Sharp Memorial Hospital and Sharp Mary Birch Hospital for Women & Newborns
Community Health Needs Assessment – Implementation Strategy
Fiscal 2018-2021

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 22,786 self-pay patients since October 01, 2015 through 07/31/2017. PointCare has expanded its website to also provide linkage to Covered CA as appropriate. The tool interfaces patient screening information in the GE record. In FY 2016, Sharp Healthcare's Patient Access Services department processed real-time Medi-Cal eligibility determinations under the Hospital Presumptive Eligibility Program for 1,990 unfunded patients in the ED. Continued unknowns in understanding the efficacy of these efforts are the increase in the patient out of pocket responsibility resulting from health plan coverage purchased off the exchange and the transition of qualified unfunded patients directly to Medi-Cal. Sharp has initiated a process of trending straight self-pay collections separate from balance after insurance collections in an effort to closely

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					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.
		c. Provide specialized financial assistance and support program to families with children in a Sharp NICU.	Patient Access Services Public Resource	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, and is also now implemented at Sharp Chula

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			Specialist Patient Access Service Self-Pay Team Manager		Vista Medical Center and Sharp Grossmont Hospital. 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). In FY 16 Public Resource Specialists 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 assistance, which can help	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. This, along with Hospital Presumptive Eligibility,

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		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.			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 FY17, 58 Sharp patients have been assisted through the ClearBalance loan program (nearly 2,000 patients since the program's inception).
		f. Continue to provide Project HELP funds for pharmaceuticals, transportation vouchers and other needs for economically	Sharp Memorial Hospital (SMH) Chief Financial Officer	Access to Care	Project HELP funds are tracked though an internal database. From FY10 – FY1F6, funds for SMH Project HELP totaled >$747K.

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		disadvantaged patients.			
	3. Improve access to health and social services for high-risk community members, particularly San Diego's homeless population.	a. Continue to collaborate with the San Diego Rescue Mission to discharge chronically homeless patients to the Rescue Mission's Recuperative Care Unit. These patients receive follow-up care through SMH in a safe space, in addition to psychiatric care, substance abuse counseling and other services through the San Diego Rescue Mission.	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. This continues as a carry-forward for Case Management.
		b. Continue to partner with Father Joe's Villages to support Project SOAR - designed to facilitate and expedite the processing of Social Security and disability applications for homeless individuals with urgent health care needs.	SHC, VP 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.

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		c. Evaluate patients applying for Medi-Cal for CalFresh (Food Stamps) through on-site hospital Patient Financial Services and Hospital Outstation Program (collaboration with the County of San Diego). Facilitate enrollment of qualified patients in CalFresh.	Manager, Patient Financial Services, Self-Pay Patients	Access to Care Access to Healthy Food (Food Insecurity) Collaboration Care Management	Across Sharp HealthCare PFS: YTD metrics through April, 2017: 367 CalFresh applications submitted, 209 applications approved, 15 applications pending.
		d. Continue to explore opportunities for collaboration with community organizations to provide medical care, financial assistance, psychiatric and social services to high-risk, chronically ill, and/or chronically homeless patients	Care Transitions Program Manager Manager, Community Benefits and Health Improvement Vice President, SHC Government Relations	Access to Care Collaboration Care Management	1.The prior success of the CCTP program, as well as the program outcomes for Sharp Grossmont Hospital's specific CTI program (following termination of the Innovation Grant) distinguish this as an opportunity for further exploration. The Integrated Care Management Plan includes reviewing program outcomes – past and current – reviewing opportunities for alternative funding, and then re-implementation of a redesigned program in FY 2019. Success will be measured through identified metrics for the target population, to include: decreased readmissions, decreased ALOS, and decreased inappropriate ED visits. 2. Integrated Care Management is currently working with leaders across the Sharp continuum (SHC, SMV, SRS, and SCMG) for

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					alternative solutions for hard to place patients requiring long-term supportive housing, assisted living, and/or custodial care, who also live with chronic behavioral health disabilities. Leaders are formulating a plan that includes working with community health care partners to vet opportunities. Care Management seeks to have options in place for strategic planning FY 2019 – 2020. Measures of success will include quality of care improvements, with decreased costs of care for the target population. This may be realized by measuring change in ALOS, transitions to safe and sustainable home or home like settings, and demonstrating improved linkages to Behavioral Health Primary Care providers.
	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, and various Sharp departments and others. Connection to community resources includes American Cancer Society, Alzheimer's Association, and the Caregiver Coalition, among others. Community presentations have also been completed for San Diego Center for the Blind. In addition, the consumer health librarian also

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					shared health literacy best practices with the larger health care community through article contribution. New this year was an article in the Journal for Consumer Health on the Internet. NOTE: Staffing for the Consumer Health Library is recently reduced to a retirement of a team member. Thus, capacity for community program participation has been temporarily diminished.
		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 2017 (August, 2017), the Health Information Ambassador Program has filled 435 and visited 1,947 patient rooms.
		c. Explore opportunities to expand health literacy education to underserved and marginalized	Consumer Health Librarian, Community	Education Collaboration Care Management	Community organization membership /collaboration includes: CHIP Health Literacy Taskforce, and various Sharp departments and

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		populations.	Health Library at the Cushman Wellness Center	Access to Care	others. Connection to community resources includes American Cancer Society, Alzheimer's Association, and the Caregiver Coalition, among others. Community presentations have also been completed for San Diego Center for the Blind. NOTE: Staffing for the Consumer Health Library is recently reduced to a retirement of a team member. Thus, capacity for community program participation has been temporarily diminished.

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	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 (SMV) and Sharp McDonald Center, which are the major providers of behavioral health and chemical dependency services in San Diego County. SMV is located on the same campus as SMH. 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-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 Oncology Patient Navigator	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, and 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. Patients meet with the navigator on their initial visit. Navigation services provided to patients are closely tracked through internal databases. In FY 2016, LCSWs served more than 2,000

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					individuals through free psychosocial and emotional support, education and referrals for patients and their family members. In FY 17, the dietician received ~ 545 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. From January 2015 to December 2016, the genetics counselors dedicated more than 3,100 hours to genetics counseling, including approximately 390 consultations and nearly 800 referrals. During this timeframe, the number of new patient consultations increased 61 percent while the number of referrals provided increased 60 percent across the entities. In FY 2017 YTD (July, 2017), the program has seen 359 patients. **Navigation Resources:** *Metric (forthcoming):* Patients served. Currently implementing systemwide changes to Cerner that capture documentation and automate this reporting.

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					Identification and Prioritization of Needs: Distress Screening to assess practical and emotional issues contributing to cancer patient distress has been conducted at Sharp Memorial Hospital over the past few years. A recent effort was initiated by Sharp Cancer Outpatient social workers to develop a consistent tool across the Sharp system that would evaluate these needs in greater detail in order to make them actionable and rate them by intensity so that they may be prioritized and addressed appropriately. **New**: A systemwide policy has been approved establishing the pivotal time to give each radiation and infusion patient at least one distress screening assessment. *Metrics:* Routine reports including number of patients screened, information on the issues that are most challenging for patients and the percentage of patients rated in high distress will be provided to the Integrated Network Cancer Program and to individual entities. The information will drive efforts to target and provide additional support and resources to better meet our patient needs. **Navigation Communication:** Currently patient navigation is not consistently documented and

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					easily accessible to all care team members. Often patients share valuable information with Navigators that can be useful to other team members for care coordination as well as identifying concerns about treatments and side effects that can be addressed by physicians and other staff for a more personalized approach to care and presenting options that may be more acceptable for cultural or personal beliefs. A project is planned for integrating Navigator care documentation in Cerner EMR to provide improved communication among all cancer team members. *Metric:* Implementation of Navigator documentation in Cerner. Current status of this is on track; received first proof to review in August, 2017 **Timely Access to Care:** Navigators have identified that timely access to specialist appointments and imaging studies is a consistent issue among our cancer patients with delays that feed patient anxiety and is a clinical concern for impacting maximum effectiveness of cancer treatment. This will be a focus for our cancer navigators and the cancer program in identifying performance improvement initiatives

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					to reduce the time from diagnosis to treatment for our cancer patients. *Metrics:* Calculation of the time from diagnosis to treatment for key sites that will capture the predominant issues and annual evaluation of the change in number of days to treatment at least annually. Also measured will metrics specific to focused projects on key processes identified that are contributing to delays in care. **Current status**: focused work has been done on breast and improvements noted; collected follow-up stats for 2016 data. Need to review and complete assessment for other top sites before year end.
		b. Continue to seek funding for the cancer patient navigator program and expand navigator services to all cancers.		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	SMH Oncology Patient Navigator	Cancer Education Care Management	Class offerings in FY 2017 included three physician-led Breast Cancer Education forums, which taught individuals with a recent breast cancer diagnosis about the pathological wording and staging of their particular cancer type and treatment options.

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		reports and explaining in layman's terms.			Sharp held a community event in Oct, 2016 on Reducing Breast Cancer Recurrence through diet and exercise led by 2 physicians, dietitian, and weight management. Approximately 80 community members participated. Development of programs and services driven by Distress Screening (see action item "Cancer: a" above) and feedback from navigators, social workers and other staff will be ongoing. Expansion of Sharp partnership with the American Cancer Society to provide education and support materials and community support connections to ACS Patient Organizers. This will be in conjunction with Sharp information for patient education, services offered, information specific to care at SMH and additional connections to community and national organizations that provide assistance to cancer patients. A specific portion of Sharp's website (sharp.com) is planned for cancer patients to provide information and tools that will be helpful to patients during the course of their cancer journey. **Status**: On track. Patient focus group completed with feedback to direct initiative in a patient-focused manner; website

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					section has been prepared; initial documents to upload in final review. **Metrics:** Number of Patient Organizers delivered for SMH (YTD 2017 = 222). Initiation of patient information website section.
		b. Continue to provide meeting space for Look Good… Feel Better classes to cancer patients.	SMH Oncology Patient Navigator	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 cancer.	SMH Medical Social Worker, Oncology Administration SMH Oncology Patient Navigator	Cancer Education Care Management	In FY 2016 free cancer support groups were provided to nearly 400 patients and community members to discuss their experiences with cancer and tools for coping. Monthly support groups were offered for individuals living with breast cancer, friends and family members of cancer patients, and individuals living with a brain tumor or brain cancer. Bimonthly groups were held for young patients with cancer and those with advanced cancer. The Laurel Amtower Cancer Institute also offered support through its Coping With Cancer Through the Holidays community seminar.

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	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 Oncology Patient Navigator	Cancer Education Collaboration Screenings	Approximately 900 individuals were reached through numerous free educational classes in FY 2016, including a variety of classes to support nutrition for individuals with cancer. Utilizing resources and guidelines from the National Cancer Institute (NCI), American Institute for Cancer Research, ACS, and the Environmental Working Group, monthly nutrition classes educated participants on maintaining optimal nutrition during and after treatment for breast cancer. A similar class was offered with a special focus on nutrition before, during and after treatment for oral, head and neck cancer. Classes on maintaining optimal nutrition for cancer patients were also offered. In FY 2016 Laurel Amtower Cancer Institute also provided a four-session Food for Life cooking series to teach 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 — the series included nutrition lectures, live cooking demonstrations and food tastings to help participants learn how to prepare simple and healthy meals at home.

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					In addition, two ACP education classes were included for patients in FY17. Also currently developing a new lymphedema education class and patient brochures discussing risks and signs to watch. Cancer education and screening events offered by SMH 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 Oncology Patient Navigator	Cancer Education Collaboration	Throughout FY 2017, the Laurel Amtower Cancer Institute staff provided cancer education and resources to hundreds of community members at a variety of community events, including the ACS Making Strides Against Breast Cancer Walk; San Diego Free to Breathe Lung Cancer Run/Walk; and the Sharp Women's Health Conference. The team also participated in the eighth annual Nine Girls Ask luncheon fundraiser to support the advancement of ovarian cancer research. In addition, for three days in June, the Laurel Amtower Cancer Institute recognized

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					National Cancer Survivors Day® by hosting a celebratory community event for cancer patients and survivors.

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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 2016, 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. **Data from FY16 demonstrated** 47% increase in

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					exercise tolerance (measured by submaximal exercise test) and 3.4% decrease in body fat with minimal change in body weight as a result of program participation. 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, Cancer Prevention Conference and Obesity Crisis Conference and provide presentations for Grossmont Hospital's Cancer Support Group. 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 Pavilion focus on wellness and integrative medicine modalities to improve health with typical attendance of 20 or more participants.
		c. Continue to participate in stroke education events in San Diego,	SHC Vice President of	Cardiovascular Disease	In FY 2017, the SMH Stroke Program collaborated with the SMH Senior Resource

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		including events targeting seniors & high-risk adults as well as individuals with identified risk factors.	Ortho/Neuro Service Line Program Coordinator, SMH Senior Resource Center (SRC)	Education Collaboration	Center to provide a screening at Point Loma Community Presbyterian Church to 20 community members. During the event, a neurologist discussed stroke prevention and warning signs, and stroke screenings were provided. 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.

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	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 Promotion, Cushman Wellness Center Clinical Nurse, Lead RN for HASP Screenings, SMH-OPP Center for Health Assessment and Promotion	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 the follow up tool indicate** continued excellent patient satisfaction (4.94 mean score/5) and exercise & nutritional lifestyle changes because of participation in the screening (95.3% of participants making positive changes). 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

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					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. **Results**: Since the start of the program in May 2012, the program has screened more than 900 participants. The Cushman Wellness Center is collaborating with Sharp Best Health to offer "stand alone" advanced blood pressure screening & advanced body composition assessment for employees *and* community members with recommendations for decreasing risk for heart disease & stroke starting Oct. 1 2017.
		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 2017, the SMH Stroke Program collaborated with the SMH Senior Resource Center to provide a screening at Point Loma Community Presbyterian Church to 20 community members. During the event, a neurologist discussed stroke prevention and warning signs, and stroke screenings were provided.

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					Also in FY2017, Sharp provided stroke screenings with pulse checks and risk education to more than 100 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 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

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					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 will once again participate in the "Strike Out Stroke" event at the Padres in September 2017 (rescheduled from May due to rain), with more than 25,000 attendees.

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	At the Sharp Women's Health Conference, the Sharp HealthCare (SHC) and SRS Diabetes Education Program provided diabetes risk assessments using the ADA's Diabetes Risk Test questionnaire as well as offered resources on pre-diabetes, diabetes management and nutrition to approximately 1,000 attendees. Through fundraising and team participation, the SHC Diabetes Education Program also continued to support the ADA's Step Out Walk to Stop Diabetes. In October, the SMH Diabetes Education Program provided education to approximately 30 Point Loma High School students on diabetes risk factors. 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.). Feedback is collected from community members on educational courses provided, in order to improve and refine educational resources for community member needs.

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 Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. In addition, the SHC Diabetes Leadership Team meets annually to evaluate the programs over the previous year.
		b. Explore opportunities with new venues/ community groups to provide additional resources. E.g. churches, YMCA's and schools.	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Diabetes Education Access to Care Collaboration	SHC Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. As a result of these discussions in FY17, the SHC Diabetes Team will be working with the Imperial Beach community to provide diabetes education and resources, in collaboration with the IB Healthy Grocery Initiative.
		c. Utilize findings in the FY 2016 CHNA to assess existing community resources and explore areas where additional diabetes education and resources may be needed in SDC's east region.	SHC Manager, Community Benefit and Health Improvement	Diabetes Food Insecurity Education Access to Care	SHC Manager, Community Benefit and Health Improvement meets with SHC Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education based on the findings and relationships generated from the 2016 CHNA.

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 Diabetes Leadership Team		Current efforts focus on: • *Clinic collaborations* (Family Health Centers Partnership continuance) • Exploring *partnerships to address food insecurity as part of nutrition education, and incorporating food insecurity screening* into patient diabetes education and counseling. • *CDC's National Diabetes Prevention Program* - a partnership of public and private organizations working to prevent or delay type 2 diabetes. Partners work to make it easier for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health. In Fall, 2017 the SHC Manager of Community Benefit and Health Improvement will be providing an in-service to Sharp's Diabetes Educators on the intersection of food insecurity and health, as well as providing tools for food insecurity screening and referrals/resource

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
					connection for patients/community members. In addition, SHC's Diabetes Education Team has become very involved with SuperFood Drive, a San Diego-based organization that focuses on improving the health of food insecure populations through outreach, education and encouragement of healthy, nutritious food donations. In partnership with SuperFood Drive, the SHC Diabetes Education Program provided an educational post on how to eat healthy on a budget, management to the Superfood Drive Instagram account, as well as a "Wellness Wednesday" educational post on the nutritional value of specific foods every week. Also in support of SuperFood Drive, the SHC Diabetes Education Program participated in Feeding San Diego's 2016 Nutrition Symposium, which was designed to facilitate innovative solutions to serve the community with dignity and provide the opportunity to share expertise and passion for ending hunger in San Diego through nutritious food and education.
	2. Improve access to diabetes educational resources for	a. Explore potential partnerships with the community clinics in order to offer diabetes classes at their clinic	SHC Diabetes Leadership Team	Access to Care Collaboration Community Clinics	The SHC Diabetes Education Program continues to collaborate with Family Health Centers of San Diego (FHCSD) to conduct outreach and

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
	underserved populations in SDC.	locations	SHC Manager, Community Benefit and Health Improvement		education to vulnerable community members in SDC. In the central region, this specifically includes the FHCSD site in North Park, City Heights and Logan Heights. Sharp Diabetes educators supported the expansion of FHCSD's Diabetes Management Care Coordination Project (DMCCP), which provides FHCSD patients with group diabetes education and encourages peer support and education from project "graduates" to current patients/project enrollees. In the central San Diego region, the SHC Diabetes Education Program provided a lecture on the basics of diabetes and nutrition to more than 90 community members at FHCSD sites in North Park, Logan Heights and City Heights. Topics included nutrition, physical activity, diabetes mellitus, self-management and goal setting. **Overall program findings, July 2016 - mid June, 2017**: • 211 unique participants completed >1 classes • 56 unique participants completed >3 classes

<table>
<tr><th>Identified Community Need: Diabetes</th><th>Objectives/Anticipated Impact</th><th>Strategy/Action Items</th><th>Responsible Party/ies</th><th>Themes in 2016 CHNA Findings</th><th>Evaluation Methods, Measurable Targets, and Other Comments</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
27% compliance
<u>A1C Changes:</u>
32% improvement of participants with an A1C >8.1%
<table>
<tr><th colspan="4">56 Participants</th></tr>
<tr><th>A1C</th><th>Initial</th><th>Final</th><th>Difference</th></tr>
<tr><td><7</td><td>20</td><td>23</td><td>3</td></tr>
<tr><td><7.5</td><td>8</td><td>8</td><td>0</td></tr>
<tr><td>7.6 to 8.0</td><td>6</td><td>10</td><td>4</td></tr>
<tr><td>>8.1</td><td>22</td><td>15</td><td>-7</td></tr>
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<u>Weight Changes</u>:
<table>
<tr><td># Participant that lost weight</td><td></td></tr>
<tr><td># Participant that gain weight</td><td></td></tr>
<tr><td># Participant that maintain weight</td><td></td></tr>
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<u>Next steps</u>: Currently, the SHC Diabetes Leadership and Educators are exploring more engaging educational methods, beyond PowerPoints. Lessons learned from the FHC partnership included that attendees responded more positively to sessions that were more
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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
					conversational rather than lecture-based. Consequently, before additional FHC sites are added, SHC's Diabetes team will revise their current educational materials to reflect this preference (e.g., less reliance on PPT, more discussion, visuals, etc.). The project monitors enrollees' A1C levels, and has proven successful outcomes in lowering and maintaining these levels through education and peer support. **In addition**, in FY 16, the SHC Diabetes Education Program continued to educate and advise underserved pregnant women and breastfeeding mothers with Type 1, Type 2 or gestational diabetes on how to manage blood sugar levels. The SHC Diabetes Education Program collaborated with community clinics to provide patients with a variety of education and resources. Clinic patients also received logbooks to track and manage blood sugar levels. In addition, the SHC Diabetes Education Program evaluated patients' management of their blood sugar levels and collaborated with community clinics' obstetrician/gynecologists (OB/GYN) to prevent complications.

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
					Findings: At SMH, the SHC Diabetes Education Program collaborated with the hospital's OB/GYN to assist more than 400 underserved pregnant women with diabetes, over the course of more than 2,000 visits. Sharp Manager, Community Benefit and Health Improvement continues to work with the Diabetes Education Team to support and facilitate the FHCSD partnership. In addition, the SHC Diabetes Leadership team meets annually to evaluate the programs over the previous year.
		b. Provide diabetes education to food-insecure adults enrolled in Feeding America San Diego's Diabetes Wellness Project – a collaboration including UCSD's Student Run Health Clinic.	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Uncontrolled Diabetes Education Access to Care Collaboration Food Insecurity	**Background**: In FY15-FY16, the SHC Diabetes Education Program provided diabetes education to food insecure adults enrolled in Feeding America San Diego's (FASD) Diabetes Wellness Project, a randomized, controlled trial and collaboration between UCSD's Student-Run Free Clinic Project, the Third Avenue Charitable Organization (TACO) and Baker Elementary School in Southeast San Diego. The Diabetes Wellness Project screens adult clinic patients with Type 2 diabetes for food insecurity, and provides them with ongoing medical treatment and diabetes management through the clinic. In addition, FASD provides Diabetes Wellness Food

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
					Boxes to project participants, in conjunction with a monthly diabetes and nutrition education course. Provided by an SHC Diabetes Educator - as well as CalFresh outreach. Approximately 200 participants enrolled in the one-year Diabetes Wellness Project. **Findings of study released in Spring, 2017:** Participants with diabetes who received healthy food at clinic-based food pantries demonstrated statistically significant improvements in: • Household food insecurity status • Fruit and vegetable intake • Diabetes distress • Depression • Blood sugar control (for patients with HbA1c levels >=7.5) • Weight and Body Mass Index (for patients with HbA1c >=7.5) • Patients who were referred to off-site food pantries had no improvements and 89.5% of them did not go to an off-site food pantry despite personalized referrals

Identified Community Need: Diabetes	Objectives/Anticipated Impact	Strategy/Action Items	Responsible Party/ies	Themes in 2016 CHNA Findings	Evaluation Methods, Measurable Targets, and Other Comments
	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 Leadership Team	Diabetes Education Care Management Collaboration	In FY 2016, the SHC Diabetes Education Program continued to provide services and resources to meet the needs of San Diego's newly immigrated Iraqi Chaldean population. The program facilitated translation as well as provided resources to better understand Chaldean cultural needs. Educational resources included How to Live Healthy With Diabetes; What You Need to Know About Diabetes; All About Blood Glucose for People With Type 2 Diabetes; All About Carbohydrate Counting; Getting the Very Best Care for Your Diabetes; All About Insulin Resistance; All About Physical Activity With Diabetes; Gestational Diabetes Mellitus Seven-Day Menu Plan; Food Groups; and Arabic language materials for pregnancy. Food diaries and logbooks were given out to the community. Handouts were provided in Arabic as well as Somali, Tagalog, Vietnamese and Spanish, and live interpreter services were available in more than 200 languages via the Stratus Video Interpreting iPad application. Education was also provided to Sharp team members regarding the different cultural needs of these communities. Also exploring new opportunities for more effective methods and resources for properly

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
					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 team members are challenged to meet the

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
					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 ductus arteriosus, an opening between the two

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
					major blood vessels leading from the baby's heart, which should close shortly after birth but can mistakenly remain open.
	2. 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 to teenage mothers in San Diego.	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
		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

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. 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 babies.	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 Programs	High Risk Pregnancy Education Care Management	Sharp Mary Birch does not collect evaluations on their support groups. • Breastfeeding support groups: 300 hours (in FY16: ~1,700 mothers) • Post-partum support groups: 150 hours (in FY16: ~ 560 mothers) • *Baby and Me Time support group: 72 hours (in FY16: 200 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	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,

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
		nutrition, positive parenting techniques, etc.).			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. In FY 16 provided 560 hours of education.
		c. Demonstrate best practices in breastfeeding and maternity care, and provide education and support to new mothers on the importance of breastfeeding. Maintain Baby-Friendly USA Designation 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. The rate of exclusive breastfeeding at discharge fiscal year-to-date is 62.5%. The baseline score 10/15-6/16 was 64.9%. 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.

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
	5. Facilitate care management and support for families with children in the NICU; provide NICU-specific support services to new mothers and their families. In addition, provide PSCU-specific support services to new mothers and their families.	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 Coordinator, SMBHWN NICU Navigator	High Risk Pregnancy Education Care Management	In FY 2016, the NICU Navigator Program provided education, encouragement and emotional support to more than 100 families with NICU newborns at SMBHWN.
		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 2016, 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	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 2016, approximately 150 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
			Program Coordinator, SMBHWN NICU Navigator		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. 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.

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. The Pavilion and various departments of SMH will 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.	Supervisor, SMH Cardiac Rehab/Health Promotion, Cushman Wellness Center	Obesity Screenings Education Collaboration	All of the screening programs offered through the Pavilion evaluate for obesity and make 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.

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
	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 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 2017: the SMH Senior Resource Center (SRC) provided three flu shot clinics for seniors and high risk adults, including a low-income senior housing and homeless community members. The SRC provided 190 shots in FY 2017. Reduced numbers are 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. Metrics on any 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.

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
		b. Continue to coordinate the notification of seniors regarding the availability of seasonal flu vaccines and the provision of flu vaccines to high-risk individuals in selected community settings. Publicize flu clinics through media and community partners.	Program Coordinator, 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 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	
	2. Continue to host a variety of senior health education and screening programs, in order to raise awareness, identify risk factors, and connect	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 Education Screenings Access to Care Collaboration	In FY2017, through July 2017 the SMH Senior Resource Center provided 20 free health education programs to more than 380 senior community members. Topics included: balance, diabetes, memory, dementia, caregiving, stroke, grief, estate

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
	seniors to helpful resources.		Senior Health Centers		planning, Medicare, prescription updates and more. 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 211 San Diego, Clairemont Lutheran Church. In addition, throughout FY 2016, Sharp Senior Health Centers provided more than 450 community seniors with health education and referrals to community resources for housing, food, depression, social services, senior centers and more. Education was provided at the Potiker Family Senior Residence and through a Sharp Speaker Series at the Gary and Mary West Wellness Center. Topics included peripheral artery disease, heart failure, caregiving, bedbugs and scabies, Medicare, Medi-Cal, Cal MediConnect, Vials of Life, memory care, Alzheimer's disease, dementia, depression, fall prevention, chair yoga, seniors and vaccines, shingles, how to find reliable health information online, end-of-life planning (including advance directives, eye health and resources), diabetes, finding healthy food, healthy eating, and how to

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
					get the most out of a doctor visit. Also at the Potiker Family Senior Residence, the Sharp Senior Health Centers provided a holiday depression screening to approximately 40 seniors in November. The Sharp Senior Health Centers also provided education on depression to approximately 25 attendees at a National Active and Retired Federal Employees Association (NARFE) meeting. In addition, in collaboration with SMV, Sharp Senior Health Centers also provided a depression screening and education to approximately 20 attendees at Potiker Family Senior Residence. Further, the Sharp 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.

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
		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	YTD for Fiscal Year 2017 (July, 2017), the SMH Senior Resource Center participated in seven community events that reached nearly 500 community members. Health fairs included (but were not limited to) the Sharp Senior Resource Center Fair at the Point Loma Community Presbyterian Church, the San Diego Community Action Network (SanDi-CAN) End of Life Conference, Sharp Women's Health Conference, San Diego County's Vital Aging Conference and a conference finding the balance in caregiving. Sharp Senior Health Centers provided education and resources to more than 550 attendees at numerous community events in FY 2016. Events included the Sharp Senior Resource Center Senior Health & Information Fair at Point Loma Community Presbyterian Church; SanDi-CAN Crucial Conversations: Navigating Your Way conference at Balboa Park; Caring for the Caregiver Conference at Point Loma Community Presbyterian Church; Advanced Illness Management: An Integrated Approach Across the Continuum of Care conference at Paradise Point Resort and Spa; and St. Paul's Villa ninth Annual Senior Resource Fair.

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
		c. Coordinate multiple conferences – one dedicated to caregiver issues in collaboration with the Caregiver Coalition of San Diego and one focused on chronic care management in collaboration with Sharp HospiceCare.	Program Coordinator, SMH Senior Resource Center	Senior Health Education Screenings Access to Care Collaboration	In April 2016, The SMH 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 Pt. Loma Community Presbyterian Church, the conference reached more than 70 community members and provided education on how to approach aging from a healthier perspective with an alert mind, vitality and a plan for the future.
		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 2016, the Speaker Series provided education and resources to more than 450 community seniors. Topics included peripheral artery disease, heart failure, caregiving, bedbugs and scabies, Medicare, Medi-Cal, Cal MediConnect, Vials of Life, memory care, Alzheimer's disease, dementia, depression, fall prevention, chair yoga, seniors and vaccines, shingles, how to find reliable health information online, end-of-life planning (including advance directives, eye health and resources), diabetes, finding healthy food, healthy eating, and how to get the most out of a doctor visit.

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		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 Manager, SHC Community Benefit and Health Improvement	Senior Health Education Food Insecurity Access to Care Collaboration	**New**: Beginning in August 2016, a new evaluation tool was implemented in the San Diego Food Bank's 6-week Senior Nutrition class series. The pre-test has 18 quantitative questions while the post-test has 25 mixed quantitative and qualitative. Participants are given a survey at both the 1st and 6th class. Data were collected from 5 separate series held at the Sharp Senior Health Centers at the Genesee and Downtown locations. Pre-test evaluations were completed by 25 participants. Post-test evaluations were completed by 11 participants (as 2 class series are still in session). All data is self-reported and analyzed via excel. Both Pre/post-tests were translated into English and Spanish. **2016-2017 SDFB/Sen Hlth Center Program Findings:** • 12% of participants identified as food insecure • 32% reported increase in exercise at end of classes • 82% reported increase in consumption of fruits and vegetables • 55% reported decrease in sugary beverages intake

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					• Knowledge of MyPlate increased from 0% to 73% **Background**: 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. 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.
		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 seven screening events in FY2017 through June 2017, reaching 140 senior community members In addition, free monthly blood pressure screenings were offered, serving nearly 400 members of the senior community. As a result of the blood pressure screenings, 40 seniors were

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					referred to physicians for follow-up care
	3. Engage and partner with local community organizations that address senior health issues in order to foster future opportunities for collaboration in provision of education, screening, and other resources to seniors and high-risk populations.	a. Maintain active relationships with community organizations serving seniors throughout San Diego.	Program Coordinator, SMH Senior Resource Center Manager, Sharp Senior Health Centers	Senior Health Collaboration	**New in FY17:** • Sharp Senior Health Centers began partnering with the GSDBA Gay San Diego Business Association to bring awareness to issues and medical conditions specific to senior Lesbian, Gay, Bisexual, and Transgender (LGBT) clients. • Sharp Senior Health Centers collaborated with the San Diego Police Department to offer a community event, “Coffee with a Cop”. • Sharp Senior Health Centers began partnering with the Veterans Network and will be featured in the Veteran-Centered Resource Guide to reach out to Senior Veterans. **Ongoing partners include**: Point Loma, the County’s central and north central regions, and downtown. Organizations include: Peninsula Shepherd Senior Center, Serving Seniors,

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					Bayside Community Center, Westminster Tower (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's San 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	Manager, Sharp Senior Health Centers	Senior Health Collaboration	Potential opportunities continue to be explored.

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		health care through technology and innovation.			
		c. Sharp Senior Health Centers is exploring opportunities with other community providers to provide opportunities to reduce social isolation of seniors, improving access to transportation for seniors, to encourage physical activity and exercise and to educate and facilitate access to caregiving resources.	Manager, Sharp Senior Health Centers	Senior Health Social Isolation Transportation Access Collaboration	In FY 2017, seminars were offered with a focus on caregiving. In FY 2017, staff noticed the San Diego Food Bank senior nutrition classes (line item 2b above) became a place for socializing and meeting other seniors. Sharp Senior Health Centers plans to utilize these and other seminars to offer improved opportunities for socialization for seniors. Also in FY2017, the Sharp Senior Health Centers offered two caregiver seminars on site. Their popularity and frequent requests for additional information indicated a need for sharing more information for caregivers.
		d. Sharp Senior Health Centers is exploring opportunities with the San Diego Futures Foundation to provide computers and computer education to seniors.	Manager, Sharp Senior Health Centers	Senior Health Social Isolation Technology Access Collaboration	In FY 2017, the Sharp Senior Health Centers began to explore a partnership with the San Diego Futures Foundation to enhance computer knowledge for Seniors. We plan to collaborate to offer computers and classes to seniors.

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	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 "Active Phase" (six weeks). Performance Target: 200 admissions across the system each year. In FY 2016, 235 admissions across the system; YTD FY 2017, 229 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 2016, ~1,400 community members received bereavement support newsletters for 13 months after the loss of their loved ones. 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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		b. Support the unique advanced illness management and end-of-life care needs of military veterans and their families through participation in veteran-oriented community events and services.	Bereavement Dept., Sharp HospiceCare;	Senior Health Veterans Education	FY 2016 veteran-specific community work included: • In May, participated in the San Diego County HVP and the Caregiver Coalition of San Diego's Veterans Resource Fair at the War Memorial Building in Balboa Park. The free event provided ~ 40 veterans, family members and caregivers with presentations on available health care services, VA benefits enrollment and estate planning. • In June, Sharp HospiceCare participated in the Operation Engage America Resource Fair at Liberty Station, an event hosted by Operation Engage America — a nonprofit organization that provides support, awareness, education and resources for veterans, community members and families living with PTSD and TBI. Nearly 200 veterans, transitioning service members, first responders, families and other members of the community attended the free event which included education and resources from community organizations.

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					• In August, Sharp HospiceCare participated in the VASDHS 2016 Community Mental Health Summit. The event brought together key community stakeholders in active dialogue around improving access to mental health services and addressing the mental health care needs of San Diego veterans and their family members. • In November, Sharp HospiceCare participated in Finding the Balance in Caregiving: Caring for Veterans, an educational seminar presented by the Caregiver Coalition of San Diego and the City of La Mesa. Held at the La Mesa Community Center, a free event provided approximately 100 attendees with education and resources on caring for veterans and their caregivers. • Sharp HospiceCare also honored the nation's veterans at various community ceremonies and events in FY 2016. • Since 2010, member of the San Diego County Hospice Veterans Partnership - a coalition of VA facilities and community hospices working together to ensure

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					excellent end-of-life care for veterans and their families. • Participation on the advisory board for the SCRC's Operation Family Caregiver. • Currently a Level 2 Partner, working towards Level 3 (4 levels available) in We Honor Veterans (WHV), a national program developed by the NHPCO in collaboration with the U.S. Department of Veterans Affairs (VA) to empower hospice professionals to meet the unique end-of-life needs of veterans and their families. As WHV partners, hospice organizations can achieve up to four levels of commitment in serving veterans. Level 2 partners have built the organizational capacity needed to provide quality care for veterans and their families. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. 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 provide community education and resource services throughout San Diego	Business Development Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of community education events through internal database. In FY 2016, Sharp HospiceCare collaborated with community organizations to provide more than 2,500 community members with end-of-life education and outreach at a variety of churches, senior living centers, and community health agencies and organizations throughout SDC, as well as through participation in community health fairs and events. Currently, this strategy is addressed by Sharp HospiceCare, licensed under Sharp Grossmont Hospital. However Sharp HospiceCare's programs are intended for community members and patients served across Sharp – including Sharp Memorial Hospital.

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		d. Continue to offer individual and family bereavement counseling and support groups	Bereavement Dept., Sharp HospiceCare	Senior Health Care Management	Track number of individual and group counseling sessions through internal database. In FY 2016, 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.
		e. Provide Advance Care Planning (ACP) for community groups as well as individual consultations	Advance Care Planning Dept., Sharp HospiceCare	Senior Health Education Care Management	Track number of sessions and individual consultations through Allscripts Business Unit, Excel spreadsheet and participant evaluations. Quarterly community presentations offered throughout San Diego County. In FY 2016, the program engaged approximately 2,000 community members in free ACP and POLST (Physician Orders for Life-Sustaining Treatment) education at a variety of community sites, including health fairs, senior centers, homecare agencies, churches and seminars.

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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. The ACP team also provided introductory education on ACP, POLST, hospice, bioethics and goals of care to more than 400 students, including nursing students from Azusa Pacific University, SDSU, and California State University San Marcos (CSUSM); social work students from University of Southern California; San Diego Mesa College students; and Advanced Placement Psychology students at Valhalla High School. In addition, the Sharp HospiceCare Bereavement team presented on Grief, Loss and Bereavement to psychiatric nursing students

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					from CSUSM. Sharp HospiceCare leadership provided education, training and outreach to local, state and national health professionals throughout the year. These efforts sought to guide industry professionals in achieving person-centered, coordinated care through the advancement of innovative hospice and palliative care initiatives. Audiences included Cape Cod Healthcare Quality of Life Management Summit; CHAPCA; Delaware Valley Accountable Care Organization conference; BIT third annual World Congress of Geriatrics and Gerontology; Rainbow Hospice Care; Outcome Resources pharmacy benefit management solutions; the Annual Assembly of the American Academy of Hospice and Palliative Medicine and HPNA; Winneshiek Medical Center Palliative Care Conference; CCCC Annual Summit; CSUSM Institute for Palliative Care and SDCCC Palliative Care Across the Continuum conference; Harvard Law School; and Caregiver Coalition of San Diego. Presentation topics included palliative care economics, advanced illness management, geriatric frailty, prognostication, delirium and treatments, ACP and POLST.

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					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 (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	Throughout the year the Sharp HospiceCare ACP team educated more than 700 local, state and national health care professionals on ACP and POLST, including, but not limited to, attendees of the San Diego Partners in Advance Care Planning Palliative Care and End-of-Life Planning conference; Cape Cod Healthcare; Arbor Hills Nursing Center; Cottage Hospital; Mountain Health; East County Action Network; SoCAN; HPNA; San Diego Professional Palliative Care Conference; Rainbow Hospice and Palliative Care; Neighborhood House Association; County AIS; Grossmont Post-Acute Care, SDCCEOLC; Coalition for Compassionate Care of California (CCCC), Sharp HealthCare's Advanced Illness Management Conference; Greater San Diego

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					Business Association; and the California Association of Marriage and Family Therapists. In addition, the ACP team collaborated with the CCCC to offer a two-day POLST Train-the-Trainer workshop which trained 50 community health care providers on identifying the target population for POLST completion, how to facilitate a POLST conversation, and how to document patient treatment wishes on the POLST form.
	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.

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		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 Hospital.
		b. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	Business Development Dept., Sharp HospiceCare	Senior Health Caregivers Collaboration	Beginning in FY 2016, the Sharp HospiceCare ACP team joined San Diego Health Connect, County AIS, Health Services Advisory Group, emergency medical services, and various health care providers in SDC to ensure that community members have access to advance directive and POLST forms in emergency situations through the San Diego Healthcare Information Exchange — a countywide program that securely connects health care providers and patients to private

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					health information exchanges. In addition, the Sharp HospiceCare ACP team participates in an initiative funded by the California Health Care Foundation (CHCF) — and supported by the CCCC and California Emergency Medical Services Authority (EMSA) — to create an electronic POLST registry (POLST eRegistry). 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.