 220 community seniors with health education and referrals to community resources including housing, food, depression, social services, senior centers and others. Education for seniors included Medicare, Medi-Cal, Vials of Life, Cal MediConnect, Alzheimer's disease, depression and advance directives. Health education was provided at the Potiker Family Senior Residence and through a Sharp Speaker Series at the Gary and Mary West Senior Wellness Center. Sharp Senior Health Centers also provided monthly education at the

Identified Community Need: Senior Health	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
					National Active and Retired Federal Employees Association (NARFE) meetings. Additionally, Sharp's Senior Health Centers provided senior resources to CVS MinuteClinic locations. Each education program provided by or in collaboration with Sharp Senior Resource Centers 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.
		b. Continue to participate in community health fairs for seniors.	Program Coordinator, SMH Senior Resource Center Manager, Sharp Senior Health Centers	Senior Health Education Screenings Access to Care Collaboration	The SMH Senior Resource Center participated in nine community events in FY 2016 through July 2016, including health fairs, conferences and seminars that reached more than 1,083 attendees. Health fairs included the Sharp Senior Resource Center Fair at the Point Loma Community Presbyterian Church, the San Diego Community Action Network (SanDi-CAN) Veterans Wellness & Resource Conference, SanDiCan End of Life Conference, Sharp Women's Health Conference, San Diego

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					County's Vital Aging Conference and the Lesbian, Gay, Bisexual, and Transgender (LGBT) Senior Resource Fair. Sharp Senior Health Centers participated in numerous community events in FY 2015, providing education and resources to more than 450 attendees. Events took place at the Sharp Senior Resource Center Senior Health & Information Fair at Point Loma Presbyterian Church; the Right Choices at the Right Time conference at Point Loma Community Presbyterian Church; the San Diego Community Action Network (SanDi-CAN) Planning Ahead…Crucial Conversations: Helping Families & Seniors Navigate End-of-Life Decisions conference; the SDCCOA The Golden Age of Intimacy Senior Health Fair at the War Memorial Building in Balboa Park; and St. Paul's Senior Health & Resource Fair.
		c. Coordinate two conferences – one dedicated to family caregiver issues in collaboration with the Caregiver Coalition of San Diego and one focused on	Program Coordinator, SMH Senior Resource Center	Senior Health Education Screenings Access to Care Collaboration	In April 2016, The SGH Senior Resource Center 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

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		chronic care management in collaboration with Sharp HospiceCare.			more than 80 community members and provided education on: Miscommunication in Health Care; Quality of Life Conversations; Legacy Planning ; Coping with Life's Challenges; available resources; coping with life's transitions; and healing touch for self-care.
		d. Continue to participate in a monthly SHC Speaker Series at the Gary and Mary West Senior Wellness Center.	Manager, Sharp Senior Health Centers	Senior Health Education Screenings Access to Care Collaboration	In FY 2015, the Speaker Series provided information on topics such as fall prevention, how to find reliable health information online, diabetes, dementia, how to find healthy food for seniors, peripheral arterial disease, healthy eating, advance directives, how to get the most out of a doctor visit, eye health and resources, and keeping an active and young brain. The Speaker series reached approximately 200 community seniors in FY 2015.
		e. Partner with community organizations to provide nutrition education and increase access to healthy food for seniors, particularly low-income, food -insecure senior community members.	Manager, Sharp Senior Health Centers Program Manager, SHC Community Benefits and Health Improvement	Senior Health Education Food Insecurity Access to Care Collaboration	In FY 2016, Sharp Senior Health Centers began collaboration with the San Diego Food Bank's SONDAS (Solving Obesity and Nutrition Related Diseases Affecting Seniors) program. The program targets low-income seniors and provides education on basic nutrition principles including reading nutrition facts labels, healthy eating on a budget, and more healthy tools to help prevent / better manage chronic diseases.

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					Classes are held for 1 hour each week for 6 weeks, participants receive fresh produce every other week. Thus far, a cohort of classes has occurred for the Clairemont Mesa location, and two more cohorts, including the Downtown location, are scheduled for FY 2017. Data forthcoming, however initial findings demonstrate positive behavior changes as a result of the classes (e.g., eating more fruits and vegetables, drinking les sugary beverages, etc.).
		f. Continue to offer screenings through the SMH Senior Resource Center, including: monthly blood pressure clinics, and four to eight types of health screenings annually.	Program Coordinator, SMH Senior Resource Center	Senior Health Education Screenings Access to Care Collaboration	The SMH Senior Resource Center provided eight screening events in FY2016 through June 2016, reaching nearly 112 senior community members In addition, free monthly blood pressure screenings were offered, serving nearly 450 members of the senior community. As a result of the blood pressure screenings, more than 60 seniors were referred to physicians for follow-up care.
	3. Engage and partner with local community organizations that address senior health issues in order to foster	a. Maintain active relationships with community organizations serving seniors throughout San Diego.	Program Coordinator, SMH Senior Resource Center	Senior Health Collaboration	Partners include: Point Loma, the County's central and north central regions, and downtown. Organizations include: Peninsula Shepherd Senior Center, Serving Seniors, Bayside Community Center, Westminster Tower

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	future opportunities for collaboration in provision of education, screening, and other resources to seniors and high-risk populations.		Manager, Sharp Senior Health Centers		(senior housing), Jewish Family Service of San Diego, Live Well San Diego, Caregiver Coalition of San Diego, Adult Protective Services, Southern Caregiver Resource Center, Alzheimer'sSan Diego, Parkinson Association, SanDi-Can, San Diego County Aging & Independence Services and Health Insurance Counseling and Advocacy Program (HICAP). As the number of community partners increases, it is expected that additional opportunities will arise. HICAP partnership includes the provision of biweekly counseling and education by a HICAP representative to community members at the Senior Health Center Clairemont. HICAP staff offered objective counseling on Medicare rights, benefits and insurance policy options to address seniors' questions and concerns.
		b. Sharp Senior Health Centers is exploring research opportunities with the West Health Institute, whose mission is to decrease cost of health care through	Manager, Sharp Senior Health Centers	Senior Health Collaboration	Potential opportunities continue to be explored.

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		technology and innovation.			
	4. 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 the Transitions program: a 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, emotional and spiritual needs.	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 "ActivePhase" (six weeks). Performance Target: 200 admissions across the system each year. In FY 2015, 300 admissions across the system; YTD FY 2016, 178 admissions.
	5. Increase the availability of education, resources and support to community members with life-limiting illness and their loved ones.	a. Provide 13 mailings of bereavement support newsletters	Bereavement Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of mailings annually through internal Access/Excel database. In FY 2015, ~1,300 community members received bereavement support newsletters. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members

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					and patients served across Sharp – including Sharp Memorial Hospital.
		b. Continue to provide community education and resource services throughout San Diego	Business Development Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of community education events through internal database. In FY 2015, Sharp HospiceCare collaborated with community organizations to provide more than 2,400 community members with end-of-life education and outreach at a variety of churches, senior living centers, and community health agencies and organizations throughout SDC, as well as through participation in community health fairs and events. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members and patients served across Sharp – including Sharp Memorial Hospital.

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		c. Continue to offer individual and family bereavement counseling and support groups	Bereavement Dept., Sharp HospiceCare	Senior Health Care Management	Track number of individual and group counseling sessions through internal database. In FY 2015, the Healing After Loss and the Widow's and Widower's ongoing bereavement support groups served approximately 200 community members. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members and patients served across Sharp – including Sharp Memorial Hospital.
		d. Provide Advance Care Planning (ACP) for community groups as well as individual consultations	Advance Care Planning Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of sessions and individual consultations through Allscripts Business Unit, Excel spreadsheet and participant evaluations. Quarterly community presentations offered throughout San Diego County. In FY 2015, the program engaged approximately 2,500 community members in free ACP and POLST (Physician Orders for Life-Sustaining Treatment) education at a variety of community sites, including health fairs, senior centers, homecare agencies, churches and seminars.

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					Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members and patients served across Sharp – including Sharp Memorial Hospital.
	6. Provide education and outreach to the San Diego community concerning hospice and palliative services within the care continuum, in order to raise awareness of the choices available towards the end of life and empower community members so that they and their family members may take an active role in their treatment.	a. Continue to conduct outreach activities and provide professional education on hospice-related topics to community groups, health care facilities, colleges and universities.	Medical Director, Sharp HospiceCare; Program Coordinator, Sharp Memorial Senior Resource Center (SRC) Business Development, Sharp HospiceCare	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. Sharp HospiceCare provided introductory education on hospice, bioethics and ACP to 36 advanced psychology students at Valhalla High School as well as delivered eight lectures on hospice, bioethics, ACP and advance directives to nearly 180 nursing students from Azusa Pacific University (APU). In addition, lectures on spiritual care in hospice were provided to more than 50 individuals in the Certified Hospice and Palliative Nursing Assistant training program through the HPNA.

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					Educational outreach to local organizations included the San Diego Rotary, SDRHCC, San Diego Hospice and Palliative Nurses Association (HPNA), SDCCOA and San Diego POLST Coalition. State and national education included the Iowa Hospital Association Palliative Care Conference, Generations HealthCare, Healthsperien, Wellspan Health, Atlanticare, Front Porch Retirement Communities administration, the U.S. News & World Report Conference, the California HealthCare Foundation (CHCF) Improvement Network and Palliative Care Action Committee, NHPCO, CHAPCA, the Coalition for Compassionate Care of California (CCCC) Conference, California Physicians Medical Group, and Scott and White Medical Group of Central, Texas. Presentation topics included advanced illness management, hospice economics, prognostication, ACP and geriatric frailty Each education program provided in collaboration with the Sharp 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

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					(participants) would like. This feedback is provided to speakers so that they may refine future educational offerings.
		b. 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, Sharp HospiceCare educated more than 500 local, state and national health professionals on ACP and POLST, including, 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 community health care providers.

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	7. Collaborate with community, state and national organizations to develop and implement appropriate services for the needs of the aging population.	a. Continue active involvement with and participation on state and national hospice organizations (California hospice and Palliative Care Association (CHAPCA) the NHPCO Leadership etc.) included presentations on understanding late-stage illness, changing our culture of Care to one of partnership and a continuum of Care perspective, advanced Care planning, etc.	Vice President, Sharp HospiceCare Medical Director, Sharp HospiceCare	Senior Health Education Collaboration	Sharp HospiceCare provides approximately six presentations each year in collaboration with state and national organizations. All community presentations provided through Sharp HospiceCare– including those to professional organizations – are evaluated through survey to evaluate effectiveness. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members and patients served across Sharp – including Sharp Memorial Hospital.
		a. 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.	Vice President, Sharp HospiceCare Medical Director, Sharp HospiceCare	Senior Health Education Collaboration	All community presentations provided through Sharp HospiceCare– including those to professional organizations – are evaluated through survey to evaluate effectiveness. Currently, this strategy is addressed by staff for Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However, these services are provided to community members and patients across Sharp – including Sharp Memorial

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					Hospital.
		b. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	Business Development Dept., Sharp HospiceCare	Senior Health Caregivers Collaboration	New community partnership: Lantern Crest in Santee; Elmcroft of San Diego (throughout the County as well as additional home care facilities. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members and patients served across Sharp – including Sharp Chula Vista Medical Center.