SHARP Grossmont Hospital

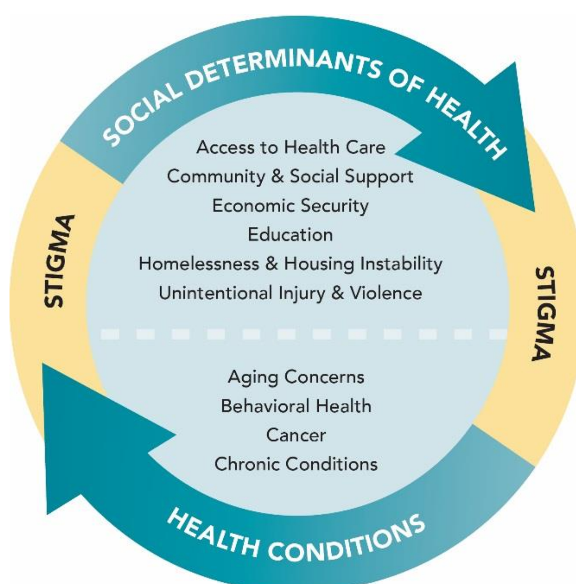
Sharp Grossmont Hospital Implementation Strategy
Fiscal Years 2020 – 2023

As a not-for-profit organization, Sharp HealthCare (Sharp) places great value on the health and wellness of the San Diego community. This value is reflected in Sharp's mission to improve the health of those it serves with a commitment to excellence in all that it does.

Sharp participates in a countywide collaborative to conduct a triennial Community Health Needs Assessment (CHNA) in an effort to identify the priority health needs facing the San Diego Community and also develops a separate CHNA for each individually licensed hospital. To learn more about Sharp's CHNA process and findings please view Sharp's 2019 CHNAs (including the Sharp Grossmont Hospital CHNA) at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

In response to the 2019 CHNA findings, each Sharp hospital, including Sharp Grossmont Hospital (SGH), created an implementation strategy that highlights the programs, services and resources provided by the hospital to address the identified health needs in its community (see graphic below).

2019 CHNA Priority Health Needs



The figure above illustrates the interactive nature of social determinants of health (SDOH) and health conditions - each influencing the other. In addition, *Maternal and Prenatal Care, including High-Risk Pregnancy,* was also identified as a community health need by the SGH 2019 CHNA. An underlying theme of stigma and the barriers it creates also rose across 2019 CHNA community engagement activities, which will be analyzed further in Phase 2 of the 2019 CHNA.

The following pages detail the strategies designed to address the community needs identified through SGH's CHNA process. In addition, the Sharp HealthCare Community Health Needs Assessment Guide (CHNA Guide) provides a general overview of Sharp's CHNA process and programs that address identified health conditions and social determinants of health. Please view Sharp's most current CHNA Guide at: https://www.sharp.com/about/community/community-benefits/health-needs-assessments.cfm.

For any questions regarding SGH's implementation strategy or CHNA, please contact Jillian Warriner, Manager, Community Benefit and Health Improvement at Jillian.Warriner@sharp.com.

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Identified Community Health Need – Aging Concerns					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase access for seniors and other high-risk populations to flu vaccines.	a. Continue to provide seasonal flu vaccinations at community sites for seniors with limited mobility and access to transportation, as well as for high-risk adults, including low-income, minority, chronically ill and refugee populations.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care Transportation	For FY 2020: provide flu vaccinations to community members facing barriers to accessing care, including homeless persons at eight community sites. Track and evaluate trends in flu clinic attendance. In FY 2019, the SGH Senior Resource Center provided nearly 400 flu shots to seniors and high-risk adults at 10 clinics, nine different sites, including senior centers, community centers, the Salvation Army and faith centers. Because of increased availability of the flu vaccine at grocery stores and pharmacies, numbers served by the SGH Senior Resource Center have continued to decrease. However, the SGH Senior Resource Center is investing additional effort to reach the uninsured and high-risk adults.
	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.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care	Seniors were notified of flu clinics through activity calendars, collaborative outreach conducted by the flu clinic site, sharp.com and both paper and electronic newspaper notices. The flu clinic sites assisted in distributing flu clinic information and encouraged their clients to get vaccinated.

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	c. Continue to direct seniors and other chronically ill adults to available seasonal flu clinics, including physicians' offices, pharmacies and public health centers.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Access to Care	Provided reminders to seniors who attend the Senior Resource Center programs that flu vaccination is important for themselves and their families. Encouraged community partners who work with seniors to remind staff and clients of the importance of vaccinations.
2. Support the safety net for seniors living alone in East County.	a. Maintain daily contact through phone calls with East County individuals (often elderly and home-bound) in rural and suburban settings who are at risk for injury or illness, and continue supporting telephone reassurance call services for East County residents.	Ongoing (evaluated annually)	Program Coordinator, Sharp Senior Resource Center	Senior Health Care Management Access to Care	In FY 2020, the SGH Senior Resource Center will explore ways to update the telephone reassurance call program and potentially increase the number of telephone calls. For FY 2018, 4,900 calls were made through the daily telephone reassurance call program with 18 alerts. Telephone reassurance call data are tracked internally by the Program Coordinator for the Sharp Senior Resource Center.
3. Continue to host a variety of senior health education and screening programs, in order to raise awareness, identify risk factors, and connect seniors to helpful resources.	a. Provide information on various senior issues such as senior mental health, memory loss, hospice, senior services, nutrition, healthy aging and balance and fall prevention.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Education Screenings Collaboration	In FY 2020, the SGH Senior Resource Center will hold two additional classes focusing on homelessness and food insecurity to help raise awareness around both of these issues. YTD FY 2019, the SGH Senior Resource Center has provided more than 30 free health education programs and presentations to nearly 1,000 community members. In FY 2018, the SGH Senior Resource Center provided nearly 60 free health education programs to more than 1,400 community members. In FY 2018, the SGH Senior Resource Center collaborated with San Diego Oasis — an

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					organization that promotes healthy aging through lifelong learning, active lifestyles and volunteer engagement to provide education on topics including mindful eating, preventing fractures and ACP. Eleven screening events were provided in FY 2018 to 190 seniors and as a result 12 attendees were referred to physicians for follow-up on their screening results. The SGH Senior Resource Center continued to sponsor the Grossmont Mall Walkers, a free fitness program to increase physical activity, improve balance and strength, and encourage a healthy lifestyle among community adults and seniors. Every Saturday, participants gathered at Grossmont Center to walk around the mall and perform gentle exercises led by an instructor from the SGH Senior Resource Center. More than 130 community members participated each month in the program in FY 2018. Each education program provided by or 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. In addition, Sharp's Senior Resource Centers track attendance and for each educational event, flu vaccination event and screening held throughout the year. Metrics on community members referred for follow-up are also tracked, and often participants' names and phone numbers are collected in order to facilitate follow-up. Often the community member talks to the department

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					directly, or their provider (if a Sharp provider) is forwarded the information directly. In addition, community members receive their results and feedback to take to their doctor on their own time.
	b. Continue to participate in community health fairs for seniors.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Education Collaboration	In FY 2019, the SGH Senior Resource Center participated in more than 10 health fairs throughout SDC, including El Cajon, Lakeside, Santee, La Mesa, the College Area, Point Loma and San Diego, reaching more than 3,600 community members. Populations served at these fairs included seniors and caregivers; Parkinson's patients and caregivers, Dementia patients and caregivers, veterans and those caring for veterans, and Lesbian, Gay, Bisexual and Transgender (LGBT) seniors. In addition, the SGH Senior Resource Center provided more than 500 free blood pressure screenings as well as educational resources on senior and caregiver services. Through participation in these events, the SGH Senior Resource Center provided education and resources to nearly 800 east region community members in FY 2019. Throughout FY 2019, the SGH Senior Resource Center also provided six health screening events at various sites in SDC's east region, reaching nearly 105 members of the senior community. Screenings included balance and fall prevention, hand, carotid artery, peripheral artery disease, stroke, and behavioral health.
	c. Coordinate two conferences – one dedicated to family caregiver issues in collaboration with the Caregiver Coalition of San Diego	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Education Collaboration	In FY 2020, the SGH Senior Resource Center will again collaborate with the Caregiver Coalition to provide education and support for their annual conference for family caregivers.

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	and one focused on chronic care and palliative care in collaboration with Sharp HospiceCare.				In April of 2018, the SGH Senior Resource Center partnered with Sharp HospiceCare and the City of La Mesa to provide a conference titled Healthy and Wellness in Aging for community seniors and their families. Held at the La Mesa Community Center, the free conference provided approximately 110 attendees with educational presentations from a marriage and family therapist, attorney, nurse practitioner, ACP specialist, and other experts on how to plan for a healthy, safe and mindful future.
4. Engage and partner with local community organizations that address senior health issues in order to foster future opportunities for collaboration in provision of education, screening, and other resources to seniors and high-risk populations.	a. Maintain active relationships with community organizations serving seniors throughout San Diego. Organizations include: East County Senior Service Providers, Meals on Wheels, Caregiver Coalition, and the Caregiver Education Committee.	Ongoing (evaluated annually)	Program Coordinator, SGH Senior Resource Center	Senior Health Collaboration	In FY 2020, the SGH Senior Resource Center plans to partner with the City of La Mesa Adult Enrichment Center as part of their Livable La Mesa project. The SGH Senior Resource Center plans to hold health-related programming for seniors at the center, as well as assist with their annual transportation expo. Livable La Mesa is a project through AARP's Livable Communities Initiative, with support from The San Diego Foundation Age-Friendly Communities Program and an affiliate of the World Health Organization's Global Network of Age-Friendly Cities and Communities. This initiative is a national effort to help cities prepare for their own and the world's growing population of older adults. With input from La Mesa residents, the project will prepare a plan to help make La Mesa a community for all ages, and will focus on outdoor spaces and buildings, transportation, social and civic participation, housing, community information and support, health and wellness, and respect and social inclusion. In FY 2019, the SGH Senior Resource Center maintained active relationships with organizations that enhance professional networking and provide quality programming for seniors in SDC's east region, including the Caregiver Coalition of San Diego (the Caregiver Education Committee), East County Senior Service

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					Providers, East County Action Network, AIS Health Promotion Committee and Meals on Wheels Greater San Diego East County Advisory Board. In addition, the Program Coordinator participates in the Sharp Equality Alliance, an internal committee that provides outreach to various community organizations. Further, in order to avoid unnecessary visits to the emergency room and the potential risks of hospitalization, SGH is a part of the Alzheimer's Response Team in East County, which links medical first-responders, social workers, Sheriff's deputies and other professionals to individuals living with dementia, to ensure proper assistance as well as the most appropriate services during an emergency. Launched in 2018, by the County of San Diego, SGH works alongside the Grossmont Healthcare District, Alzheimer's San Diego and Live Well San Diego. The team also collaborates to provide ongoing support to families and help prevent future crises. The Alzheimer's Response Team is an outgrowth of The Alzheimer's Project, the county-led initiative to find a cure for Alzheimer's and help families struggling with the disease. As the Senior Resource Center increases the number of community partners it collaborates with, it is expected that additional opportunities will arise.
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.	9/30/2019 Ongoing (evaluated annually)	Bereavement Dept., Sharp HospiceCare;	Senior Health Education	In FY 2019, approximately, 1,400 community members received bereavement support newsletters. The amount of bereavement mailings is growing each year. Track number of mailings annually through internal Access/Excel database.

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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.	9/30/2019 Ongoing (evaluated annually)	Bereavement Dept., Sharp HospiceCare;	Senior Health Veterans Education	At a variety of community events throughout 2019, Sharp HospiceCare provided resources and information on veteran programs. FY 2018 veteran-specific community work included: • In honor of Veterans Day, Sharp HospiceCare celebrated patients who served in the U.S. military by holding 21 flag ceremonies throughout the month of November. • Sharp HospiceCare provided veteran-specific community education and outreach, including a presentation on the WHV program to approximately 150 attendees of the CSU Institute for Palliative Care at California State University San Marcos (CSUSM) and SDCCC's High Tech High Touch palliative care conference in June. The annual conference strives to educate community members as well as current and future health care professionals about palliative care options and ACP. • In October, Sharp HospiceCare, the San Diego County Hospice-Veteran Partnership and the Caregiver Coalition of San Diego hosted the Veterans Resource Fair at the Silverado Encinitas Memory Care Community. The free event provided veterans, family members and caregivers with community resources, presentations on available health care services. • Sharp HospiceCare also honored the nation's veterans at various community ceremonies and events in FY 2018. • Since 2010, member of the San Diego County Hospice-Veteran Partnership. • Participation on the advisory board for the Southern Caregiver Resource Center's Operation Family Caregiver.

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					• Currently a Level 3 Partner, working towards Level 4 (4 levels available) in WHV, a national program developed by the NHPCO in collaboration with the 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 3 Partners have developed and strengthened relationships with VA medical centers and other veteran organizations.
	c. Continue to provide the community end-of-life and advanced illness managment education and resource services throughout San Diego.	9/30/2019 Ongoing (evaluated annually)	Business Development, Sharp HospiceCare	Senior Health Education Collaboration	YTD in FY 2019, Sharp HospiceCare collaborated with community organizations to provide more than 2,300 community members with end-of-life and advanced illness management 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. In FY 2019, Sharp HospiceCare will continue to host two aging conferences with the Sharp Senior Resource Centers and a Health and Wellness in Aging Conference in August with Sharp Chula Vista Medical Center at the Elks Lodge in Chula Vista. In FY 2018, Sharp HospiceCare helped plan and facilitate the San Diego Community Action Network (SanDi-CAN) 11th annual community conference at the Balboa Park Club titled Planning Ahead: Ensuring Your Decisions Will Be Honored for approximately 100 seniors. Sharp HospiceCare partnered with the Sharp Senior Resource Centers to provide two aging conferences for more than 200 community seniors, family members and caregivers, titled Healthy and Safe Aging. Sharp HospiceCare partnered with the Caregiver Coalition of San Diego to

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					offer free conferences to approximately 200 community members who provide care for a friend or family member. Track number of community education events through internal database.
	d. Continue to offer individual and family bereavement counseling and support groups.	9/30/2019 Ongoing (evaluated annually)	Bereavement Dept., Sharp HospiceCare	Senior Health Care Management	In FY 2018, the Healing After Loss and the Widow's and Widower's ongoing bereavement support groups served approximately 400 community members. In May, Sharp HospiceCare hosted classes and support groups for 60 adults who have lost a parent. Held at the Peninsula Family YMCA and the Grossmont Healthcare District, two Remembering Our Parents classes highlighted the unique aspects of parent loss, coping strategies and how to discover a sense of hope. In addition, in July and August, Sharp HospiceCare provided community members with education on coping skills during bereavement support groups hosted by the John D. Spreckels Center in Coronado. Track number of individual and group counseling sessions through internal database.
	e. Provide Advance Care Planning (ACP) for community groups as well as individual consultations.	9/30/2019 Ongoing (evaluated annually)	Advance Care Planning Dept., Sharp HospiceCare	Senior Health Education Care Management	In FY 2018, the program engaged more than 1,100 community members and caregivers 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, senior living communities and seminars. This number continues to grow, and FY 2019 data is forthcoming; anticipate a higher figure. Throughout FY 2018, the Sharp ACP team provided approximately 80 phone and in-person consultations to community members seeking guidance with

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					identifying their personal goals of care and health care preferences, appointing an appropriate health care agent, and completing an advance directive. In FY 2018, Sharp HospiceCare was one of 50 sites across the country selected to receive grant funding from the Hospice Foundation of America (HFA) to provide community outreach aimed at understanding the ACP needs of underserved populations. Using an interactive, end-of-life game called Hello, Sharp HospiceCare engaged individuals who face barriers to health care due to socioeconomic, geographic, linguistic, cultural or educational circumstances. This included 12 transgender and heterosexual women at Christie's Place as well as five community members at the Valencia Park/Malcolm X Library. As a Hello game community outreach site, Sharp HospiceCare helped the HFA assess the game's effectiveness and the readiness of underserved groups to engage in further ACP. The "Hello" initiative concluded in FY 2018. In addition, in FY 2018, Sharp's ACP team partnered with the CSU Institute for Palliative Care at CSUSM to discuss potential outreach strategies for bringing information about advance health care directives to the county's homeless community. Sharp HospiceCare honored National Healthcare Decisions Day by providing ACP presentations to more than 600 community members. Sharp's ACP team reached an additional 30 community members through free ACP workshops in FY 2018, including a monthly workshop at the David and Donna Long Center for Cancer Treatment at SGH.

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					Track number of sessions and individual consultations through Allscripts Business Unit, Excel spreadsheet and participant evaluations. Quarterly community presentations offered throughout SDC.
	f. Continue to conduct outreach activities and provide professional education on hospice-related topics to community agencies, health care facilities, colleges and universities on hospice and palliative care.	Ongoing (evaluated annually)	Medical Director, Sharp HospiceCare Business Development, Sharp HospiceCare Program Coordinator, Sharp Senior Resource Center	Senior Health Education Collaboration	In FY 2018, the team provided classroom-based lectures on hospice and palliative care to approximately 225 nursing students from Azusa Pacific University, University of San Diego and CSUSM, as well as to more than 50 social work students from SDSU. Topics included ACP, POLST, goals of care, hospice, palliative care, bioethics and bereavement Sharp HospiceCare leadership provided education, training and outreach to more than 1,500 local, state and national health professionals at various national conferences and community centers 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 the National Association of ACOs Conference; Baptist MD Anderson Cancer Center; Center to Advance Palliative Care National Seminar; Coalition to Transform Advanced Care National Summit; St. Joseph Home Health; Dignity Health and many others. 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.

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6. Provide education and outreach to the San Diego health care community concerning hospice and palliative services within the care continuum, in order to raise awareness of the choices available towards the end of life and empower community members so that they and their family members may take an active role in their treatment.	a. Provide hospice, palliative care and ACP training to physicians, case managers and other health care professionals.	Ongoing (evaluated annually)	Advance Care Planning Coordinator	Senior Health Education	Throughout the year, Sharp's ACP team educated nearly 600 local, state and national health care professionals on ACP and POLST. In addition, in January, the ACP team served as a speaker and facilitator of a workshop titled The Road Ahead for Serious Illness Care, which engaged more than 50 community providers from nonprofit organizations and health care agencies in planning for better community engagement in ACP and palliative care. In addition, the ACP team provided classroom-based lectures designed to enhance students' understanding of hospice and palliative care to approximately 225 nursing students from various local universities, as well as to more than 50 social work students from San Diego State University. The Sharp HospiceCare Resource and Educational Expo in February 2019 included approximately 50 exhibitors and provided tools for nearly 100 community health care professionals – including nurses, social workers, spiritual care providers and physicians – on how to best balance modern issues of technology while providing compassionate care to patients Sharp HospiceCare plans to hold the Resource and Educational Expo again in 2020.
	b. Continue active involvement with and participation on state and national hospice organizations (CHAPCA, NHPCO, etc.) included presentations on understanding late-stage illness, changing our culture of Care to one of	Ongoing (evaluated annually)	Vice President, Sharp HospiceCare Medical Director,	Senior Health Education Collaboration	Sharp HospiceCare provides approximately six presentations provided each year in collaboration with state and national organizations. Sharp HospiceCare leadership continues to serve as the board, and as a state hospice representative, for NHPCO and CHAPCA. Community presentations provided through Sharp HospiceCare – including

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	partnership and a continuum of Care perspective, advance Care planning, etc.		Sharp HospiceCare		those to professional organizations – are evaluated through survey to evaluate effectiveness and revise program content.
7. Collaborate with community, state and national organizations to develop and implement appropriate services for the needs of the aging population.	a. Explore partnership with community organizations designed specifically to meet the needs of caregivers.	9/30/2019 Ongoing (evaluated annually)	Business Development Dept., Sharp HospiceCare	Senior Health Collaboration	In March 2018, Sharp became the first health care system in SDC to begin electronic uploads of patient POLST forms to the POLST eRegistry. As of late 2018, nearly 23,000 POLST forms faxed by Sharp hospitals, Sharp Rees-Stealy Medical Group, Sharp HospiceCare and other patient care departments have been uploaded to the POLST eRegistry. More current data forthcoming. **Background**: Since FY 2016, Sharp's ACP team has partnered with San Diego Health Connect, Health and Human Services Agency's Aging and Independence Services, Health Services Advisory Group, County of San Diego Emergency Medical Services, and various health care providers in SDC to ensure that community providers have access to POLST forms through the San Diego Healthcare Information Exchange, a countywide program that securely connects health care providers and patients to private health information exchanges. The Sharp HospiceCare ACP team participates in this initiative — funded by the California Health Care Foundation and supported by the CCCC and California Emergency Medical Services Authority — to create an electronic POLST registry (POLST eRegistry).
	b. Continue to collaborate with a variety of local networking groups and community-oriented agencies to provide caregiver classes, end-	Ongoing (evaluated annually)	Business Development, Sharp HospiceCare	Senior Health Education Collaboration	No new updates; efforts ongoing.

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	of-life programs, ACP seminars and web presentations for consumers and health care professionals.				
	c. Sharp HospiceCare (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Manager, Sharp HealthCare Community Benefit and Health Improvement Director, SGH Case Management & Social Work VP Sharp HospiceCare	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	Beginning in July, 2019 Sharp HospiceCare will participate along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the CIE stewarded by 2-1-1 San Diego. CIE training for Sharp HospiceCare staff was completed in July, 2019. Sharp teams are working closely with 2-1-1 San Diego on the implementation plan for CIE, which includes ongoing metrics, such as CIE utilization across the system, referral tracking, impact on case management efficacy and successful connection to needed social services, health care utilization (e.g., inpatient readmissions, unnecessary ED visits, LOS, etc.) and others. This data will be used to re-evaluate the value and sustainability of CIE for Sharp HealthCare after the one-year pilot.

Identified Community Health Need – Behavioral Health					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide comprehensive behavioral health programs to adults and older adults in East County with acute or persistent psychiatric disorders. Programs will help individuals in crisis regain their optimal level of functioning and achieve a renewed sense of emotional stability and wellness.	a. Continue to provide a dedicated psychiatric assessment team in the ED and acute care.	Ongoing	Director, SGH Behavioral Health Services Manager, SGH Behavioral Health Services Chief Medical Officer, Sharp Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders	SGH is the only hospital in East County to provide this assessment to patients in the ED. Average daily census of psychiatric consults in the ED is 20 patients per day. This is 7% of the total patient population seen in the ED. 95% of psychiatric admissions are from the ED. Psychiatric consultations in the ED have increased approximately 70% from 2012 (5008 consults) to 2018 (7219 consults). Although Behavioral Health is identified as a health need in the communities served by SGH, beyond clinical services, the facility does not have the resources to comprehensively address the elements of community education and support around this health need. Consequently, the community education and support elements of behavioral health care are addressed through collaboration with the programs/services provided through Sharp Mesa Vista Hospital and Sharp McDonald Center, which are the major providers of behavioral health and chemical dependency services in San Diego County (SDC).
	b. Continue to provide hospital-based outpatient programs that serve individuals dealing with a variety of behavioral health issues, including schizophrenia, depression and bipolar or anxiety disorders, as well as psychiatric diagnosis for patients 18 or older.	Ongoing	Director, SGH Behavioral Health Services Manager, SGH Behavioral Health Services	Behavioral Health Screening Access to Care Co-occurring disorders	Current outpatient programs include: Adult Mental Health Program for adults with acute and chronic disorders such as schizophrenia and bipolar disease; Bridges Program, based on the Recovery Model for adults diagnosed with schizophrenia and bipolar disorder; Dual Recovery Program, for adults with co-existing mental illness and chemical-use/addictive behavior disorder; Outpatient Electroconvulsive Therapy (ECT) Program; and Medication Clinic for adults that benefit from Long Acting Injectable medications.

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				Depression Bipolar Anxiety Substance Use	
	c. Continue to offer specialized inpatient treatment programs designed to address the specific needs and conditions of patients.	Ongoing	Director, SGH Behavioral Health Services Manager, SGH Behavioral Health Services Chief Medical Officer, Sharp Behavioral Health	Behavioral Health Screening Access to Care Co-occurring disorders	Current inpatient programs include: comprehensive program for adults suffering from psychiatric illness such as psychosis, delusions, depression, grief, anxiety, panic, obsessive-compulsive disorder, and traumatic stress syndromes; Intensive treatment programs for short-term crisis intervention, rapid recovery and return home; and a Medical Psychiatric Program.
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker	Clinical Community Linkages Data Sharing Collaboration	Beginning in July, 2019 SGH will participate along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the CIE stewarded by 2-1-1 San Diego. Sharp teams are working closely with 2-1-1 San Diego on the implementation plan for CIE, which includes ongoing metrics, such as CIE utilization across the system, referral tracking, impact on case management efficacy and successful connection to needed social services, health care utilization (e.g., inpatient readmissions, unnecessary ED visits, LOS, etc.) and others. This data will be

Identified Community Health Need – Behavioral Health					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Manager, Sharp HealthCare Community Benefit and Health Improvement	All SDOH, e.g., housing, nutrition, transportation, etc.	used to re-evaluate the value and sustainability of CIE for Sharp HealthCare after the one-year pilot.

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Improve navigation of the health care system for cancer patients in San Diego's east region through patient navigation services.	a. Continue to offer the cancer patient navigator program to SGH cancer patients.	Ongoing	SGH Cancer Patient Navigator Coordinator	Access to Care Care Management	In FY 2018, the SGH breast health navigator facilitated access to care for nearly 200 breast cancer patients in need — many with late-stage cancer diagnoses — through the provision of referrals to various community and national organizations. See below for details. Sharp's 2019 CHNA process included a facilitated discussion with Sharp Cancer Patient Navigators. In this discussion – and through other tools discussed below – financial distress was identified as a critical need to address for cancer patients and their families. Includes concerns in both inpatient and outpatient settings. As such, there is work in progress to bring Sharp teams together for system-wide strategies and resource utilization to address patient financial needs. This includes exploration of software (Vivor) and financial navigation resource implementation. To better assist the community, the Sharp Cancer Centers share direct links to community resources and agencies by service needed as well as information on advance care planning on sharp.com. Patient record is easy to access and also downloadable for documenting mediations, allergies, screenings and treatments. The Sharp Cancer Centers also include a new online assessment on sharp.com for individuals to assess if at risk and qualify for a lung screening. **Cancer Navigation Background:** SGH offers a cancer patient navigator program through which trained and certified navigators provide personalized education, support and guidance to patients At SGH, a licensed clinical social worker, nurses and nurse navigators

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					work in unison to provide the patient with the necessary services based upon their needs. The breast health navigator is a registered nurse certified in breast health who personally assists breast cancer patients and their families with navigating the health care system. The breast health navigator offers support, guidance, education, financial assistance referrals and recommendations to community resources. Through collaboration with community clinics — including Family Health Centers of San Diego (FHCSD), Neighborhood Healthcare and Borrego Health — the breast health navigator identifies patients who may financially benefit from the Breast and Cervical Cancer Treatment Program. Offered through the California Department of Health Care Services, the program provides urgently needed cancer treatment coverage for unfunded or underfunded low-income patients, while local clinics help facilitate the enrollment process. Sharp patients are tracked internally, and patients meet with a navigator on their initial visit to Radiation Oncology. Navigation services provided to patients are closely tracked through internal databases. Systemwide Patient Navigation documentation in Cerner was rolled out in 2018, which allows for all Cerner users to view the Patient Navigation notes.
	b. Provide and refine SGH Cancer Patient Navigator Distress Screening technology to screen, track and respond to	Ongoing (evaluated annually)	VP Oncology Service Line	Cancer Fear Care Management	**New**: Beginning in June, 2019, an electronic distress screening (available in both English and Spanish), using a validated tool distributed by the Cancer Support Community, was implemented. New tool provides easier methods for completion, timely results sharing, report tabulation and provides chronologic

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	psychological, spiritual, practical and other social needs experienced by cancer patients and their families.		SGH Cancer Patient Navigator Coordinator Oncology Social Workers Sharp Nurses	Data Management/ Technology Logistical support services Social Determinants of Health (especially financial)	comparison of results for each patient for monitoring. Algorithms established for each question to identify information resources for concern and staff member to provide support if desired. Goals for 2019 and future include expanded use of tool to increase number of patients screened at least one time, as well as number of patients screened more than one time, especially at times of care transitions. Financial concerns were a key source of distress for cancer patients. Will compare financial distress data form Distress Screening Reports in FY2019 to FY2020 and/or FY 2021 According to 2018 Sharp oncology data, nearly half (46%) of the 518 SGH cancer patients who received the cancer psychosocial distress screening scored at a range of high to very high distress. In addition, 3% (17) of these patients reported some level of suicidal ideation. All of these identified patients were referred to internal or external resources, such as social workers or community cancer resources. From 2017-2018, anxiety levels increased across all Sharp cancer centers. **Distress Screening Background** Distress Screening to assess psychological, social, spiritual and practical issues contributing to cancer patient distress has been conducted at SGH over the past several years. This tool identifies patient needs in greater detail in order to make them actionable and rate them by intensity so that they may be prioritized and addressed appropriately. Routine reports including number of patients screened, information on the issues that are most challenging for

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					patients and the percentage of patients rated in high distress are reported to the Integrated Network Cancer Program and to hospital entities annually. The information will drive efforts to target and provide additional support and resources to better meet our patient needs. Data collected via the distress screening has shown financial issues are a main area of concern for patients served (per above, there is work in progress to secure a part-time financial navigator).
	c. Provide and refine SGH Cancer Patient Navigator PowerForm technology to screen, track and respond to psychological, spiritual, practical and other social needs experienced by cancer patients and their families.		VP Oncology Service Line	Cancer Fear Care Management Data Management/ Technology Logistical Support Services Social Determinants of Health (especially financial)	In April 2019, Sharp Cancer Centers implemented a revised Powerform for better capture and reporting on logistical support services needed and referrals provided. **Cancer Patient Navigator PowerForm Background**: Cancer patient navigators across Sharp collaborated to define, develop and propose a new Cerner Oncology Navigator PowerForm. The PowerForm was designed to standardize the cancer patient navigator's documentation, increase efficiency in patient care coordination, and improve overall patient care. By utilizing the PowerForm, navigators can document their assessment of patient needs and barriers to care, in addition to how they addressed patient unmet needs with appropriate internal and external support services and referrals. The need of financial assistance was selected as the Integrated Network Cancer Program annual goal, and now navigators document interventions specifically for financial barriers. The data from the documentation will be analyzed to optimize Sharp cancer care continuum.

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	d. SGH Cancer Patient Navigators (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Manager, Sharp HealthCare Community Benefit and Health Improvement VP Oncology Service Line SGH Cancer Patient Navigator Coordinator Oncology Social Workers	Clinical Community Linkages Data Sharing Collaboration All Social Determinants of Health (SDOH), e.g., finances, nutrition, transportation, etc.	Beginning in July, 2019 SGH will participate along with multiple Sharp entities (hospitals, medical groups, and health plan) in a one-year pilot with the Community Information Exchange stewarded by 2-1-1 San Diego. SGH Cancer Patient Navigators at all three Cancer Centers will be trained on CIE in order to better support challenges with social determinant of health identified in cancer patients and their families. Specific metrics to be tracked for Oncology: • # of oncology patients served via CIE linkages; FY 2019 baseline compared to FY2020/FY2021 utilization • # of services accessed by cancer patients via CIE; FY 2019 baseline compared to FY2020/FY2021 utilization Sharp teams are working closely with 2-1-1 San Diego on the implementation plan for CIE, which includes ongoing metrics, such as CIE utilization across the system, referral tracking, impact on case management efficacy and successful connection to needed social services, health care utilization (e.g., inpatient readmissions, unnecessary ED visits, LOS, etc.) and others. This data will be used to re-evaluate the value and sustainability of CIE for Sharp HealthCare after the one-year pilot. CIE is a multi-sector data-sharing collaboration in San Diego County, stewarded by 2-1-1 San Diego to proactively, efficiently address the social determinants of health needs in the community. CIE provides a longitudinal client record with patient history, access to social programs (e.g., housing/ HMIS, Food Banks, community clinics, etc.), emergency transport data, and care team data. CIE

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	Strategy/Action Items	Target Completion Date	Responsible Party/ies	Identified Themes in 2019 CHNA	Evaluation Methods, Measurable Targets, and Other Comments
					provides the capability to generate direct referrals to community resource, track referrals and outcomes and share reports among care team members.
	e. Seek funding for the cancer patient navigator program and expand navigator services to all cancers.	Ongoing	SGH Cancer Patient Navigator	Access to Care Care Management	Navigator Program grant funding at SHC Cancer Centers (SGH, Sharp Chula Vista Medical Center and Sharp Memorial Hospital) will be sought in collaboration with Sharp Foundation efforts. External funding sources are also being explored to further enhance/expand navigator services.
2. Increase cancer education and support for community members in the east region with cancer diagnoses.	a. Continue to provide free support programs for community members with cancer diagnoses.	Ongoing	SGH Cancer Patient Navigator Coordinator	Cancer Education Care Management	In FY 2018, the SGH Cancer Center provided a variety of free support groups for approximately 100 community members impacted by cancer. Offered twice monthly, the breast cancer support group allowed women in all stages of breast cancer — from recent diagnosis, to treatment and survivorship — to share experiences and discover coping strategies. The weekly Art and Chat support group offered cancer patients, survivors and their loved ones support to increase focus, creativity, self-confidence and personal well-being. Monthly Lunch and Learn education series were available as well as a monthly Man Cave support group for men with cancer. Expansion of Sharp partnership with the American Cancer Society (ACS) to provide education and support materials and community support connections to ACS Patient Organizers. This will be in conjunction with Sharp information for patient education, services offered, information specific to care at SGH and additional connections to community and national organizations that provide assistance to cancer patients.

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Metrics: Number of Patient Organizers delivered for SGH (YTD FY 2019 = 23 and FY 2018 = 88). Initiation of patient information website section.
	b. Continue to provide Look Good Feel Better classes to community members with cancer diagnoses.	Ongoing	SGH Cancer Patient Navigator Coordinator	Cancer Education Care Management Collaboration	The SGH Cancer Center also provided meeting space for ACS' Look Good Feel Better classes, which teach women techniques to manage the appearance-related side effects of cancer treatment (e.g., hair loss, etc.) and boost self-confidence. Classes included a complimentary makeup kit and instruction from a licensed beauty professional on makeup application, skin care, and wearing wigs and headwear. Four classes were offered at the SGH Cancer Center in FY 2018, reaching more than 30 women.
	c. Continue to provide ongoing social and psychosocial supports to community member with cancer diagnoses.	Ongoing	SGH Cancer Licensed Clinical Social Worker	Cancer Education Care Management	The LCSW served more than 300 patients and family members in FY 2018, as well as approximately 100 community members that contacted the LCSW for consultation regarding support groups and other SGH Cancer Center services and community resources. This included improving patient and family connections to community resources, such as the ACS, San Diego Brain Tumor Foundation, Leukemia and Lymphoma Society, Lung Cancer Alliance, Mama's Kitchen, 2-1-1 San Diego, JFS, Feeding San Diego, and the Food Bank's Breast Cancer Case Management program, as well as other food and financial assistance programs. SGH created a Moving Ahead Clinic that provides support for patients after radiation therapy that have feeding tubes to ensure they stay nourished, hydrated, and continue utilizing muscles for swallowing. More than 30 patients meet monthly with a nurse, social worker, dietitian, and speech pathologist.

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Background: The LCSW offers psychosocial services (assessments, crisis intervention, counseling, bereavement, cognitive behavioral therapy and stress management), support group leadership, and advocacy and resources for transportation, palliative care and hospice, food and financial assistance.
3. Increase community education on the signs and symptoms of cancer through education and screening events.	a. Continue to conduct comprehensive community cancer health seminars with health screenings in SDC's east region.	Ongoing (evaluated annually)	Manager, SGH Radiation Oncology HBO/WHC SGH Cancer Patient Navigator Coordinator	Cancer Education Collaboration Screening	In FY 2018, the SGH Cancer Center provided education on cancer, breast self-examination demonstrations, breast cancer awareness, and resources to approximately 200 individuals at community events throughout SDC's east region. At Sharp's annual Women's Health Conference in April, the SGH Cancer Center offered cancer education, screenings, recommendations and literature to 1,000 community members. Throughout the year, the SGH Cancer Center continued to collaborate with Chaldean and Middle-Eastern community leaders in El Cajon to determine the most common barriers to obtaining breast health care among the Middle-Eastern community as well as how to provide appropriate, culturally sensitive educational materials and trainings for this population. The SGH Cancer Center continued to host educational classes at no cost for patients and community members facing cancer. Through the monthly Survivorship Lunch and Learn series, community members, patients and families hear local experts speak about a unique cancer-related topic and participate in a question-and-answer session alongside a complimentary lunch. The series reached an average of 8 to 14 individuals per session in FY 2018.

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Throughout the year, the SGH Cancer Center offered free workshops for patients and community members, including monthly ACP workshops provided in collaboration with Sharp's ACP program. The SGH Cancer Center also offered a workshop to help cancer patients and their loved ones manage the stress, anxiety and difficult emotions that accompany a cancer diagnosis. A Managing Sleep and Fatigue Workshop was also offered to patients and family members, as well as a quarterly Chemo Brain Workshop: Improving Memory and Concentration. In FY 2019, the SHC Cancer Centers plan to coordinate at least one prevention event and one screening event (see line item "b" below).
	b. Continue with annual, systemwide INCP community event for prevention, including provision of education and screenings.	Ongoing (Annual Calendar Year Event) In planning stages for CY 2019 – 2023 events	VP Oncology Service Line	Cancer Education Screening Prevention	Sharp's systemwide Integrated Network Cancer Program (INCP) in FY2019 provided its annual community event, focused on cancer prevention. FY 2019 was an online event on HPV vaccination for prevention of various cancers including head and neck cancers. Event was conducted over ten days and 665 adults (72% female) participated. **Collected metrics included**: • Awareness of HPV health complications (somewhat or extremely familiar): Baseline=75.8% of participants. Post-education = 91.6%. • Awareness of HPV risk factors (somewhat/extremely familiar): females baseline: 75.3%; post-ed: 92.6%. Males baseline: 58%; post-ed: 87.2%. • Awareness of HPV vax benefits: Baseline: 76.5%; post-ed: 92.6%. • Post-ed, 41.3% were somewhat or very likely to discuss HPV risk and prevention with their PCP (w/28% of men having already done so).

Identified Community Health Need – Cancer					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					• Post ed, more than half of respondents who are adults or share a household with adults 27+ y/o were very likely to recommend HPV vax to those they thought could benefit from it. Sharp's INCP annual community screening events included breast screening events in SDC's south region and skin cancer screenings. While the latter screening event produced minimal impactful metrics (Results were not readily available due to non-reportability of basal cell carcinomas), the breast cancer screening event was more successful, through collaboration with La Maestra Health Clinic and Las Damas de San Diego. Outcome data from this event is unavailable.
	c. Increase access to appropriate cancer screenings for high-risk community members through expansion of cancer genetics program.	Ongoing Evaluated annually	VP Oncology Service Line	Cancer Screening Prevention Access to Care	Systemwide initiative to improve access to cancer screenings and other preventive measures (e.g., surgeries) for individuals with genetic predispositions to cancer. In 2019, an increase in recommended annual breast MRIs, clinical breast exams, and colonoscopy screenings was observed (compared to 2018) due to this effort.

Sharp Grossmont Hospital
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2020-2023

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Empower community members with cardiovascular and cerebrovascular disease through education, screening and support; promote accountability and behavioral change through education on chronic disease self-management.	a. Continue to provide free bimonthly cardiac education classes.	Ongoing (evaluated annually)	Lead, SGH Cardiac Rehabilitation Manager, Noninvasive Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication	Cardiovascular Disease Education	A free Heart and Vascular Risk Factors Education class was offered twice a month to individuals who were hospitalized within the last six months due to select heart conditions, reaching more than 270 individuals in FY 2018. SGH educational programs are evaluated by participants through survey.
	b. Continue to provide free congestive heart failure (CHF) education classes and support groups.	Ongoing	Lead, SGH Cardiac Rehabilitation SGH Heart Failure Senior Specialist Manager, Noninvasive	Cardiovascular Disease Education	In FY 2019, a free, monthly CHF class and support group provided nearly 65 individuals with a supportive environment to discuss various topics about living well with CHF, covering topics such as exercise, nutrition, treatment plans and symptoms. SGH educational programs are evaluated by participants through survey.

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Director, SGH Cardiac/ Vascular Services Director, SGH Marketing and Communication		
	c. Provide free support groups to stroke survivors and their family members.	Ongoing (Evaluated annually)		Cardiovascular Disease Support Education Collaboration	In FY 2018, the SGH Outpatient Rehabilitation Department offered a weekly Stroke Communication Support Group for stroke survivors and their family members with a focus on stroke and brain injury survivors with aphasia or other speech or language difficulties. Topics included games to improve visual skills, language stimulation, listening activities and social interaction. The support group is sponsored by Young Enthusiastic Stroke Survivors, a community network that offers social, recreational and support group activities to stoke survivors and their families and caregivers. An average of six community members attended each session.
	d. Educational sessions focused on heart disease and cardiovascular health for the east region communities.	Ongoing (evaluated annually)	Manager, SGH 5 West, Cardiac Rehabilitation Director, SGH Cardiac/ Vascular Services	Cardiovascular Disease Education	SGH's Cardiac Training Center and Cardiac Rehabilitation Departments participated in a variety of community events throughout San Diego in FY 2019. Together, they offered community members free blood pressure screenings, cardiopulmonary resuscitation (CPR) demonstrations, and cardiac health education and resources, including prevention, symptom recognition, evaluation and treatment. Events included the Sharp Disaster Preparedness Expo, Celebrando Latinas, Live Well San Diego's (LWSD's) Love Your Heart event, SGH's Burr Heart & Vascular Community Open House, AHA Heart & Stroke Walk and annual Sharp Women's Health Conference. The Cardiac

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Director, SGH Marketing and Communication		Rehabilitation team also collaborated with the SGH Senior Resource Center in February to educate seniors at a local library about the importance of exercise and nutrition to maintain a healthy heart. Further, the Cardiac Rehabilitation team provided free flu shots to community seniors during a flu clinic held at the hospital in October. Throughout FY 2019, SGH-affiliated cardiologists shared heart-related information with various media outlets on topics including aspirin and heart health, cannabis and heart heath, and sex after a heart attack. Throughout the year, SGH provided its Peripheral Vascular Disease Rehabilitation Program to provide education and coaching on exercise, diet and medication to keep patients — particularly low-income patients — at the highest functional level. The program is partially funded by donations to the Grossmont Hospital Foundation to help defray the cost for patients with limited resources. Annual target is at least one to two community events per year – including health fairs and lectures. SGH educational programs are evaluated by participants through survey.
	e. Continue to provide educational resources on cardiac health at community events throughout San Diego.	Ongoing (evaluated annually)	Director, SGH Cardiac/ Vascular Services	Cardiovascular Disease Education	In FY 2018, SGH's Cardiac Training and Cardiac Rehabilitation Departments provided education and free cardiovascular screenings at various community events throughout San Diego (see item 1c above).

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	f. Continue to provide preventative cardiovascular screenings to community members in San Diego's east region.	Ongoing (evaluated annually)	Director, SGH Cardiac/ Vascular Services Manager, Noninvasive Director, SGH Marketing and Communications	Cardiovascular Disease Screenings	Preventive cardiovascular screenings (fee-based) are comprehensive, include ultrasound, lab tests, and calcium scoring as well as assessing and educating the patient on his or her risk of a heart attack or stroke. Preventive cardiovascular screenings (fee-based) are comprehensive, include ultrasound, lab tests, and offer a calcium scoring option as well as assessing and educating the patient on his or her risk of a heart attack or stroke. SGH has screened more than 1,200 individuals since 2008.
	g. Continue to provide stroke education and screening for SDC's east region; education events to including events targeting seniors & high-risk adults as well as individuals with identified risk factors.	Ongoing	Vice President, Sharp Ortho/Neuro Service Line Director, Sharp Neuroscience Service Line Director, SGH Acute Care Nursing Administration Program Coordinator,	Stroke Education Screening Collaboration	In FY 2019, SGH will participate in Sharp's partnership with the City of San Diego to provide stroke education and resources to employees and residents in the City's nine districts. In FY 2018, the SGH Stroke Center provided stroke education and screenings at 11 community events in SDC's east region. At these events, the team provided more than 600 community members with information about stroke risk factors, warning signs, and appropriate interventions, including arrival at the hospital within early onset of symptoms. In addition, more than 80 community members received blood pressure checks or stroke screenings. During the screenings, the SGH Stroke Center identified risk factors as well as provided education and advised behavior modification. The SGH Stroke Center also provided stroke education to nearly 20 members of the Grossmont Mall Walkers group at Grossmont Center and nearly 30 members of a local weight loss support group at Renette Recreation Center in El Cajon. Further, the SGH Stroke Center provided education and tours at the SGH's Burr Heart & Vascular

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
			Sharp Senior Resource Center		Community Open House, AHA Heart & Stroke Walk and annual Sharp Women's Health Conference. The Sharp HealthCare Stroke service line team also once again participated in Stroke Awareness Day at Petco Park in May 2019, with nearly 30,000 attendees. Sharp offered stroke and blood pressure screenings, education about stroke prevention, recovery, the warning signs of stroke and how to respond using FAST (Face, Arms, Speech, Time). In collaboration with the SGH Senior Resource Center, the SGH Stroke Center and a Sharp interventional neuroradiologist presented on the recent advances in the treatment of stroke and provided resources to nearly 50 community members at San Diego Oasis in May. The SGH Stroke Center also conducted personal health interviews, blood pressure and pulse checks, and provided education on emergency treatment for stroke, prevention and warning signs, and how to respond. Also in partnership with the SGH Senior Resource Center, the SGH Stroke Center provided stroke screenings to approximately 10 community seniors at a community library. Educational events conducted in collaboration with the Sharp Senior Resource Center collect evaluation forms to assess the quality of education/screening events. Feedback from these evaluations is incorporated for future planning. In addition, Sharp's Senior Resource Centers track attendance for each educational event and screening. Metrics on community members referred for follow-up are also tracked, and often participant's name and phone number are collected in order to facilitate follow-up. Often the community member

Identified Community Health Need – Cardiovascular Disease					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					talks to the department directly, or their provider (if a Sharp provider) is forwarded the information directly. Community members receive their results and feedback to take to their doctor on their own time.
	h. Continue to collaborate with community organizations to provide support for community members impacted by stroke.	Ongoing	Director, Sharp Neuroscience Service Line Director, SGH Acute Care Nursing Administration	Stroke Collaboration Support	In FY 2018, the SGH Outpatient Rehabilitation Department offered a weekly Stroke Communication Support Group for stroke survivors and their family members with a focus on stroke and brain injury survivors with aphasia or other speech or language difficulties. The support group is sponsored by Young Enthusiastic Stroke Survivors. An average of six community members attended each session.
2. Collaborate with other health care organizations in San Diego to provide cardiovascular and stroke data in order to support prevention and successful treatment of San Diegans with cardiovascular and stroke issues.	a. Continue participation in the San Diego County Stroke Consortium.	Ongoing	Vice President, Sharp Ortho/Neuro Service Line Director, Sharp Neuroscience Service Line Director, SGH Acute Care Nursing Administration	Stroke Collaboration Data Sharing	SGH continues to actively participate in the quarterly San Diego County Stroke Consortium, a collaborative effort to improve stroke care and discuss issues impacting stroke care in SDC. Additionally, SGH continues to collaborate with the County of San Diego Emergency Medical Services to provide data for the SDC stroke registry.

Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase education of signs and symptoms of diabetes in East County.	a. Participate in educational forums, health fairs and events in San Diego's east region.	Ongoing (evaluated annually)	SHC Diabetes Leadership Team	Diabetes Education Collaboration	As of YTD FY 2019, the SGH Diabetes Education Program provided 11 lectures to nearly 150 community members at the Family Health Centers of San Diego (FHCSD) Lemon Grove, El Cajon and Grossmont Spring Valley sites. In FY 2018, the SGH Diabetes Education Program provided eight diabetes lectures to more than 50 community members at the FHCSD Lemon Grove site. Topics included creating an active lifestyle, nutrition, diabetes self-management, goal setting, and diabetes risk factors, symptoms and treatment. In FY 2019, the Sharp Diabetes Education Program provided a presentation on diabetes including the different types of diabetes, medicine, technology and diagnosis, as well as resources and career information to more than 20 students at San Diego State University. Also in FY 2019, the SGH Diabetes Education Program educated approximately 15 community members on heart healthy cooking at the Temple Emanu-El in Del Cerro. In addition, at the Grossmont Healthcare District Conference Center, the SGH Diabetes Education Program provided a community lecture on lifestyle change. In FY 2019, the Sharp Diabetes Education Program offered diabetes education, support and risk assessments to approximately 1,000 attendees at the Sharp Women's Health Conference. In addition, in October 2018, the Sharp Diabetes Education Program provided fundraising and team participation for the ADA's Step Out Walk to Stop Diabetes. **Evaluation Methods:** Collect feedback from community members on educational courses provided, in order to improve and refine educational resources tailored to community

Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					member needs. In addition, the Sharp 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.	9/30/2019 (Currently evaluated annually)	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Diabetes Education Access to Care Collaboration	In FY 2019, the educational collaboration with the City of San Diego included the SHC Diabetes Educators, leaving little staffing capacity for additional community collaborations (beyond the activities listed in item 1.a. above, and 2.a. below). 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.
	c. Utilize findings in the FY 2019 CHNA to assess existing community resources and explore areas where additional diabetes education and resources may be needed in SDC's east region.	9/30/2019 (Ongoing, evaluated annually)	SHC Manager, Community Benefit and Health Improvement SHC Diabetes Leadership Team	Diabetes Food Insecurity Education Access to Care	In FY 2019, the Sharp Diabetes Education Program plans to explore additional collaborations to assist and educate food insecure community members and participate in Sharp's partnership with the City of San Diego to provide diabetes education and resources to employees and residents in the city's nine districts. In FY 2020, the Sharp Diabetes Education Program will train one of its team members on 2-1-1 San Diego's Community Information Exchange (CIE) in order to assess the value of this technology as a support for their patients. Please see Identified Community Health Need: Behavioral Health 2a for details on the CIE. Sharp Manager, Community Benefit and Health Improvement meets with Sharp Diabetes Leadership Team regularly to assess, grow and support additional opportunities for outreach and education. Continued efforts focus on:

Identified Community Health Need – Diabetes					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					• *Clinic collaborations* (FHCSD 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. The Sharp Manager of Community Benefit and Health Improvement also spoke on the food insecurity-health connection at Sharp's annual Obesity Conference in May, 2018 (FY 2019) at the invitation of the SHC Diabetes Education Team.
	d. Provide diabetes education to high-risk women with gestational diabetes, through collaboration with community clinics.	Ongoing - evaluated Annually	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Gestational Diabetes Community Clinics Education Access to Care Collaboration	In FY 2019, the Sharp Diabetes Education Program plans to continue to provide gestational services and resources to underserved pregnant women, both at the hospital and in collaboration with community clinics. **<u>Findings</u>**: At SGH, the Sharp Diabetes Education Program provided services and education to nearly 420 underserved pregnant women with diabetes in FY 2018. **<u>Background</u>**: The Sharp Diabetes Education Program is an affiliate of the California Diabetes and Pregnancy Program's Sweet Success Program, which provides comprehensive technical support and education to medical personnel

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					and community liaisons to promote improved outcomes for high-risk pregnant women with diabetes. As an affiliate, the Sharp Diabetes Education Program educates underserved pregnant women and breastfeeding mothers with Type 1, Type 2 or gestational diabetes (diabetes developed during pregnancy) on how to manage their blood sugar levels. In collaboration with community clinics, in FY 2018 the team provided these patients with a variety of education and resources. Clinic patients also received logbooks to track and manage their blood sugar levels. In addition, the Sharp Diabetes Education Program evaluated patients' management of their blood sugar levels and collaborated with community clinics' obstetrician/gynecologists to prevent complications.
2. Improve access to diabetes educational resources for underserved populations in SDC's east region.	a. Explore potential partnerships with the community clinics in order to offer diabetes classes at their clinic locations.	9/30/2019 (Ongoing, evaluate annually)	SHC Diabetes Leadership Team SHC Manager, Community Benefit and Health Improvement	Access to Care Collaboration Community Clinics	As of YTD FY 2019, the SGH Diabetes Education Program provided 11 lectures to nearly 150 community members at the Family Health Centers (FHCSD) Lemon Grove, El Cajon and Grossmont Spring Valley sites. In FY 2018, the SGH Diabetes Education Program provided eight diabetes lectures to more than 50 community members at the FHCSD Lemon Grove site. Topics included creating an active lifestyle, nutrition, diabetes self-management, goal setting, and diabetes risk factors, symptoms and treatment. Moving forward, the Sharp Diabetes Education Program plans to continue to foster relationships and collaborate with FHCSD to provide education and resources to their diabetic patients. **Background**: The Sharp Diabetes Education Program continues to collaborate with FHCSD to conduct outreach and education to vulnerable community members in SDC's east region at multiple FHCSD sites, through the

Identified Community Health Need – Diabetes					
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					organization's Diabetes Management Care Coordination Project (DMCCP). DMCCP provides FHCSD patients with group diabetes education and encourages peer support and education from project "graduates" to current patients/project enrollees. The project monitors enrollees' physical activity, as well as their A1C and blood glucose levels, which it has proven to successfully maintain and lower. In FY 2018, participants with more severe cases of diabetes (i.e., higher blood glucose levels) compared to the overall group experienced a decrease of 30 percent in blood glucose levels. 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. Create language-appropriate and culturally sensitive diabetes educational materials.	9/30/2019 Ongoing (evaluate annually)	SHC Diabetes Leadership Team	Diabetes Education Care Management Collaboration Cultural Competency	In FY 2019, the Sharp 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 assist 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

Identified Community Health Need – Diabetes					
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				Language/ Translation Services	language materials about pregnancy. Handouts were provided in Arabic, Somali, Tagalog, Vietnamese and Spanish, and food diaries and logbooks were distributed for community members to track blood sugar levels. Live interpreter services were available in more than 200 languages via the Stratus Video Interpreting iPad application, and the program facilitated translation and other resources to specifically assist Chaldean cultural needs. Further, Sharp team members received education regarding the different cultural needs of these diverse communities. Also exploring new opportunities for more effective methods and resources for properly translated educational materials (e.g. multi-lingual interns, etc.).

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide support and education for women on a variety of health topics, including prenatal care and parenting skills.	a. Provide education, outreach and support to help meet the unique needs of women, mothers and newborns in SDC's east region.	Ongoing	Manager, SGH Obstetrics and Gynecology Manager, SGH Labor and Delivery Lead Clinical Nurse, SGH Neonatal Intensive Care Unit (NICU)	Maternal and Prenatal Care High-Risk Pregnancy Education Support	The SGH Women's Health Center provided free support groups to assist women and families with the challenges and adaptations of having a newborn in FY 2018. A breastfeeding support group was offered twice a week and served nearly 20 attendees per session, including fathers. A weekly postpartum support group supported more than 30 mothers per session. In FY 2018, educational classes covered a variety of parenting and newborn care topics, including breastfeeding, Baby Care Basics, caesarean delivery preparation, childbirth preparation, infant and child CPR, and preparing new siblings and grandparents. The SGH Women's Health Center also supported the community through participation in the Sharp Women's Health Conference in April 2018. Team members offered information on women's health including labor and delivery, prenatal care, obstetrics/gynecology care, neonatal intensive care options and more to 1,000 attendees.
2. Demonstrate best practices in breastfeeding and maternity care, and provide education and support to new mothers on the importance of breastfeeding.	a. Implement process improvements to increase breastfeeding rates among new mothers. Explore and participate in opportunities to share these best practices with the broader health care community.	Ongoing (evaluated annually)	Manager, SGH Obstetrics and Gynecology Lead Clinical Nurse, SGH Lactation	Maternal and Prenatal Care High-Risk Pregnancy Education Support	Following the implementation of the 10 Steps to Successful Breastfeeding initiative in 2012, the SGH Women's Health Center has pursued various quality strategies to promote exclusive breastfeeding and exclusive breast milk in the NICU. In addition, educational resources provided at community clinics and in the hospital's childbirth education classes have been updated to reflect best practices in breastfeeding for mothers and their families. NICU nurses also continued to encourage mothers to use a pump log to document and increase accountability of their 24-hour breastmilk volumes.

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Early intervention strategies were incorporated to promote the establishment of breastmilk in the first couple of weeks. The SGH Women's Health Center also continued to track mothers of premature infants 28 to 34 weeks who had established breastmilk supply at two weeks. As a result of these comprehensive efforts, the SGH Women's Health Center increased the exclusive newborn breastfeeding rate at discharge from 49 percent in 2011 to 59 percent in 2018. **Background**: In 2015, the SGH Prenatal Clinic joined the Breastfeeding-Friendly Community Health Centers project (BFCHC) — an initiative of Live Well San Diego and funded through a grant from the First 5 Commission of San Diego. Through the BFCHC collaboration, the SGH Prenatal Clinic was selected out of six participating clinics as the pilot clinic to help establish Baby-Friendly USA guidelines around breastfeeding during the prenatal period and after discharge, and support other prenatal clinics in achieving Baby-Friendly USA standards. Though the pilot program ended in 2016, SGH continues its collaboration in the BFCHC to ensure sustainability of the model.
3. Collaborate with community organizations to: raise awareness of women's health issues and services; provide low-income and underserved women in SDC's	a. Support low-income and underserved women in the community through collaboration with community organizations.	Ongoing (evaluated annually)	Perinatal Advanced Practitioner, SGH Perinatal Services	Maternal and Prenatal Care High-Risk Pregnancy Collaboration	New in FY 2019, SGH began a collaboration with San Diego Food Bank's Diaper Bank Program, designed to help solve a critical challenge (namely, the expense of diapers, often required to enroll/keep a child in daycare) for young parents living in poverty. Through this program, SGH will serve as a diaper distributor for high-need mothers/patients in need of this economic support. Implementation is planned for Aug/Sept 2019.

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
east region with critical prenatal services.			Manager, SGH Obstetrics and Gynecology	Support Economic Security Behavioral Health	Throughout FY 2018, SGH Prenatal Clinic midwives provided in-kind help at Neighborhood Health Centers in El Cajon to support the underserved population in SDC's east region. This included nearly 1,000 hours of care for pregnant women, with midwife coverage five days per week. The SGH Prenatal Clinic also continued to participate in the CDPH Comprehensive Perinatal Services Program to offer comprehensive prenatal clinical and social services to low-income, low-literacy women with Medi-Cal benefits. Services included health education, nutritional guidance, and psychological and social issue support as well as translation services for non-English-speaking women. Nutrition classes were offered to help reduce the number of women who meet the criteria for gestational diabetes. Women with a current diabetes diagnosis were referred to the SGH Diabetes Education Program, while those with nutrition issues were referred to an SGH registered dietitian (RD) or the SGH Diabetes Education Program. At-risk women with elevated BMIs received education and glucometers in order to measure their blood sugar and prevent the development of gestational diabetes. In addition, the SGH Prenatal Clinic provided education on gestational diabetes to pregnant community members. The SGH Women's Health Center continued its partnership with Vista Hill ParentCare to assist chemically dependent (addicted) women with psychological and social issues during pregnancy. These approaches have been shown to reduce both LBW rates and health care costs for women and infants. The SGH Women's Health Center also provided women with referrals to a variety of community resources, including, but not limited to California

Identified Community Health Need – Maternal and Prenatal Care, including High-Risk Pregnancy					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Teratogen Information Service, WIC, and the County of San Diego Public Health Nursing.
	b. Continue to participate in and partner with several community organizations and advisory boards for maternal and child health.	Ongoing	Manager, SGH Obstetrics and Gynecology Manager, SGH Labor and Delivery Lead Clinical Nurse, SGH Neonatal Intensive Care Unit (NICU)	Maternal and Prenatal Care High-Risk Pregnancy Collaboration	Community organizations include: WIC; California Teratogen Information Service; Partnership for Smoke-Free Families; San Diego County Breastfeeding Coalition Advisory Board; Beacon Council's Patient Safety Collaborative; ACNL; the regional Perinatal Care Network; the local chapter of AWHONN; California Maternal Quality Care Collaborative; California Perinatal Quality Care Collaborative; American Association of Critical-Care Nurses — Clinical Scene Investigator Academy; and the County of San Diego Public Health Nursing Advisory Board.

Identified Community Health Need – Obesity					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Provide free education and screenings for community members that address risk factors for obesity.	a. Coordinate and provide various health screenings, including body mass index and blood pressure screenings at community events.	Ongoing	Manager, SGH Community Relations	Screenings Collaboration	In FY 2018 SGH participated in a variety of community events and provided education and health screenings for diabetes, stroke and heart health; many of which address risk factors and interventions for obesity as well. Education and screenings include nutrition, and exercise education, as well as emphasis on maintaining a healthy weight and lifestyle. SGH also provides educational resources on risk factors for obesity and resulting chronic diseases. In April, staff from a range of hospital departments participated in Sharp's annual Women's Health Conference, where they offered wellness education and services to approximately 1,000 attendees. This included the provision of nutrition education, handouts, recipes and healthy food samples as well as answering nutrition-related questions. In FY 2018, SGH RDs offered more than 100 community members nutrition handouts and healthy food samples, as well as answered nutrition-related questions at multiple community events, including Sempra/San Diego Gas & Electric's employee health fair, SGH's Burr Heart & Vascular Center Community Open House and a National Nutrition Month table located at the SGH cafeteria. In January, an SGH RD presented on eating well in the new year to nearly 20 seniors at the Dr. William C. Herrick Community Health Care Library. In addition, an SGH RD presented on mindful eating to nearly 50 community members at the SGH Cancer Center and San Diego Oasis. Education and programs provided by SGH are evaluated by participants through survey.

Identified Community Health Need – Obesity					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
2. Provide care management in support of weight loss and healthy life style choices for San Diego community members.	Not Applicable (NA)	NA	NA	Obesity Cardiovascular Hypertension Diabetes Chronic Disease Care Management	In general, resource limitations restrict growth beyond current programs and services provided at SGH that specifically address obesity at this time. However, free, New Weigh Program classes are provided to community members through Sharp HealthCare's medical group, Sharp Rees-Stealy, including sites in SDC's east region. The free ten-week class emphasizes nutrition education and healthy lifestyle development. Classes offer access to a skilled health coach or registered dietitian for continued support and accountability and are offered at various locations around San Diego County, including the east region. To create a semi-structured food plan, participants will have the choice of using either their own foods or meal replacements. A free online program is also available for those unable to attend the in-person class.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase coverage for patients seen in the Emergency Department (ED) by providing assistance to secure health coverage for all individuals entitled to the benefit; also provide payment options for individuals that chose not to secure coverage or are not currently eligible for health benefits. Secure benefit concurrent with stay when Medi-Cal Presumptive Eligibility rules apply.	a. Continue to provide services to help every unfunded patient received in the ED find coverage options.	Ongoing (evaluated annually)	Supervisor, Patient Assistance Navigators	Access to Care Education	The PointCare program continues to collect metrics on a number of individuals served and cost savings. From October 2015 to June 2019, Sharp helped nearly 47,934 self-pay patients through PointCare, while maintaining each patient's dignity throughout the process. PointCare has expanded its website to also provide linkage to Covered California as appropriate. The tool interfaces patient screening information in the GE record. Thus far in FY 2019, Sharp's Patient Access Services department has assisted 1,840 recipients in maintaining Medi-Cal eligibility after the HPE period lapse via advanced advocacy efforts. Continued unknowns in understanding the efficacy of efforts include: the increase in the patient out- of-pocket responsibility resulting from health plan coverage purchased off the insurance exchange; and the transition of qualified unfunded patients directly to Medi-Cal. Sharp has initiated a process of trending straight self-pay collections separate from balance after insurance collections in an effort to closely monitor these two distinct populations. **Background**: PointCare is a quick, web-based screening, enrollment and reporting technology designed by a team of health coverage experts to provide community members with health coverage and financial assistance

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					options. At Sharp HealthCare (Sharp), patients use PointCare's simple online questionnaire to generate personalized coverage options that are filed in their account for future reference and accessibility. The results of the questionnaire enable Sharp staff to have an informed and supportive discussion with the patient about health care coverage, and empower them with options. PointCare also directs patients to the Covered California website for health coverage or Medi-Cal enrollment as Presumptively Eligible and/or full scope benefits.
2. Provide payment options, education and support to high-risk, uninsured, underinsured, and patients admitted to hospital facilities with an inability to pay their financial responsibility after health insurance.	a. Provide the Maximum Out of Pocket Program to patients who express an inability to pay their financial responsibility after health insurance.	Ongoing	All Revenue Cycle Staff	Access to care Financial assistance Provide education on patient financial services	In FY 2019 YTD, the Maximum Out of Pocket Program made a total of more than $384,500 in adjustments to patient bills. **<u>Background</u>**: 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 to patients needing advanced guidance on available funding options.	Ongoing	Patient Access Services (system- level) Public Resource Specialists	Access to care Financial assistance Provide education on patient financial services	In 2015, positions were created within Sharp's Patient Access Services department (system level) entitled Public Resource Specialists – to support patients at all Sharp hospitals needing extra guidance on available funding options. Public Resource Specialists also perform what is traditionally called "field calls" (home visits) to patients who required assistance with completing the coverage application process after leaving the hospital.

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	c. Provide specialized financial assistance and support program to families with children in a Sharp Neonatal Intensive Care Unit (NICU).	Ongoing	Patient Access Services Public Resource Specialist Patient Access Service Self-Pay Team Manager	Access to care Financial assistance	This program was expanded to SGH in 2017 – outcomes/case data forthcoming. 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. **Background**: In summer 2015, a pilot program was launched at SMBHWN to evaluate both insured and unfunded families with Neonatal Intensive Care Unit (NICU) babies for financial assistance. This process included helping families whose newborn had been diagnosed with a devastating medical condition or extremely low birth weight apply for Supplemental Security Income (SSI) to help with the cost of care for their newborn both within and outside of the hospital. Public Resource Specialists have assisted more than 260 families through the SSI application process.
	d. The Patient Assistance Team will continue to assist patients in need of assistance gain access to free or low-cost medications.	Ongoing	Supervisor, Patient Assistance Navigators Manager Patient Access Services, Self-Pay Patients	Access to care Provide education on patient financial services	Cost savings for replacement drugs are monitored through pharmacy and supply chain. The patient accounting staff remove the charges from the patient's statement. Patients are identified through usage reports, or referred through case management, nursing, physicians or even other patients. If eligible, uninsured patients are offered assistance, which can help decrease readmissions due to lack of medication access. The team members research all options available, including programs offered by drug manufacturers, grant-based programs offered by foundations, copay assistance, low-cost

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					alternatives, or research where the patient might find their medication at a lower cost. 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.	Ongoing	Supervisor, Patient Assistance Navigators Manager Patient Access Services, Self-Pay Patients	Access to Care	YTD FY 2019, nearly 4, 079 Sharp hospital encounters have been assisted through the ClearBalance zero-interest loan program since its inception.
	f. Continue to provide Project HELP and other funds as available for pharmaceuticals, transportation vouchers and other needs for economically disadvantaged patients.	Ongoing	SGH Chief Financial Officer	Access to Care	Project HELP funds are tracked though an internal database. From FY 2010 – FY 2018, Project HELP funds totaled more than $371K. In addition, SGH pharmacists assisted more than 400 economically disadvantaged patients with outpatient prescriptions valued at more than $228,000 in FY 2018.

Identified Community Health Need – Access to Care and Health Insurance					
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3. Improve access and health outcomes for high-risk community members, particularly San Diego's homeless population.	a. Expand Sharp HealthCare integrated delivery system access to post acute recuperative care services offered in collaboration with the San Diego Rescue Mission (SDRM), to include: • All Sharp HealthCare acute hospitals • Sharp Rees-Stealy Medical Group • Sharp Community Medical Group Here, individuals experiencing homelessness find a safe environment to support respite and recovery. In addition, the SDRM offers counseling and education services, access to continued ambulatory care through Federally Qualified Health Center clinics, and information and referral resources for supportive housing.	Ongoing	Sharp VP Integrated Care Management	Access to Care Care Management Collaboration	In January 2019, SDRM unexpectedly and with very short notice, closed their recuperative care unit. This created a critical void for SHC. Moreover, one that comes at a time when we were seeking to expand our relationship with the SDRM allowing for increased volumes for individuals experiencing homelessness that likewise are in need of recuperative care services. With regard to this need, our focus is two-fold. Firstly, we are seeking to identify short-term solutions for immediate needs as they occur. Each patient is independently considered for exact care need, likely term for the need, and various care setting options immediately available.
4. Seek to provide health care funding options, education, and/or support to the high-	a. Integrated Care Management and Patient Access Services (PFS)	Ongoing with Annual Evaluation	Manager, Patient Access Services	Access to Care Health Insurance	Integrated Care Management (ICM) has expanded efforts for patient education related to funding options/access to care, as well as San Diego community resources.

Identified Community Health Need – Access to Care and Health Insurance					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
risk, uninsured/underinsured patients admitted to hospitals of the Sharp HealthCare system.	support education and access to: • Medi-Cal for CalFresh (Food Stamps) • Hospital Outstation Program (collaboration with the County of San Diego) • Enrollment of qualified patients in CalFresh		Sharp VP Integrated Care Management	Access to Healthy Food (Food Insecurity) Collaboration Clinical-Community Linkages	In regard to funding opportunities, ICM now works more aggressively and closely with Sharp Patient Access Services (PFS) to ensure patients are aware of all funding opportunities for which they may be eligible. Also, patients may receive education related to structure and access for managed Medi-Cal products within San Diego County. This year, ICM has expanded their relationship and utilization of 2-1-1. For FY 2020, in collaboration with 2-1-1 ICM will identify metrics to gage successes, benefits, and value to SHC patients as a result of improved community engagement. SGH's Patient Access Services team worked closely with the hospital's Care Transitions Intervention program to evaluate patients for CalFresh — California's Supplemental Nutrition Assistance Program — prior to hospital discharge, which dramatically increased the likelihood that patients will complete CalFresh applications and receive benefits. In February 2017, Sharp's Patient Access Services team expanded CalFresh consults to the remainder of Sharp's acute care hospitals. From FY 2016 through June 2019, more than 650 Sharp patients have been granted CalFresh benefits.

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	b. Continued partnership and collaboration with Father Joe's Villages in support of Project SOAR:
	• A program through the County of San Diego's Aging and Independence Services (AIS)
	• Provides care management services to frail and disabled adults – aged 60 years or older
	• Adults are at risk for nursing home placement
	• Adults who do not have access or qualify for supportive services through other programs and/or in-home-care service programs
		Ongoing with Annual Evaluation	Sharp Clinical Social Workers
			
			Sharp VP Integrated Care Management
				Access to Care
				Collaboration
				Care Management
				Food Security
					Eligibility for Project SOAR's programming is incorporated into Sharp HealthCare's current eligibility review process for all patients.
					
					• Patient files are assessed for possible eligibility
					• Referrals are conducted for qualified patients
					• Currently there are no mechanisms in place to track cost or volume for this program
					  ○ The nature of the program is cooperative collaboration, referral, and/or sharing of information as appropriate
					  ○ There are no direct costs for Sharp HealthCare. Thus, it is difficult to measure any savings that Sharp might experience

5. Continue to explore opportunities for collaboration with community organizations to enhance access as appropriate for individuals experiencing homelessness to:	a. Creation of a Homeless Task Force within Sharp HealthCare, led by Integrated Care Management, and including leaders across the Sharp continuum (Sharp, Sharp Mesa Vista Hospital, Sharp Rees-Stealy Medical Group, and Sharp	Ongoing (annual evaluation)	Sharp VP Integrated Care Management	Access to Care Homelessness Housing Instability Collaboration	Integrated Care Management (ICM): In FY2019, in conjunction with the passing and signing of SB 1152, Hospital Discharge Processes: Homeless Patients, SHC develop formalized processes, procedures, and protocols to improve care for patients experiencing homelessness. This work includes technology to track and measure care and utilization of individuals experiencing homelessness served within the SHC system.

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• Medical care • Financial assistance • Psychiatric and social services	Community Medical Group) for the purposes of: • Identifying alternative solutions for hard to place patients requiring long-term supportive care, assisted living, and/or custodial care • To guide assessment and planning for: ○ Allocation of internal resources ○ Possible expansion of existing external relationships ○ Identification of new opportunities for partnership and/or collaboration			Care Management	For FY2020, ICM will use captured data to isolate trends and gaps in care related to homeless populations served. The SB1152 Task Force (formally Homeless Task Force) will use the data to identify action planning for go-forward.
	b. Continue to offer high-risk, vulnerable SGH patients (Self-Pay, Medi-Cal, Medi-Cal Presumptive, with complex chronic health conditions and limited social support) health coaching and resources (through multiple	Ongoing with Annual Evaluation	Sharp VP Case Management Service Line Director,	Access to Care Care Management Collaboration	As of March, 2019 nearly 2,200 patients were enrolled in the CTI program. The readmission rate for CTI patients since partnership with 2-1-1 San Diego dropped from nearly 30% to below 9%. For the third project year, all CTI patients referred to 2-1-1's Health Navigation (about 70): reduced social determinant of health (SDOH) vulnerability; 96% of referred patients reported improved ability to manage their health; and 91% reported improved care

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	community partnerships) upon discharge to help ensure safe transition from hospital to home, and improve their quality of life; a Care Transitions Intervention (CTI) model pilot.		SGH Case Management & Social Work Manager, Community Benefit and Health Improvement		coordination. In particular, marked improvements regarding vulnerability related to housing and nutrition were observed over the past three years. Further, the CTI program data revealed significant reduction in cost between average LOS for high-risk vulnerable patients, as well as average direct costs (per day) and average hospital day direct cost. In FY 2019, the CTI team in conjunction with ICM and 2-1-1 leadership held a retreat to identify gaps and priorities for advancing value through measurable data from CTI services. For FY 2020, ICM leadership will continue isolation of metrics to benchmark CTI value and successes. ICM will use information to assess opportunities for CTI across the SHC system. This will be accompanied with evaluation of the new CIE pilot partnership (see Identified Community Health Need: Behavioral Health 2a). Currently, the SGH CTI team are active participants in the CIE pilot. **Background**: The CTI© program focuses on transitioning patient home safely by reviewing Medications, early recognition of symptoms, establishing a Medical Home, providing Advance Care Planning (ACP) choices and ensuring the patient has a plan for managing their care across the care continuum. Part of this is accomplished by connecting to patients to community resources (e.g., the San Diego Food Bank, 2-1-1 San Diego, Feeding San Diego) that help them maintain their health and safety, including: food (directly), hunger relief organizations, transportation resources, access to a primary care physician for follow up care, medical equipment, and other social supports. With generous support from the Grossmont Hospital Foundation, the program has been able

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Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					to support CTI patients with post-discharge social service navigation, food, blood pressure cuffs, diabetes kits, pulse oximeters and pill boxes. The program is also able to assist with co-pays for medications should the need arise.
6. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Community and Social Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with community organizations to help raise awareness of women's health issues and services, as well as provide low-income and underserved women in the San Diego community with critical prenatal services.	a. Support low-income and underserved women in the community through collaboration with community organizations.	Ongoing			This strategy also addresses Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 3a. Please refer to that section for details.
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Community and Social Support					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
3. Offer various support groups to community members.	a. Continue to support community members by offering various support groups.	Ongoing			For details on SGH community support and patient support groups, please refer to the following line items: • Identified Community Health Need: Aging Concerns 5d • Identified Community Health Need: Cancer 2a • Identified Community Health Need: Cardiovascular Disease 1b • Identified Community Health Need: Cardiovascular Disease 1c • Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 1a

Identified Community Health Need – Economic Security					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2016 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Improve outcomes for high-risk underfunded patients and community members through facilitated referral and connection to social, practical and other services in the community.	a. Connect high-risk, underfunded patients and community members to local resources and organizations for low-cost medical equipment, housing options and follow-up care.			Access to Care Care Management Collaboration Social Determinants of Health	In FY 2018, SGH continued to provide post-acute care facilitation for high-risk patients, including individuals who were homeless or without a safe home environment. Individuals received referrals to and assistance from a variety of local resources and organizations. These groups provided support with transportation, placement, medical equipment, medications, outpatient dialysis and nursing home stays. SGH referred high-risk patients, families and community members to churches, shelters and other community resources for food, safe shelter and other resources. For unemployed, uninsured and underinsured patients, or for those who simply cannot afford the expense of durable medical equipment, including a wheelchair, walker or cane due to a fixed income, SGH has committed to providing medically necessary equipment for high-risk patients upon discharge. SGH case managers and social workers actively seek DME donations from the community and SGH Volunteer Services, providing nearly 300 DME items in 2018. In addition, SGH paid nearly $46,000 for uninsured patients to receive continued short-term rehabilitative care in a skilled nursing facility to improve patient mobility and stability.
	b. Continue to offer high-risk, vulnerable SGH patients (Self-Pay, Medi-Cal, Medi-Cal Presumptive, with complex chronic health conditions and limited social support) health coaching and resources (through multiple	Ongoing with Annual Evaluation	Sharp VP Case Management Service Line Director,	Access to Care Care Management Collaboration	This strategy also addresses Access to Care/Health Insurance 5b. Please refer to that section for details.

Identified Community Health Need – Economic Security					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2016 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	community partnerships) upon discharge to help ensure safe transition from hospital to home, and improve their quality of life; a Care Transitions Intervention (CTI) model pilot.		SGH Case Management & Social Work Manager, Community Benefit and Health Improvement	Social Determinants of Health	
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Education					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with local colleges and universities to provide professional development lectures to students from local colleges and universities	a. Continue to provide elementary, middle and high school students with opportunities to explore health care professions.	Ongoing	Varies – Preceptors throughout SGH	Education Career Pipeline Economic Security	Throughout the academic year, SGH provided more than 840 students from colleges and universities throughout San Diego with various placement and professional development opportunities. Approximately 580 nursing students spent nearly 56,000 hours at SGH, including time spent both in clinical rotations and individual preceptor training, while more than 260 ancillary students spent more than 65,300 hours on the SGH campus.
2. Collaborate with local middle and high schools to provide opportunities for students to explore health care professions.	a. Continue to provide elementary, middle and high school students with opportunities to explore health care professions.	Ongoing	Varies – Preceptors throughout SGH Manager, SGH Community Relations	Education Career Pipeline Economic Security	For FY 2019: SGH plans to continue to participate in HESI, Healthcare Towne, In Inspire and Health Sciences High and Middle College (HSHMC) programs. See background information below for details on these programs. *I Inspire*: New in FY 2018 SGH created the I Inspire program, a weeklong program that encourages high school students from underrepresented backgrounds to consider careers in health care and learn about nursing directly from those in the field. SGH partnered with License to Freedom, a local nonprofit that advocates for and empowers immigrants and refugees in SDC, to recruit participants. Students shadowed nurses in outpatient, acute and critical care; women's health and surgical services; and administrative settings. In addition, daily meet-and-greet luncheons with representatives from local colleges and universities including PLNU, National University, USD were held and lastly, students created community-based education projects on topics chosen from the SGH CHNA. In small groups, the students performed research and created poster presentations and handouts on obesity, mental health,

Identified Community Health Need – Education					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					diabetes and heart health and shared these projects at both SGH and a community health fair in El Cajon. In FY 2018, SGH continued to collaborate with the Grossmont Union High School District (GUHSD) in the Healthcare Exploration Summer Institute (HESI), providing 23 high school students with opportunities for classroom instruction, job shadowing, observations and limited hands-on experiences. SGH continued to provide HealthCare Towne in FY 2018, an early outreach program for middle and junior high school students designed to build the health care workforce of tomorrow through a field trip to the SGH campus. SGH also continued its participation in the HSHMC program in FY 2018, providing early professional development for approximately 160 students in ninth through 12th grades. Students spent more than 28,440 hours shadowing staff in various areas throughout the hospital. **Background**: *Health Sciences High and Middle College (HSHMC)*: Sixty-seven percent of HSHMC students are economically disadvantaged, and the school's free and reduced-price meal eligibility rate is higher than the average for both SDC and California. Despite these challenges, HSHMC maintains a 95 percent attendance rate and excels in preparing students for high school graduation, college entrance and a future career. In 2018, 91 percent of the HSHMC graduating class went on to attend two- or four-year colleges, while 83 percent of students said they wanted to pursue a career in health care. In addition,

Identified Community Health Need – Education					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					HSHMC has a 98.7 percent graduation rate, which is higher than the state of California's average of 82.7 percent. *HealthCare Towne*: This unique event encouraged students to connect what they learn in the classroom to real-life career opportunities in health care. Healthcare Towne has four major components that include: World of Work, the Puzzle Room, Scenario Tour and In-the-Round Activity. The first component, World of Work, empowered students to develop self-awareness by exploring their strengths, interests and values. Students were divided into three groups to solve three different scenarios. In the Puzzle Room, students collaborated to diagnose a hypothetical patient before they arrived at the hospital by interpreting clues to find the answer and reveal the next piece. In the Scenario Room, students learned about and walked through clinical areas where the patient would receive care, including the ambulance bay, ED, operating room, catheterization laboratory, imaging and intensive care unit. During the final component, In-the-Round Activity, students applied clues, lab results and what they learned throughout the day to help fully diagnose the patient with several conditions. In April and September 2018, approximately 70 local middle school students participated in HealthCare Towne. SGH plans to continue to offer HealthCare Towne to middle and junior high school students in FY 2019.
3. Provide a variety of health and wellness education and services at events and sites throughout the community.	a. Continue participation in City of San Diego Partnership to provide community health education for	Ongoing	Varies – Educators throughout SGH	Education Chronic Health Conditions	In FY 2018, this education included classes focused on: diabetes, behavioral health, cardiovascular disease, and aging concerns.

Identified Community Health Need – Education					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	City of San Diego employees and community residents.			Aging Concerns	Participate in Sharp's partnership with the City of San Diego to provide a variety of education topics and resources to employees and residents in the City's nine districts. Please see the following line items for additional details on SGH community health education addressing identified health needs: • Identified Community Health Need: Aging Concerns 3 • Identified Community Health Need: Aging Concerns 5c • Identified Community Health Need: Aging Concerns 6 • Identified Community Health Need: Cancer 3 • Identified Community Health Need: Cardiovascular Disease 1a and 1b • Identified Community Health Need: Cardiovascular Disease 1d and 1e • Identified Community Health Need: Cardiovascular Disease 1g • Identified Community Health Need: Diabetes • Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 1a • Identified Community Health Need: Maternal and Prenatal Health, Including High-Risk Pregnancy 3a • Identified Community Health Need: Obesity • Identified Community Health Need: Unintentional Injury & Violence 1a • Identified Community Health Need: Unintentional Injury & Violence 1b

Sharp Grossmont Hospital
Community Health Needs Assessment – Implementation Strategy
Fiscal Years 2020-2023

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Collaborate with organizations in San Diego to serve homeless individuals.	a. Sponsor and participate in the Downtown San Diego Partnership Family Reunification Program.	Ongoing	Sharp Executive Vice President Hospital Operations	Homelessness Housing Instability Transportation Collaboration	With Sharp's help, the Family Reunification Program has reunited nearly 2,200 homeless individuals in Downtown San Diego with friends and family across the nation. In FY 2019, Sharp provided financial assistance for two additional vans to support the program. **Background**: Since 2011, Sharp has sponsored the Downtown San Diego Partnership's Family Reunification Program, which serves to reduce the number of homeless individuals on the streets of downtown San Diego. Through the program, homeless outreach coordinators from the Downtown San Diego Partnership's Clean & Safe Program identify homeless individuals who will be best served by traveling back home to loved ones. Family and friends are contacted to ensure that the individuals have a place to stay and the support they need to get back on their feet. Once confirmed, the outreach team provides the transportation needed to reconnect with their support system.
	b. Assist high-risk and homeless patients, and refer them to local community organizations and resources.	Ongoing	Director, SGH Case Management and Social Work	Homelessness Housing Instability Collaboration Economic Security	In FY 2018, SGH continued to provide post-acute care facilitation for high-risk patients, including individuals who were homeless or without a safe home environment. Individuals received referrals to and assistance from a variety of local resources and organizations. These groups provided support with transportation, placement, medical equipment, medications, outpatient dialysis and nursing home stays. SGH referred high-risk patients, families and community members to churches, shelters and other community resources for food, safe shelter and other resources.

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
				Transportation	Further, in FY 2018, collaboration with Sharp Global Patient Services, SGH transferred three homeless hospice patients to their native countries and reunited them with family and friends.
	c. Expand Sharp HealthCare integrated delivery system access to post acute recuperative care services offered in collaboration with the San Diego Rescue Mission (SDRM), to include: • All Sharp HealthCare acute hospitals • Sharp Rees-Stealy Medical Group • Sharp Community Medical Group Here, individuals experiencing homelessness find a safe environment to support respite and recovery. In addition, the SDRM offers counseling and education services, access to continued ambulatory care through Federally Qualified Health Center clinics, and information and referral resources for supportive housing.	Ongoing	Sharp VP Integrated Care Management	Homelessness Housing Instability Care Management Collaboration	This strategy also addresses Identified Community Health Need: Access to Care and Health Insurance. Line 3a. Please refer to that section for details.

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
	d. Creation of a Homeless Task Force within Sharp HealthCare, led by Integrated Care Management, and including leaders across the Sharp continuum (Sharp, Sharp Mesa Vista Hospital, Sharp Rees-Stealy Medical Group, and Sharp Community Medical Group) for the purposes of: • Identifying alternative solutions for hard to place patients requiring long-term supportive care, assisted living, and/or custodial care • To guide assessment and planning for: ○ Allocation of internal resources ○ Possible expansion of existing external relationships e. Identification of new opportunities for partnership and/or collaboration	Ongoing	Sharp VP Integrated Care Management	Access to Care Homelessness Housing Instability Collaboration Care Management	This strategy also addresses Identified Community Health Need: Access to Care and Health Insurance. Line 5a. Please refer to that section for details.

Identified Community Health Need – Homelessness and Housing Instability					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
3. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that shares health and social services data across health care and social service sectors.	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation after the one-year pilot.	Director, SGH Case Management & Social Work SGH Lead Medical Social Worker Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
1. Increase education and awareness of high school students in SDC's east region around injury and violence prevention, and health care career readiness in these areas (e.g., rehabilitation).	a. Through the ThinkFirst/Sharp on Survival program, continue to partner with Health and Science Pipeline Initiative (HASPI) to increase unintentional injury, violence prevention and associated health career awareness.	Ongoing	Sharp Community Health Educator	Unintentional Injury Violence Prevention Education Collaboration Career Pipleline	FY 2019 plan: • With grant funding, continue linking injury prevention with career readiness and career paths • As part of the HASPI partnership, continue to evolve program curricula to meet the needs of health career pathway classes. • Grow partnership with HASPI through participation in conferences, round table events and collaboration on letters of support for various funding opportunities • Explore further opportunities to provide education to health care professionals and college students interested in health care careers In FY 2018, ThinkFirst/Sharp on Survival provided injury prevention education in a variety of settings to approximately 3,000 East County residents. More than 1,400 of these residents were students in grades nine through 12 who are part of the HASPI program. In FY 2018, ThinkFirst/Sharp on Survival expanded its delivery of HASPI education within East County through presentations to 65 students at Mountain Empire High School, located in the rural backcountry of southeastern SDC. Through the partnership and financial support from HASPI, the ThinkFirst/Sharp on Survival program offered schools in SDC's east region: classroom presentations, small assemblies and offsite learning expos. HASPI school-site programs consisted of classes on the modes of injury, disability awareness, the anatomy and physiology of the brain and spinal cord and other topics. Programs included personal testimonies from individuals with traumatic brain injury or SCI.

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					Background: Sharp's ThinkFirst/Sharp on Survival program is a chapter of the ThinkFirst National Injury Prevention Foundation, a nonprofit organization dedicated to preventing brain, spinal cord, and other traumatic injuries through education, research and advocacy. HASPI is a collaborative network of educators, community organizations and health care industry representatives all working together to increase health and medical career awareness, improve science proficiency in schools and prepare students for future health care careers.
	b. Through the ThinkFirst/Sharp on Survival program, continue to provide education on safety and injury prevention to East County schools, from elementary students to college/university students.	Ongoing	Community Health Educator	Unintentional Injury Violence Prevention Education Collaboration Career Pipeline	FY 2019 plan: • With grant funding, provide educational programming and presentations for local schools and organizations • With grant funding, increase community awareness of ThinkFirst/Sharp on Survival through participation in community events • Continue to provide booster seat education to elementary school children and their parents with funding support from grants • With grant funding, continue to expand program to reach new populations, including throughout SDC's east region and Imperial County • Explore further opportunities to provide education to health care professionals and college students interested in health care careers With grant funding from the Grossmont Healthcare District (GHD), ThinkFirst/Sharp on Survival provided further outreach to East County schools through presentations reaching more than 70 students at Avocado Elementary

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
					School. Presentations were provided to students during three assemblies that focused on TBI, SCI and disabilities. In addition, a group of fourth graders received education on booster seat safety. Students engaged in hands-on learning and disability education through exploration of wheelchair accessible vans. In October, ThinkFirst/Sharp on Survival provided injury prevention education to approximately 550 youth and their parents at the annual GHD-sponsored Kids Care Fest at the Lakeside Rodeo Grounds. Education included proper helmet fitting and booster and car seat use; TBI and SCI; and state safety laws. ThinkFirst/Sharp on Survival also presented on injury prevention, TBI, SCI and disability awareness to approximately 900 college students in SDSU's Disability in Society course. In July, ThinkFirst/Sharp on Survival presented to 20 members of the Casa De Oro, El Cajon and Sunrise Optimist Clubs **Background**: Sharp's ThinkFirst/Sharp on Survival program is a chapter of the ThinkFirst National Injury Prevention Foundation, a nonprofit organization dedicated to preventing brain, spinal cord, and other traumatic injuries through education, research and advocacy.
2. Improve care management and clinical-community linkages that address social determinants of health (SDOH) through implementation of a new technology platform that	a. SGH (along with other Sharp HealthCare entities) will participate in a one-year pilot utilizing 2-1-1 San Diego's Community Information Exchange (CIE).	July, 2020 To be evaluated in May 2020, for continued participation	Manager, Sharp HealthCare Community Benefit and Health Improvement	Clinical Community Linkages Data Sharing	This strategy also addresses Identified Community Health Need: Behavioral Health 2a. Please refer to that section for details.

Identified Community Health Need – Unintentional Injury & Violence					
Objectives/Anticipated Impact	**Strategy/Action Items**	**Target Completion Date**	**Responsible Party/ies**	**Identified Themes in 2019 CHNA**	**Evaluation Methods, Measurable Targets, and Other Comments**
shares health and social services data across health care and social service sectors.		after the one-year pilot.	Director, Case Management & Social Work	Community Collaboration All SDOH, e.g., housing, nutrition, transportation, etc.	