Scripps Health Implementation Plan

General Information

Contact Person: Anette Blatt  
Director, Community Benefits and Advocacy, Office of the President  
Community Benefit Services, 858-678-7095  
www.Scripps.org/communitybenefit

Authorized governing body that adopted the Implementation Plan: Strategic Planning Committee of the Scripps Board of Trustees

Date Implementation Plan was approved: September 2016

Tax Year in which CHNA was made available to the public: Tax Year 2016 (available on www.scripps.org)

Name and state license number of Hospital Organization Operating Hospital Facility:
Scripps Mercy Hospital  
4077 5th Avenue  
San Diego CA, 92103  
090000074  
*Scripps Mercy hospital has a second campus in Chula Vista and they share the same license

Scripps Memorial Hospital La Jolla  
9888 Genesee Avenue  
La Jolla, CA 92037  
080000050

Scripps Green Hospital  
10666 North Torrey Pines Road  
San Diego, CA 92037  
080000139

Scripps Memorial Hospital Encinitas  
354 Santa Fe Drive  
La Jolla, CA 92037  
080000148
Scripps Health Implementation Plan

About Scripps Health

Founded in 1924 by philanthropist Ellen Browning Scripps, Scripps Health is a nonprofit integrated health system based in San Diego, Calif. Scripps treats more than 600,000 patients annually through the dedication of 3,000 affiliated physicians and more than 15,000 employees among its five acute-care hospital campuses, hospice and home-based care services, 28 outpatient centers and clinics, and hundreds of physician offices throughout the region.

Recognized as a leader in prevention, diagnosis and treatment, Scripps is also at the forefront of clinical research, genomic medicine and wireless health care. With three highly respected graduate medical education programs, Scripps is a longstanding member of the Association of American Medical Colleges. Scripps has been ranked four times as one of the nation’s best health care systems by Truven Health Analytics. Its hospitals are consistently ranked by U.S. News & World Report among the nation’s best and Scripps is regularly recognized by Fortune, Working Mother magazine and AARP as one of the best places in the nation to work. More information can be found at www.scripps.org.

Organizational Foundation

Scripps provides a comprehensive range of inpatient and ambulatory services through our system of hospitals and clinics. In addition, Scripps participates in dozens of partnerships with government and not-for-profit agencies across our region to improve our community’s health. And our partnerships don’t stop at our local borders. Our participation at the state, national and international levels includes work with government and private disaster preparedness and relief agencies, the State Commission on Emergency Medical Services, national health advocacy organizations and even international partnerships for physician education, training and direct patient care. In all that we do, we are committed to quality patient outcomes, service excellence, operating efficiency, caring for those who need us today and planning for those who may need us in the future.
Approval from Governing Body

As a tax exempt health care system, Scripps takes pride in its service to the community. The Scripps system is governed by a 14-member, volunteer Board of Trustees. This single point of authority for organizational policy ensures a unified approach to serving patients across the region. The Scripps Health Board of Trustees Strategic Planning Committee approved both the triennial 2016 CHNA report and corresponding Implementation Plan during its 2016 tax year. The 2017-2019 Implementation Plan is outlined in the remainder of this document and is updated annually with metrics. The CHNA written report is posted separately on the Scripps Health website, www.scripps.org/about-us_scripps-in-the-community.

Scripps Facilities
• Scripps Green Hospital
• Scripps Memorial Hospital Encinitas
• Scripps Memorial Hospital La Jolla
• Scripps Mercy Hospital
  • San Diego Campus
  • Chula Vista Campus

About Scripps Health Community Benefit

In addition to the CHNA and Implementation Plan, Scripps Health continues to meet community needs by providing charity care and uncompensated care, professional education and an array of community benefit programs. Scripps offers community benefit services through our five acute-care hospital campuses, home-based health services, wellness centers and ambulatory clinics.

Scripps Health documents and tracks its community benefit programs and activities on an annual basis and reports these benefits through an annual report submitted to the State of California under the requirements of SB697. Scripps Health community benefit programs are commitments Scripps makes to improve the health of both patients and the diverse San Diego communities. As a longstanding member of these communities, and as a not-for-profit community resource, Scripps’ goal and responsibility is to assist all who come to us for care, and to reach out especially to those who find themselves vulnerable and without support. Through our continued actions and community partnerships, we strive to raise the quality of life in the community as a whole.
In FY 2015, Scripps documented more than $353 million in local community benefit programs and services. For more information about the programs and services offered by Scripps Health, visit www.scripps.org/communitybenefit or contact the Scripps Health Office of Community Benefit Services at 858-678-7095.

## Total Community Benefits in FY15: $353,578,378*

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Shortfalls</td>
<td>$217,210,276</td>
<td>56.7%</td>
</tr>
<tr>
<td>Medi-Cal Shortfalls</td>
<td>$52,282,439</td>
<td>21.4%</td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$9,646,432</td>
<td>2.5%</td>
</tr>
<tr>
<td>Charity Care</td>
<td>$36,894,589</td>
<td>9.6%</td>
</tr>
<tr>
<td>Health Research</td>
<td>$5,347,928</td>
<td>1.4%</td>
</tr>
<tr>
<td>Professional Education</td>
<td>$20,836,262</td>
<td>5.4%</td>
</tr>
<tr>
<td>Community Building</td>
<td>$1,799,149</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cash and In-kind</td>
<td>$929,440</td>
<td>0.2%</td>
</tr>
<tr>
<td>Subsidized Health</td>
<td>$6,490,142</td>
<td>1.7%</td>
</tr>
<tr>
<td>Community Health Improvement Services</td>
<td>$2,141,720</td>
<td>0.6%</td>
</tr>
<tr>
<td>Health Research &amp; Community Benefit Operations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13% of our total operating expenses in 2015 were devoted to community benefit services at cost*

*Hospital Provider Fee was reported as offsetting revenue from Medi-Cal.

## Scripps Health Community Served

Hospitals and health care systems define the community served as those individuals residing within their service areas. A hospital or health care system service area includes all residents in a defined geographic area surrounding the hospital.

Scripps serves the entire San Diego county region with services concentrated in North Coastal, North Central, Central and Southern region of San Diego. Community outreach efforts are focused in those areas with proximity to a Scripps facility. Scripps hosts, sponsors and participates in many community-building events throughout the year.

### Scripps Health

<table>
<thead>
<tr>
<th>Hospital/Health Care System*</th>
<th>Location</th>
<th>Location</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scripps Memorial Hospital La Jolla</td>
<td>9888 Genesee Ave.</td>
<td>La Jolla</td>
<td>92037</td>
</tr>
<tr>
<td>Scripps Mercy Hospital</td>
<td>4077 5th Ave.</td>
<td>San Diego</td>
<td>92103</td>
</tr>
<tr>
<td>Scripps Green Hospital</td>
<td>10666 N. Torrey Pines Road</td>
<td>La Jolla</td>
<td>92037</td>
</tr>
<tr>
<td>Scripps Memorial Hospital Encinitas</td>
<td>354 Santa Fe Drive</td>
<td>Encinitas</td>
<td>92024</td>
</tr>
<tr>
<td>Scripps Mercy Hospital Chula Vista</td>
<td>435 H St.</td>
<td>Chula Vista</td>
<td>91910</td>
</tr>
</tbody>
</table>

*Locations represent the major hospital or health care/system locations and do not represent all types of hospital or health care locations.
The trended table below shows the primary service area as defined by those zip codes from which 70% of Scripps patients originate for discharge years 2012-2014 (top 70% of inpatient discharges by zip code). Figure 1 is a map of Scripps Health and service areas.

### Table 1 – Scripps Health Inpatient Discharges for Years 2012–2014 from Which the Top 70% of Scripps Patients Originate

<table>
<thead>
<tr>
<th>City</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego</td>
<td>38%</td>
<td>38%</td>
<td>37%</td>
</tr>
<tr>
<td>Chula Vista</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Carlsbad</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Oceanside</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Encinitas</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>La Jolla</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>National City</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>San Ysidro</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>San Marcos</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Spring Valley</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Imperial Beach</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>70%</strong></td>
<td><strong>70%</strong></td>
<td><strong>70%</strong></td>
</tr>
</tbody>
</table>
Scripps Health Locations

A. Scripps Memorial Hospital Encinitas
B. Scripps Green Hospital
C. Scripps Memorial Hospital La Jolla
  • Prebys Cardiovascular Institute
D. Scripps Mercy Hospital, San Diego
E. Scripps Mercy Hospital, Chula Vista
   • Scripps Cardiovascular and Thoracic Surgery Group

- Scripps Clinic
- Scripps Coastal Medical Center
- Imaging Centers
- Scripps Drug and Alcohol Treatment Program
- Scripps Proton Therapy Center
- Radiation Therapy Center
- Scripps Whittier Diabetes Institute
- Well Being Center

Scripps offers more than 3,000 physicians in convenient locations throughout San Diego County. Access to locations and services is based on your individual health plan and physician referral. Please check with your physician and health plan to determine which locations are appropriate for your care.
Background/Required Components of the Community Health Needs Assessment

In 2010, Congress added several new requirements for hospital organizations to maintain federal income tax exempt status under Section 501(r) of the Internal Revenue Code (the “Code”) as part of the Affordable Care Act. One of the requirements set forth in Section 501(r) of the Code is for each hospital organization to conduct a Community Health Needs Assessment (CHNA) at least once every three tax years. The requirement to conduct a CHNA applies to Scripps Health, which is a health system that operates five hospital facilities.

Background/Required Components of the Implementation Strategy

Provisions in the Affordable Care Act require a tax-exempt hospital to:
• Adopt an implementation strategy to meet community health needs identified in the CHNA
• Describe how it is addressing needs identified in the CHNA
• Describe any needs identified in the CHNA that are not being addressed and the reasons for not addressing them

The written implementation strategy describes either:
• How the hospital plans to meet the significant health need
  • Describe actions the hospital facility intends to take to address each significant health need identified in the CHNA, and the anticipated impact of those actions, or identify the health need as one it does not intend to address and explain why
  • The anticipated impact of these actions
  • The programs and resources the hospital plans to commit to address the health need
  • Describe any planned collaboration between hospital facility and other facilities or organizations in addressing the health need.

Or
• The significant health need the hospital does not intend to meet, explaining why the hospital does not intend to meet the health need.
Parties Involved in the Implementation Strategy Development

The Scripps Implementation Strategy Team included the following individuals:

**Scripps Executives**
- Robin Brown, SVP, Chief Executive, Scripps Green
- Carl Etter, SVP, Chief Executive, SMH Encinitas
- Gary Fybel, SVP, Chief Executive, SMH La Jolla
- Tom Gammierie, SVP, Chief Executive, Scripps Mercy
- June Komar, EVP, Strategy and Administration

**Clinical Care Line Leaders**
- Jerry Gold, Administrator, Behavioral Health Clinical Care, Nursing Administration
- Debra McQuillen, Chief Nursing Executive, Scripps Mercy
- Athena Philis-Tsimikas, Corp VP, Scripps Whittier Institute, Administration
- Barbara Price, Corporate Sr. Vice President, Business and Clinical Line Development, Project Manager
- Chris Walker, Senior Director, Scripps Whittier Institute, Administration

**Community Benefit Representatives and Others**
- Anette Blatt, Director, Community Benefits and Advocacy
- Sandy Boller-Bilbrey, Director, Medical/Substance Abuse Services, Op Drug & Alcohol Treatment Program
- Kendra Brandstein, Director, Community Benefits
- Addie Fortmann, Manager, Diabetes Care Line Research, Scripps Whittier Institute, Administration
- George Hayes, Manager, Market Outreach
- Karen McCabe, Director, Community Benefits
- Helene Raymond, Director, Patient Care Services, Nursing, Scripps Encinitas
- Kimberley Roberts, Director, Clinical Services, Community Health & Advocacy, Scripps La Jolla
- Monica Ruiz, Supervisor, Community Program & Research, Scripps Whittier Institute
- Lindsay Olson-Mack, Director Stroke Programs, Clinical Care Lines
- Pat Untied, Coordinator, Clinical Psychiatric Acute
- Mark Zangrando, Senior Director, Mission Integration
Scripps Health has a long history of responding to the health needs of the communities it serves, extending beyond traditional hospital care to provide community benefit programs that address the health care needs of the region’s most vulnerable populations. Scripps strives to improve community health through collaboration. Working with other health systems, community groups, government agencies, businesses and grassroots movements, Scripps is better able to build upon existing assets to achieve broad community health goals.

The 2016 CHNA identified behavioral health as the number one health need in San Diego County. In addition, cardiovascular disease, diabetes (type 2), and obesity were identified as having equal importance due to their interrelatedness. Health needs were further broken down into priority areas due to the overwhelming agreement among all data sources and in recognition of the complexities within each health need. Within the category of behavioral health, Alzheimer’s disease, anxiety, drug and alcohol issues, and mood disorders are significant health needs within San Diego County. Among the other chronic health needs, hypertension was consistently found to be a significant priority area related to cardiovascular disease, uncontrolled diabetes was an important factor leading to complications related to diabetes, and obesity was often found to co-occur with other conditions and contribute to worsening health status. The impact of the top health needs differed among age groups; with type 2 diabetes, obesity, and anxiety affecting all age groups, drug and alcohol issues affecting teens and adults, and Alzheimer’s disease, cardiovascular disease, and hypertension affecting older adults.

With the 2016 CHNA complete and health priority areas identified, Scripps Health has developed a corresponding Implementation Strategy—a multi-faceted, multi-stakeholder plan that addresses the community health needs identified in the CHNA. The Implementation Plan translates the research and analysis presented in the Assessment into actual, measurable strategies and objectives that can be carried out to improve community health outcomes.

Scripps Health anticipates the implementation strategies may evolve due to the fast pace at which the community and health care industry change. Therefore, a flexible approach is best suited for the development of its response to the Scripps Health Community Health Needs Assessment (CHNA). On an annual basis Scripps Health evaluates the implementation strategy and its resources and interventions; and makes adjustments as needed to achieve its stated goals and outcome measures as well as to adapt to the changes and resources available. Scripps describes any challenges encountered to achieve the outcomes described and makes modifications as needed.
In addition, Scripps Health Implementation Plan is filed with the Internal Revenue Service using Form 990 Schedule H on annual basis.

In response to identified unmet health needs in the 2016 Community Health Needs Assessment, during FY17–19 Scripps Health is focusing on the strategies and initiatives, their measures of implementation and the metrics used to evaluate their effectiveness described below.
Cardiovascular Disease

Heart disease is the leading cause of death for people of most racial/ethnic groups in the United States, including African Americans, Hispanics and Caucasians. Between 70 percent and 89 percent of sudden cardiac events occur in men. About two-thirds (64 percent) of women who die suddenly of coronary heart disease have no previous symptoms. Individuals with low incomes are much more likely to suffer from high blood pressure, heart attack, and stroke.

Heart disease prevalence reports the percentage of adults who have ever been told by a doctor that they have any kind of heart disease. In San Diego County (SDC), the reported prevalence is 5.8%. It is also a significant cause of death in San Diego with ‘Diseases of the Heart’ ranked second, ‘cerebrovascular disease’ ranked fifth, and ‘Essential (primary) Hypertension and Hypertensive Renal Disease’ ranked tenth. According to the California Department of Public Health, the age-adjusted death rate for ischemic heart disease and stroke is 148.3 and 163.2 per 100,000 population for San Diego and California respectively. These rates are particularly high for the Black (211.9) and Native Hawaiian/Pacific Islander (241.4) populations in SDC. Unmanaged high blood pressure is also a problem in San Diego. According to the 2006–2010 Behavioral Risk Factor Surveillance System (BRFSS), roughly a third of adults reported that they are not taking medication for their high blood pressure compared to just 21.7% reporting non-compliance in the United States overall. The following tables provide a summary of the quantitative data relevant to cardiovascular disease.

Table 2. Cardiovascular Disease Indicators

<table>
<thead>
<tr>
<th></th>
<th>San Diego County</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage with Heart Disease&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5.80%</td>
<td>6.30%</td>
<td>NA</td>
</tr>
<tr>
<td>Stroke Age-Adjusted Death Rate (per 100,000)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>32.8</td>
<td>37.38</td>
<td>NA</td>
</tr>
<tr>
<td>Ischemic Heart Disease Age-Adjusted Death Rate (per 100,000)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>148.27</td>
<td>163.18</td>
<td>NA</td>
</tr>
<tr>
<td>HP 2020 Target for Ischemic Heart Disease Death Rate&lt;sup&gt;c&lt;/sup&gt;</td>
<td>&lt;=100.8</td>
<td>&lt;=100.8</td>
<td>&lt;=100.8</td>
</tr>
</tbody>
</table>

<sup>a</sup>Source: University of California Center for Health Policy Research, California Health Interview Survey. 2011–2012.


<sup>c</sup>Source: Healthy People 2020. https://www.healthypeople.gov
Table 3. Hypertension San Diego County Trends Over Time, 2009–2013

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ever diagnosed with hypertension (Adults 18–64 years old) % Diagnosed.</td>
<td>26.3%</td>
<td>25.8%</td>
<td>26.4%</td>
</tr>
</tbody>
</table>


Community input was collected on the most common health issues that contribute significantly to overall morbidity through key informant interviews and community partner discussions. The results for cardiovascular disease are summarized in Table 5.

Table 4. Summary Of Community Input On Common Cardiovascular Disease Issues, HASD&IC 2016 CHNA

<table>
<thead>
<tr>
<th>Summary of Cardiovascular Disease-Related Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the most common health issues or needs?</td>
</tr>
<tr>
<td>• Adolescent hypertension &amp; cardio converters</td>
</tr>
<tr>
<td>• Hypertension</td>
</tr>
<tr>
<td>• High cholesterol</td>
</tr>
<tr>
<td>• Hypertension and poor cardiovascular disease outcomes among Latinos, African Americans and Asians</td>
</tr>
<tr>
<td>• Mobility issues and barriers to healthy food for seniors</td>
</tr>
<tr>
<td>• Salt intake/Diet</td>
</tr>
<tr>
<td>• Stroke</td>
</tr>
</tbody>
</table>

*Based on feedback during Key Informant Interviews and Community Partner Discussions

An assessment of health needs by Health Human Services Agency (HHSA) region found that heart disease was cited as being among the top five most important health problems in Central, North Central, and South. Additionally, high blood pressure was selected as a problem that has a substantial impact on overall community health in North Central region. Hypertension was found to be a major contributor to poor cardiovascular disease-related outcomes and a significant area of need in San Diego County.
Scripps Health is addressing cardiovascular disease through the following programs and interventions:

1. **Eric Paredes Save A Life Foundation**

Scripps Health is addressing cardiovascular disease in our partnership with the Eric Paredes Save A Life Foundation. Eric was a healthy Steele Canyon High School sophomore athlete who died suddenly and unexpectedly from Sudden Cardiac Arrest (SCA) in 2009. His parents established the EP Save A life Foundation to honor Eric through their commitment to prevent this tragedy from reoccurring. Eric’s foundation provides free screenings to youth to identify cardiac anomalies that may lead to SCA, with the ultimate goal of standardizing cardiac screenings among the youth. The goal is to prevent sudden cardiac arrest and death in middle and high school aged children, including underserved areas in San Diego County, through awareness, education and action. It’s most common in student athletes. Each year 7,000 teens in the United States lose their lives due to sudden cardiac arrest (SCA). SCA is not a heart attack — it is caused by an abnormality in the heart’s electrical system that can be easily detected with a simple EKG. If abnormalities are detected, a second test called an echo cardiogram, an ultrasound for the heart, is administered.

Unfortunately, heart screenings are not part of a regular, well child exam or pre-participation sports physical. The first symptom of SCA could be death. San Diego alone annually loses three to five teens from SCA. Screenings are non-invasive and include a health history and EKG. Since 2010, nearly 20,056 youth have been screened. Of those, about 383 had heart abnormalities, and 165 were found to be at risk for Sudden Cardiac arrest. In addition, half of screened youth represent diverse ethnicities and 40% of youth are from moderate to extremely low-income households. Hundreds are without regular doctors and dozens without health insurance. Thirty-six percent of the schools represented are Title I schools, in which the majority of the students at the schools meet poverty guidelines. The schools qualify for federal government assistance funding such as free or reduced fee lunch programs. When findings are positive, Scripps takes the following steps:

- Checks for an abnormal heartbeat that could signal an underlying heart condition using an echocardiogram.
- Notifies parents of the results for follow up with their family physicians.

**Strategies**

Scripps partners with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by Scripps physicians (cardiologists) before high school students participate in organized sports and activities. As a sponsor of the Eric Paredes Save A Life Foundation, Scripps has held more than 10,000 free cardiac screenings for local teens, including the homeless and the underinsured. Scripps provides financial contribution annually to help pay for the screenings.
Evaluation Methods and Measurable Targets

- Track number of teen screened
- Track number of teens with heart abnormalities
- Track number of uninsured (according to survey of onsite parents)
- Number who do not have a pediatrician
- Number who check they use a community clinic
- Families that surveyed as extremely low to moderate income according to survey of onsite parents

2. **Adults Screenings in Conjunction with the EP Save a Life “Screen Your Teen” Events.**

Strategies
Scripps Health will empower community members with cardiovascular screenings, education and support. Scripps will promote accountability and behavior change through education on chronic disease self-management by providing Lipid panel/glucose screenings, body analysis screenings and heart care information for adults in conjunction with the EP Save a Life “Screen Your Teen” events.

Evaluation Methods and Measurable Targets

- Track number of cardio check tests for adults screened
- Track number of adults found at risk
- Track number of referrals

3. **Southwest Union High School District Pre-Participation Sports Screening Assessments**

Scripps Health will prevent sudden cardiac arrest and death primarily in the South Bay, for high school aged students by increasing education and awareness related to cardiovascular screenings and healthy lifestyles.

Strategies
Scripps will partner with local Sweetwater High School District yearly to implement cardiac screenings and sports physicals before students participate in organized sports. Scripps Community Benefits, Chula Vista Scripps Family Medicine Residents will assist with the screenings.

Evaluation Methods and Measurable Targets

- Track total number of youth screened
- Track the number of youth with heart abnormalities
- Track number of referrals made
- Track number of individuals that are uninsured/underinsured
The metrics are collected via surveys bi-annually. The insurance information is collected via surveys at injury clinics. The sports physicals are conducted once a year before students participate in organized sports.

4. *Su Vida, Su Corazon, Your Heart, Your Life — Scripps Mercy Hospital, Chula Vista*

Scripps Health will support individuals to manage their heart health through a community intervention program which decreases the readmission rates for heart failure patients, reduces medical costs for patients and improves their quality of life in underserved population in the South Bay San Diego, an underserved community along the US/Mexico border region.

**Strategies**

Scripps will implement a five-week educational based community intervention program to support improved quality of life for patients diagnosed with heart disease. Patients in the intervention group will be followed up weekly via phone for five consecutive weeks. These calls will be focused on motivational support and encouragement. An educational packet will support the initial educational seminar that includes information from the *Your Heart, Your Life* curriculum.

**Evaluation Methods and Measurable Targets**

- Participants will receive an initial heart health educational session that includes review of daily-self assessment, salt avoidance, and exercise and medication adherence.
- Outcomes explored will include decreased hospitalizations and improved biometric measures including weight and blood pressure pre and post.
- Readmissions related to heart failure will be tracked in each participant. (The number of times a patient is admitted to the hospital for a condition related to heart disease will be tracked over the course of the intervention).
- Each participant will be given a “Health Habits” pre-test and post-test to measure behavior change.

5. *Stroke Risk Factor Program*

Stroke is the fifth leading cause of death in the United States. As of 2010, 2.8% of San Diego residents had been told by a doctor they had a stroke. In 2009, the age-adjusted death rate due to stroke was 32.6 per 100,000 among all SDC residents. Seventy to Seventy five percent of strokes and heart attacks can be reduced by eliminating risk factors. Scripps and its partners will work to make San Diego a heart attack and stroke free zone by educating and engaging individuals and communities in understanding and taking action to address the risk factors that cause heart attack and strokes.

**Strategies**

Scripps Health will educate and engage the San Diego community for stroke by attending
at least one community event and screening for stroke via a stroke risk factor score card and educating individuals on the FAST test. The FAST test was developed in the UK in 1998 by a group of stroke physicians, ambulance personnel, and an emergency room physician and was designed to be an integral part of a training package for ambulance staff. The FAST test is any easy way to recognize and remember the most common signs of stroke. Using the FAST test involves asking three simple questions. The acronym stands for Facial drooping, Arm weakness, Speech difficulties and Time.

- Facial drooping: A section of the face, usually only on one side, that is drooping and hard to move. This can be recognized by a crooked smile.
- Arm weakness: The inability to raise one’s arm fully
- Speech difficulties: An inability or difficulty to understand or produce speech
- Time: If any of the symptoms above are showing, time is of the essence; call the emergency services or go to the hospital

Stroke Risk Assessment Tools

Stroke Risk Factor Screening Card

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>High Risk</th>
<th>Caution</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Higher than 140/90</td>
<td>120-139/80-89</td>
<td>Lower than 120/80</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Higher than 240</td>
<td>200-239</td>
<td>Lower than 200</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>Borderline</td>
<td>No</td>
</tr>
<tr>
<td>Smoking</td>
<td>I still smoke</td>
<td>I’m trying to quit</td>
<td>I am a non-smoker</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>I have an irregular heartbeat</td>
<td>I don’t know</td>
<td>My heartbeat is not irregular</td>
</tr>
<tr>
<td>Diet</td>
<td>I am overweight</td>
<td>I am slightly overweight</td>
<td>I am healthy</td>
</tr>
<tr>
<td>Exercise</td>
<td>I am a couch potato</td>
<td>I exercise sometimes</td>
<td>I exercise regularly</td>
</tr>
<tr>
<td>History of Stroke</td>
<td>Yes</td>
<td>Not sure</td>
<td>No</td>
</tr>
</tbody>
</table>

Total:

If your High Risk score is 3 or more, ask your doctor about stroke prevention right away.

If your Caution score is 4-6, you’re off to a great start. Keep working on it!

If your Low Risk score is 0-2, congratulations! You’re doing well at controlling your risk of stroke.

Evaluation Methods and Measurable Targets

- Track total number of risk factor scored cards completed
- Track the number of high risk individuals identified
- Track number of referrals made
- Track number of individuals that are uninsured/underinsured
### Identified Community Need: Cardiovascular Disease

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2. Provide Lipid panel/glucose screenings, body analysis screenings and heart care information for adults in conjunction with the EP Save a Life “Screen Your Teen” event. | • Track number of teen screened  
• Track number of teens with heart abnormalities  
• Track number of uninsured (according to survey of onsite parents)  
• Number who do not have a pediatrician  
• Number who check they use a community clinic  
• Families that surveyed as extremely low to moderate income according to survey of onsite parents  
• Track number of cardio check tests for adults screened  
• Track number of adults found at risk  
• Track number of referrals                                                                                         |

1 Based on FY14 HUD Metropolitan FMR Area 36% of the schools represented are Title I schools, the majority of students at the school meet poverty guidelines.
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<td>Local Schools Countywide</td>
<td>1. Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by Scripps physicians (cardiologists) before high school students participate in organized sports and activities. 2. Provide Lipid panel/glucose screenings, body analysis screenings and heart care information for adults in conjunction with the EP Save a Life “Screen Your Teen” event.</td>
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| Eric Paredes               | 1. To prevent sudden cardiac arrest and death in middle and high school aged children, including underserved areas in San Diego county through awareness, education and action.                                | Scripps Mercy Hospital  | Local Schools Countywide  | 1. Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by Scripps physicians (cardiologists) before high school students participate in organized sports and activities. 2. Provide Lipid panel/glucose screenings, body analysis screenings and heart care information for adults in conjunction with the EP Save a Life “Screen Your Teen” event. | • Track number of teen screened  
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• Track number of cardio check tests for adults screened  
• Track number of adults found at risk  
• Track number of referrals                                                                                     |
| Save a Life Foundation     | 2. Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.                                         |                         |                           |                                                                                                                                                                                                                                  |                                                                                                               |
| (Screenings)               |                                                                                                                                                                                                           |                         |                           |                                                                                                                                                                                                                                  |                                                                                                               |

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<tr>
<td>Su Vida, Su Corazon, Your Heart, Your Life</td>
<td>Empower Latina women to manage their heart health through a community intervention program which decreases the readmission rates for heart failure patients, reduces medical costs for patients and improves their quality of life in underserved population in the South Bay San Diego, an underserved community along the US/Mexico border region.</td>
<td>Scripps Mercy Hospital</td>
<td>Partnerships with local South Bay clinics, Scripps Whitter Institute for Diabetes. Educational materials are used from CDC, American Heart, Lung, Blood Institute. Curriculum is adapted from Your Heart, Your Life: A Community Health Educator’s Manual for the Hispanic Community developed by the National Heart Lung Blood Institute.</td>
<td>Implement a five-week educational based community intervention program to support improved quality of life for patients diagnosed with heart disease. Patients in the intervention group will be followed up weekly via phone for five consecutive weeks. These calls will be focused on motivational support and encouragement. An educational packet will support the initial educational seminar that includes information from the <em>Your Heart, Your Life</em> curriculum.</td>
<td>Participants receive an initial heart health educational session that includes review of daily-self assessment, salt avoidance, medication adherence and exercise. Outcomes explored will include decreased hospitalizations and improved biometric measures including weight and blood pressure pre and post. <em>Readmissions</em> related to heart failure will be tracked in each participant. (The number of times a patient is admitted to the hospital for a condition related to heart disease will be tracked over the course of the intervention). Each participant will be given a “Health Habits” pre-test and post-test to measure behavior change.</td>
</tr>
</tbody>
</table>

*Proper lifestyle changes take by those with heart disease can greatly reduce risk of further intermediate and fatal outcomes. Tobacco use, alcohol abuse, lack of physical activity, poor nutrition, stress and depression are some of the major contributing factors leading to heart disease, heart failure and readmission.*
## Identified Community Need: Cardiovascular Disease and Stroke

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<th>Partners</th>
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</table>
| Sweetwater Union High School District Pre-Participation Sports Screening Assessments | Prevent sudden cardiac arrest and death in South bay Chula Vista high school aged students by increasing education and awareness related to cardiovascular screenings and healthy lifestyles. | Scripps Mercy Hospital           | Southwestern Sports Wellness Foundation, Scripps Family Medicine Residency, Sweetwater Union High School | 1. Partner with local Sweetwater High School District yearly to implement cardiac screenings and sports physicals before students participate in organized sports. Scripps Community Benefits, Chula Vista Scripps Family Medicine Residents will assist with the screenings.  
2. Implement an injury clinic during football season | - Track total number of youth screened  
- Track the number of youth with heart abnormalities  
- Track number of referrals made  
- Track number of individuals that are uninsured/underinsured |
**Identified Community Need: Cardiovascular Disease and Stroke**

| Program Name          | Objectives                                                                 | Hospital Sites              | Partners                                                                 | Action Items                                                                                                                                  | Evaluation Methods and Measureable Targets |
|-----------------------|----------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| **Stroke Risk Factor Program** | Stroke is the fifth leading cause of death in the United States. As of 2010, 2.8% of San Diego residents had been told by a doctor they had a stroke. In 2009, the age-adjusted death rate due to stroke was 32.6 per 100,000 among all SDC residents. Scripps and its partners will work to make San Diego a heart attack and stroke free zone by educating and engaging individuals and communities in understanding and taking action to address the risk factors that cause heart attack and strokes. | **Scripps Memorial Hospital Encinitas** | Be There San Diego
Strike Out Stroke Event which Partners with the San Diego County Stroke Consortium and San Diego Padres | Scripps Health will educate and engage the San Diego community for stroke by attending at least one community event and screening for stroke via a stroke risk factor score card and educating individuals on the FAST test. The acronym stands for Facial drooping, Arm weakness, Speech difficulties and Time. | • Track total number of risk factor scored cards completed.
• Track the number of high risk individuals identified.
• Track number of referrals made
• Track number of individuals that are uninsured/underinsured |
**Scripps Health**

**Community Health Needs Assessment – Implementation Plan**

**Fiscal Year 2017–2019**

**2016 CHNA**

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**Identified Community Need: Cardiovascular Disease and Stroke**

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---

**Additional Note:**

Each box that applies to you equals 1 point. Total your score at the bottom of each column and compare with the stroke risk levels.

- **Risk Factor**
  - Blood Pressure: Higher than 140/90, 120-129/90-99, Lower than 120/80
  - Cholesterol: Higher than 240, 200-239, Lower than 200
  - Diabetes: Yes, Borderline, No
  - Smoking: I still smoke, I’m trying to quit, I am a non-smoker
  - Arrhythmia: I have an irregular heartbeat, I don’t know, My heartbeat is not irregular
  - Diet: I am overweight, I am slightly overweight, My weight is healthy
  - Exercise: I am a couch potato, I exercise sometimes, I exercise regularly
  - History of Stroke: Yes, Not sure, No

- **Caution**
  - Total: If your High Risk score is 3 or more, seek your doctor about stroke prevention right away.
  - If your Caution score is 4-6, you’re off to a good start. Keep working on it.
  - If your Low/Risk score is 0-2, congratulations! You’re doing well at controlling your risk of stroke.
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![Stroke Risk Factor Program](image-url)
**Program Name**: Stroke Risk Factor Program  
**Objectives**: Stroke is the fifth leading cause of death in the United States. As of 2010, 2.8% of San Diego residents had been told by a doctor they had a stroke. In 2009, the age-adjusted death rate due to stroke was 32.6 per 100,000 among all SDC residents. Scripps and its partners will work to make San Diego a heart attack and stroke free zone by educating and engaging individuals and communities in understanding and taking action to address the risk factors that cause heart attack and strokes.

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Diabetes (Type 2)

There are 29 million people with diabetes in the United States and 382 million worldwide, and the rates are highest in diverse racial and ethnic communities and low-income populations. Type 2 diabetes has reached epidemic proportions, and people of Hispanic origin have dramatically higher rates of the disease and the complications that go along with its poor management, including cardiovascular disease, eye disease and limb amputation. Diabetes is a major cause of heart disease and stroke, and is the 7th leading cause of death in the United States and California. More than 1 out of 3 adults have prediabetes and 15-30% of those with prediabetes will develop type 2 diabetes within 5 years. This is especially true in the South Bay communities in San Diego. Specifically, the city of Chula Vista is home to 26,000 Latinos with diagnosed diabetes and tens of thousands more who are undiagnosed, have pre-diabetes and at high risk of developing diabetes.

Diabetes is an important health need because of its prevalence, its impact on morbidity and mortality, and its preventability. An analysis of mortality data for San Diego County found that in 2012 ‘Diabetes mellitus’ was the seventh leading cause of death. The percentage of adults aged 20 and older who have ever been diagnosed with diabetes was 7.2% in 2012 in San Diego County and has been steadily rising since 2005 according to the National Center for Chronic Disease Prevention and Health Promotion (Table 5). Type 2 diabetes is an important target for intervention because hospitalizations due to diabetes-related complications are potentially preventable with proper management and a healthy lifestyle. In San Diego, approximately 1.5% of discharges in the black patient population were attributable to diabetes compared to 0.7% of discharges among whites.

Hospital emergency department encounters, inpatient discharges, and clinic utilization data for patients with a primary diagnosis of a diabetes-related ICD-9 code in 2013 was used to provide an overview of the main reasons individuals sought care related to diabetes by age group. A summary of the trends found were as follows:

‘Diabetes ... Uncontrolled’ was the top inpatient primary diagnosis related to diabetes (type 2) for those age 15-24 and 45 and older. For individuals age 25–44, the top inpatient primary diagnosis was ‘Abnormal Glucose Tolerance of Mother with Delivery’ followed by ‘Diabetes...Uncontrolled.’

Data gathered from North County Health Services, a local FQHC, found that ‘Diabetes mellitus’ and ‘Abnormal glucose of mother antepartum’ ranked 4th and 5th respectively out of the top 8 primary diagnosis in 2014 among seniors and adults who visited their clinic. See Table6 for additional trend data.
Table 5. Diabetes Indicators

<table>
<thead>
<tr>
<th></th>
<th>San Diego County</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population with Diagnosed Diabetes Age-Adjusted Rate(^a)</td>
<td>7.20%</td>
<td>8.05%</td>
<td>9.11%</td>
</tr>
<tr>
<td>Diabetes Age-Adjusted Discharge Rate (per 10,000)(^b)</td>
<td>8.96</td>
<td>10.4</td>
<td>NA</td>
</tr>
</tbody>
</table>

\(^a\)Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
\(^b\)Source: California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2011.

Table 6. Diabetes San Diego County Trends Over Time, 2009–2013

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever diagnosed with diabetes (Adults 18–64 years old)</td>
<td>7.8%</td>
<td>7.9%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

% Diagnosed. Excludes ever been diagnosed with gestational diabetes.

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013

Community input was also collected through the CHNA on the most common health issues that contribute significantly to overall morbidity through key informant interviews and community partner discussions. The results for diabetes (type 2) are summarized in Table 8.

Table 7. Summary Of Community Input On Common Diabetes (Type 2) Issues, HASD&IC 2016 CHNA

<table>
<thead>
<tr>
<th>Summary of Diabetes (Type 2)-Related Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the most common health issues or needs?</td>
</tr>
<tr>
<td>• Assumption that diabetes only affects older individuals</td>
</tr>
<tr>
<td>• Chronic kidney disease related to diabetes</td>
</tr>
<tr>
<td>• Diabetes related to low income and food insecure population</td>
</tr>
<tr>
<td>• Diet and sugar</td>
</tr>
<tr>
<td>• Lack of supplies</td>
</tr>
<tr>
<td>• Treatment compliance issues</td>
</tr>
</tbody>
</table>

*Based on feedback during Key Informant Interviews and Community Partner Discussions

An assessment of health needs by HHSA regions found that diabetes was cited as being among the top five most important health problems in Central, East and North County (comprised of North Coastal and North Inland). Uncontrolled type 2 diabetes was found to be a major contributor to poor diabetes-related outcomes and a significant area of need in San Diego County.
Scripps Health is addressing diabetes disease through the following programs and interventions:

1. The Scripps Diabetes Care Retinal Screening Program

It is estimated that every 24 hours, 55 people will lose their vision as a direct result of diabetic retinopathy. With early diagnosis and appropriate treatment, 95 percent of diabetic blindness could be prevented. The Scripps Whittier Diabetes Institute collaborates with community clinics and organizations to provide much needed services and solutions. For the past decade, the Scripps Diabetes Care Retinal Screening Program has provided low-cost or free screenings to the community. Retinal Screenings are important for the prevention and early treatment of diabetic retinopathy.

**Strategies**

Scripps will improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population. With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program will provide low-cost and/or free screenings to the community. Patients are screened and retinal photographs are taken. After the screenings are interpreted, follow-up care will be arranged as needed. The impacts of such a community retinal program create the following benefits:

- Prevention or diagnosis of vision problems, including blindness.
- A reduction in visits to the emergency department for uncontrolled complications of diabetes.
- Cost savings to patients and health care systems. (The cost to screen each patient is about $30 versus emergency department fees, possible laser treatment and office visits that could potentially cost up to $23,000 per year per patient.)

**Evaluation Methods and Measurable Targets**

- Track the number of retinal screening events & individuals seen
- Track the percentage of individuals that screen positive
- Track the percentage of individuals referrals to Primary Care Physician
- Track the retinal specialist referrals

2. Project Dulce Care Management

The Project Dulce program has been fighting the diabetes epidemic for more than 19 years by providing diabetes care, self-management education and continuous support to low-income and uninsured populations throughout San Diego County. Recognized for its impact, the comprehensive program serves as an international model of patient care and advocacy, helping individuals with the disease learn to improve their health. One of
the primary components of the program is recruiting peer educators from the community to work directly with patients. These educators reflect the diverse population affected by diabetes and help teach others about changing eating habits, adopting exercise routines and other ways to help manage this chronic disease. The impacts of such a community diabetes care management program create the following benefits:
- Higher quality of care.
- Reduced hospital and emergency department care costs.
- Decreased incidence of diabetes-related complications and hospitalizations.
- Improvements in health status and quality of life.

**Strategies**
Scripps will improve self-management education for underserved population living with diabetes. It will offer a comprehensive, culturally sensitive diabetes self-management program for underserved and uninsured populations. These educators, “promotoras,” reflect the diverse population affected by diabetes and will help teach others about changing eating habits, adopting exercise routines and other ways to help manage this chronic disease.

**Evaluation Methods and Measurable Targets**

*Intake Forms/New Patients*
- *Track the total number of new patients cared for by clinical team. Does not include retinal screenings.*
  - *Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be tracked through this Implementation Plan.*

*Pre/Post Survey*
- Track diabetes self-care behaviors (fruit/vegetable consumption, exercise, BG monitoring, medication adherence, foot checks).
- Track knowledge of diabetes recommendations
- Track diabetes distress
- Track support for diabetes management
Diabetes affects nearly 26 million individuals in the U.S., and if current trends continue, 1 of 3 adults will have diabetes by 2050. Diabetes self-management education and support (DSME) is a cornerstone of effective care that improves clinical control and health outcomes; however, DSME participation is low, particularly among underserved populations, and ongoing support is often needed to maintain DSME gains. The complex needs of individuals with diabetes cannot be adequately addressed in the typical 15-minute primary care visit. By adopting a “team-based” approach that is informed by the Chronic Care Model, other primary care personnel [e.g., medical assistants (MAs)] can be trained as health coaches to work in tandem with primary care providers to deliver self-management support. Although research is limited, several studies have shown that MA-provided self-management support improves outcomes in diabetes. The MAC program offers a potential solution to the burgeoning primary care demand-capacity imbalance that can be applied in diverse healthcare settings to better address the needs of the growing number of individuals with Type 2 diabetes management.

**Strategies**

The program will take place within primary care clinics of two health systems that serve large, ethnically/racially, and socioeconomically diverse populations in San Diego County: Neighborhood Healthcare (a FQHC) and Scripps. One clinic within each system is designated to MAC (Scripps Clinic Encinitas, n=150; Neighborhood Healthcare Temecula, n=150), and one to Usual Care (UC) (Scripps Coastal Carlsbad, n=150; Neighborhood Healthcare Escondido, n=150). In addition to usual care, MAC clinic patients will receive brief, targeted self-management support from the MA Health Coach. The MA will incorporate health behavior assessment, medication reconciliation, motivational interviewing, goal-setting, problem-solving, and “closing the loop” techniques — all tailored to patient-specific needs and priorities. As needed, MAs will coordinate brief phone follow-up to review progress and problem-solve barriers.
Evaluation Methods and Measurable Targets

Electronic health records will be used to identify eligible patients and to examine change in clinical outcomes over 12 months. Phone surveys will be used to assess changes in behavioral (diabetes self-care) and psychosocial (quality of life, patient activation) outcomes in 50% of participants at baseline, and months 6 and 12. Specific outcomes include:

*Track Number of Patients*
- Track number of eligible patients
- Track number of enrolled patients
- Track number of patients that decline


## Identified Community Need: Diabetes

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<td>The Scripps Diabetes Care Retinal Screening Program</td>
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<td>Scripps Memorial Hospital Encinitas</td>
<td>Neighborhood Healthcare Escondido</td>
<td>Retinal Screenings</td>
<td>- Number of Retinal Screening events &amp; individuals seen. - Percentage of individuals that screen positive - Percentage of individuals that are self-referred to Primary Care Physician - Retinal Specialist Referrals</td>
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### Identified Community Need: Diabetes

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| The Scripps Diabetes Care Retinal Screening Program | Improve identification of diabetic retinopathy (vision complications because of diabetes) through prevention, early diagnosis and appropriate treatment in the underserved population. | Scripps Green Hospital | Braille Institute | **Retinal Screenings**<br>With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program will provide low-cost and or free screenings to the community. Scripps will partner with either the community clinic or not-for-profit organization to read the images and provide the necessary follow up. After the screenings are interpreted, follow-up care will be arranged as needed. | - Number of Retinal Screening events & individuals seen.  
- Percentage of individuals that screen positive  
- Percentage of individuals that are self-referred to Primary Care Physician  
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| **Project Dulce Care Management** | Improve self-management education for underserved population living with diabetes. | Scripps Memorial Hospital La Jolla | TBD: Faith Community          | Offer a comprehensive, culturally sensitive diabetes self-management program for underserved and uninsured populations. These educators “promotoras” reflect the diverse population affected by diabetes and will help teach others about changing eating habits, adopting exercise routines and other ways to help manage this chronic disease. | • *Total number of new patients cared for by clinical team. Does not include retinal screenings.  
• Pre/Post Survey  
  - Diabetes self-care behaviors (fruit/vegetable consumption, exercise, BG monitoring, medication adherence, foot checks).  
  - Knowledge of diabetes recommendations  
  - Diabetes distress  
  - Support for diabetes management |

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| Project Dulce Care Management | Improve self-management education for underserved population living with diabetes. | Scripps Memorial Hospital Encinitas | Neighborhood Healthcare Escondido | Offer a comprehensive, culturally sensitive diabetes self-management program for underserved and uninsured populations. These educators “promotoras” reflect the diverse population affected by diabetes and will help teach others about changing eating habits, adopting exercise routines and other ways to help manage this chronic disease. | • *Total number of new patients cared for by clinical team. Does not include retinal screenings.  
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### Identified Community Need: Diabetes

**Program Name** | **Objectives** | **Hospital Sites** | **Partners** | **Action Items** | **Evaluation Methods and Measureable Targets**
--- | --- | --- | --- | --- | ---
**Project Dulce Care Management** | Improve self-management education for underserved population living with diabetes. | Scripps Mercy Hospital | Family Health Centers of San Diego | Offer a comprehensive, culturally sensitive diabetes self-management program for underserved and uninsured populations. These educators “promotoras” reflect the diverse population affected by diabetes and will help teach others about changing eating habits, adopting exercise routines and other ways to help manage this chronic disease. | • *Total number of new patients cared for by clinical team. Does not include retinal screenings.*  
• Pre/Post Survey  
  o Diabetes self-care behaviors (fruit/vegetable consumption, exercise, BG monitoring, medication adherence, foot checks).  
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| Medical Assistant Health Coaching (MAC) | One of every 3 US adults will have diabetes by 2050. Diabetes self-management education and support (DSME) is a cornerstone of effective care; however, DSME participation is low, particularly among underserved populations, and ongoing support is often needed to maintain DSME gains. The complex needs of individuals with diabetes cannot be adequately addressed in the typical 15-minute primary care visit. By adopting a “team-based” approach, other primary care personnel [e.g., medical assistants (MAs)] can be trained as health coaches to work in tandem with primary care providers to deliver self-management support. The MAC program offers a potential solution to the burgeoning primary care demand-capacity imbalance that can be applied in diverse healthcare settings to better address the needs of the growing number of individuals with Type 2 diabetes management. | Scripps Memorial Hospital Encinitas | Neighborhood Healthcare (a FQHC) | Scripps Coastal Carlsbad, n=150; Neighborhood Healthcare Escondido, n=150). <br> In addition to usual care, MAC clinic patients will receive brief, targeted self-management support from the MA Health Coach. The MA will incorporate health behavior assessment, medication reconciliation, motivational interviewing, goal-setting, problem-solving, and “closing the loop” techniques -- all tailored to patient-specific needs and priorities. As needed, MAs will coordinate brief phone follow-up to review progress and problem-solve barriers.  | Electronic health records will be used to identify eligible patients and to examine change in clinical outcomes over 12 months. Phone surveys will be used to assess changes in behavioral (diabetes self-care) and psychosocial (quality of life, patient activation) outcomes in 50% of participants at baseline, and months 6 and 12. Specific outcomes include: Track Number of Patients <ul><li># Eligible</li><li># Enrolled</li><li># Declined</li></ul>
Behavioral Health

Behavioral health encompasses many different areas including mental health and substance abuse. Because of the broadness of this health issue, it is often difficult to capture the need for behavioral health services with a single measure. Mental Health can be defined as “a state of complete physical, mental and social well-being, and not merely the absence of disease”. Mental illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning”. Behavioral health is an important health need because it impacts an individual’s overall health status and is a comorbidity often associated with multiple chronic conditions, such as diabetes, obesity and asthma.

In the 2016 CHNA, an analysis of mortality data in San Diego County found that in 2012, Alzheimer’s was the third leading cause of death and intentional self-harm (suicide) was the eighth. Hospital emergency department encounters and inpatient discharge data for patients with a primary diagnosis of a behavioral health-associated ICD-9 code in 2013 was used to provide an overview of main reasons individuals sought care related to behavioral health by age group. A summary of the trends found were as follows:

- **OSHPD ED discharge data:** Anxiety disorders were the top primary diagnosis for ED discharge among those age 5 through 44 and those 65 and older. For those aged 45-64, the top ED discharge for behavioral health was alcohol-related disorders followed by anxiety and mood disorders. Alcohol related disorders was the number two primary diagnosis for discharge for those aged 15 through 44 and those 65 years and older.
- **OSHPD inpatient discharge data** revealed that when examining the ICD-9 codes related to behavioral health, ‘mood disorders’ was the top primary diagnosis for inpatient discharge for ages 5 through 24 and 45 and over. For those aged 25 through 44, the top behavioral health primary diagnosis was ‘schizophrenia and other psychotic disorders’ followed by ‘mood disorders.’
- **Feedback from behavioral health discussions** found that high rates of psychotic discharges in ages 25 to 44 were likely linked to underlying substance abuse problems. Although participants agreed with the findings, it was found that hospital coding may potentially underrepresent the prevalence of underlying issues and miss certain conditions. Most notably missing from the OSHPD data was developmental disorders. The groups also pointed out the importance of emerging data trends. In recent years, discussion participants cited a significant increase in drug-related discharges, particularly methamphetamine (~over 100%).
Anxiety: Anxiety is a normal reaction to stress but can become excessive, difficult to control, and ultimately interfere with normal day-to-day living. There are a wide variety of anxiety disorders including post-traumatic stress disorder, generalized anxiety disorder, panic disorder, and social anxiety disorder. National prevalence data estimates that 18% of the population has an anxiety disorder, with phobias and generalized anxiety being the most common. In San Diego County, there has been a steady increase in the rate of ED discharges with a primary diagnosis of anxiety. In particular, there has been a 64.2% increase in children up to age 14 from 25.0 per 100,000 in 2010 to 41.0 per 100,000 in 2013.

Substance Abuse: The Substance Abuse and Mental Health Services Administration (SAMHSA) defines substance use disorders as the recurrent use of alcohol and/or drugs which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The percentage of adults age 18 and older in San Diego County who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women) is 17.2%; additionally, 12.1% reported currently smoking cigarettes some days or every day according to the BRFSS. Acute substance abuse hospitalization rates increased 37.4% from 2010 to 2013 and increased most among 15-24 year olds (58.0%). Acute alcohol hospitalization rates grew most among 25-44 year olds with a 45.9% increase between 2010 and 2013. Finally, chronic alcohol ED visits among seniors age 65 and older increased 89.7% during the same time period.

Alzheimer’s disease: Alzheimer’s is the most common form of dementia although all dementias are characterized by a decline in memory, thinking skills, and ability to perform everyday activities. According to the 2015 San Diego County Senior Health Report, roughly 60,000 individuals in San Diego are living with Alzheimer’s disease or other dementia (ADOD) in 2012. It is projected that the number of San Diego adults age 55 and older with ADOD will increase by 55.9% between 2012 and 2030. The largest majority of individuals live in East region though the largest percentage increase is projected in North Central. ADOD also affects caregivers physically and emotionally so significant increases in the number of people living with ADOD will have an impact that extends beyond those affected.

1 Substance Abuse and Mental Health Services Administration. Mental Disorders. Retrieved from http://www.samhsa.gov/disorders/mental
Mood Disorders: Mood disorders are particularly prevalent in the community and increasing. Data from the Centers for Medicare and Medicaid show that among the fee-for-service population, 14.5% suffer from depression compared to 13.4% in California in 2012. In addition, an analysis of OSHPD data shows that the rate of ED discharges per 100,000 individuals with a primary diagnosis of mood disorders increased by 38.7% from 2010 to 2013 for children up to age 14; hospitalizations also went up by 26.8% in this age group. Mood disorders are often associated with comorbidities including diabetes, obesity and asthma. Suicide is also an indicator of poor mental health and is one of the major complications of depression. In San Diego County, the suicide rate according to the California Department of Public Health is 11.3 per 100,000 population which is above the state suicide rate of 9.8 per 100,000 (Table 8) and above the HP2020 benchmark of 10.2 per 100,000 population. It is also the eighth leading cause of death in San Diego County. When adjusting for race/ethnicity, Non-Hispanic whites are more likely to commit suicide followed by Native Hawaiian/Pacific Islander. Comparing suicide rates by race, non-Hispanic, black, Asian, Native Hawaiian/Pacific Islander, and those of multiple races were all above state levels. See Table 8 for additional trend data.

Table 8. Mental Health San Diego County Trends Over Time, 2009–2013

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Serious psychological distress in the past year (Adults 18–64 years old)</td>
<td>5.3%</td>
<td>7.7%</td>
<td>7.6%</td>
</tr>
<tr>
<td>% based on 6 questions, known as the “Kessler 6”, to assess symptoms of distress during a 30-day period in the past year. Often used as a proxy measure for severe mental illness.</td>
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</tr>
</tbody>
</table>

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013

Table 9. Suicide Mortality and Poor Mental Health Indicators

<table>
<thead>
<tr>
<th>Poor Mental Health*</th>
<th>San Diego County</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.75%</td>
<td>14.3%</td>
<td>NA</td>
</tr>
<tr>
<td>Suicide Mortality, Age-Adjusted Rate (per 100,000)*</td>
<td>11.29</td>
<td>9.8</td>
<td>NA</td>
</tr>
<tr>
<td>HP 2020 Target for Suicide*</td>
<td>&lt;=10.2</td>
<td>&lt;=10.2</td>
<td>&lt;=10.2</td>
</tr>
</tbody>
</table>

*Source: University of California Center for Health Policy Research, California Health Interview Survey. 2011-2012.


Community input was also collected on the most common health issues that contribute significantly to overall morbidity through key informant interviews and community partner discussions. The results for behavioral health are summarized in Table 10.
### Table 10. Summary Of Community Input On Common Behavioral Health Issues, HASD&IC 2016 CHNA

**Summary of Behavioral Health-Related Responses***

<table>
<thead>
<tr>
<th>1. What are the most common health issues or needs?</th>
<th>2. What are the common behavioral health-related issues?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Lack of training in schools</td>
</tr>
<tr>
<td>Behavioral health affects all other diseases</td>
<td>Problems with compliance/coverage</td>
</tr>
<tr>
<td>Depression</td>
<td>Self-injury/suicidal ideation in youth</td>
</tr>
<tr>
<td>Dementia and Alzheimer's in seniors</td>
<td>Smoking</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Social media/bullying</td>
</tr>
<tr>
<td>Increase in developmental disorders in children</td>
<td>Stress</td>
</tr>
<tr>
<td>Lack of psychiatrists</td>
<td>Substance Abuse — Drugs/alcohol</td>
</tr>
</tbody>
</table>

*Based on feedback during Key Informant Interviews and Community Partner Discussions*

Behavioral health issues and alcohol/drug abuse issues were consistently selected by the highest number of HHSA survey participants in all regions as health problems that have the greatest impact on overall community health. In addition, aging concerns including Alzheimer’s was cited among the top five most important health needs in all regions in San Diego except Central. The following categories were found to be important health needs within behavioral health in San Diego County:

- Alzheimer’s disease (seniors)
- Anxiety (all age groups)
- Drug and alcohol Issues (teens and adults)
- Mood disorders (all age groups)

Scripps Health is addressing behavioral health disease through the following programs and interventions:

1. **Psychiatric Liaison Team (PLT)**

   The Psychiatric Liaison Team is a mobile psychiatric assessment team with clinicians providing mental health evaluation and triage services. Although based at Scripps Mercy Hospitals, the team travels countywide serving all Scripps Hospitals.

**Strategies**

The Psychiatric Liaison Team (PLT) will help to accurately access patients and provide them with best and safest community resources in order to enhance the continuity of care for every patient. The goal is to reduce rates of readmission to the hospital, help people adhere to treatment plans, bring about the relief of symptoms and ensure the long-term stabilization of individual’s health. Scripps will continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and urgent care settings (Rancho Bernardo and Torrey Pines).
**Evaluation Methods and Measurable Targets**

The PLT clinicians are a resource to the acute care and urgent care settings with a primary responsibility to; perform a psychosocial evaluation upon receipt of a physician order, serve as liaisons between the system-wide patients care settings, Scripps Mercy Hospital’s Behavioral Health Unit and provide community behavioral health resources. Information will be retrieved from the Midas Data Base for all patients seen by the Psychiatric Liaison Team.

1. Track number of encounters (visits) referred to inpatient setting
   a. Behavioral Health Mercy
   b. Other inpatient facilities
   c. Crisis Residential Placement
2. Track the number of encounters referred to an outpatient setting
   a. Patient given outpatient referrals
   b. Family Health Centers
   c. Outpatient psychiatrist
   d. Detox
   e. Shelter
3. Track visits to the behavioral health unit within 90 days.

**2. Scripps Drug and Alcohol Resources Nurses**

Through a contract with the Volunteers of America (VOA), Scripps provides safe detox up to five patients per week with Case Management from the Scripps Drug and Alcohol Resource Nurses to help them into community based programs. The role of the Resource Nurse is to work directly with the nursing staff at each of the hospitals in search of patients who may be at risk for alcohol/drug withdrawal. The proactive approach involves daily discussions with the Charge Nurse characteristics of an addicted patient as well as specific diagnosis common to those with substance.

**Strategies**

Patients presenting with mental health and drug and alcohol will be identified to the appropriate level of care including community clinics. Providers will have an increased ability to provide treatment to those who are unfunded or underfunded.
**Evaluation Methods and Measurable Targets**
The VOA uses intensive wrap-around approaches to provide clients with top-quality clinical services, as well as the support they need to best manage their behavioral health. An enhanced case management approach is used, promoting intensive coordination and communication with Scripps staff. The following metrics will be tracked with this program:

- Track number of referrals sent to VOA

**3. Mi Puente/My Bridge — Scripps Mercy Hospital, Chula Vista**

Individuals of low socioeconomic (SES) and ethnic minority status, including Hispanics, the largest U.S. ethnic minority group, are disproportionately burdened by chronic cardiovascular and metabolic conditions (“cardio metabolic” e.g., obesity, diabetes, hypertension, heart disease). High levels of unmet behavioral health in this population contribute to the striking disparities in disease prevalence and outcomes.

*Mi Puente* applies an RN plus volunteer approach, and builds upon a strong collaborative partnership between inpatient (“referring”) and outpatient (“receiving”) care settings.

*Mi Puente* aims to improve continuity of care and address the (physical and behavioral) health needs of the at-risk Hispanic population. This program holds promise for impactful expansion to other conditions and underserved populations.

**Strategies**
Mi Puente includes in-hospital coaching visit(s) from a Behavioral Health RN, and post-discharge supportive telephone calls from the RN (week 1) and a specially-trained Volunteer Peer Mentor (weeks 1-4).

**Evaluation Methods and Measurable Targets**
This program will compare Mi Puente (“My Bridge”, n=260) to Usual Care (n=260) in a total of 560 Hispanics adults, hospitalized with multiple cardio metabolic conditions and 1+ behavioral health concern(s) at Scripps Mercy Chula Vista.
The following hospital utilization will be evaluated across six months.
- Track number of patients
- Track number of eligible patients
- Track number of enrolled patients
- Track number of patients that decline

4. Scripps Mercy and Family Health Centers Behavioral Health Partnership

Community Clinics have become better prepared to treat the traditional pre-expansion Medi-Cal population. Thanks to a longstanding focus on integrating behavioral health into primary, community clinics have developed considerable in-house resources and expertise to deal with mild to moderate behavioral health issues. For example, since the late 2000s, Family Health Centers of San Diego (FHCSD) has embedded mental health services into most of its primary care clinic sites. Every primary care visit includes mental health screening, and FHCSD clinics handle between 125 and 200 mental health visits a day in-house.¹ Scripps Mercy has a wonderful opportunity to establish a stronger integration of care with Family Health Centers of San Diego (FHCSD) to prevent hospitalizations and ensure ongoing care upon discharge. The goal will be to strengthen services in the community and ensure patients are seen in a timely access to medically necessary care at community clinics and through hospital outpatient services before their behavioral health issues become acute and that they do not return to the Emergency Department.

Strategies
Scripps will partner with FHCSD to help ensure behavioral health patients transition into appropriate outpatient care when discharged from Scripps Mercy. Scripps Mercy and Family Health Centers will work on a seamless transition post discharge with mental health intake centers. Parties will form a Joint Operating Committee between both parties to study, address and improve patient flow (including establishing baseline metrics for reporting outcomes).

Evaluation Methods and Measurable Targets
• Track the number of referrals to Family Health Center of San Diego
• Track the number of referrals for medical follow up (Referrals are made to the transition clinic for medical follow up when patients leave the ED)
• Track the number of patients referred using ER Connect and expect a 10% increase from prior year. ER Connect is software program that tracks appointments, and no-show rates and other useful data.

5. Behavioral Health Integration Program (BHIP) in Diabetes

Behavioral Health Integration Program (BHIP) in Diabetes is an integrated, interdisciplinary approach to managing the emotional and behavioral needs of individuals with type 1 and type 2 diabetes. The co-location of medical and behavioral health services in the same facility allows for convenient, warm hand-off from physician to behavioral health specialist. It also affords opportunities for physicians, diabetes educators, and others to receive consultation on behavioral health concerns, and in turn, more comprehensively address the multi-faceted needs of their patients with diabetes.
**Strategies**
The BHIP service is delivered by a Scripps Whittier Diabetes Institute licensed clinical health psychologist and supervised, AIU pre-doctoral clinical psychology trainees at the Scripps Clinic Anderson Medical Pavilion (AMP) facility. The clinical staff does not currently bill for these services as this is supported through philanthropy. The BHIP team receives referrals and warm hand-offs from physicians, diabetes educators, and other providers in order to support patients who are facing challenges related to health behaviors, adjustment/coping, and/or emotional well-being in the context of diabetes. Patient-facing services include intake assessment, and 1:1 and group treatment sessions.

**Evaluation Methods and Measurable Targets**

*Process/Utilization Measures*
- Track number of referrals received (% completed, and reasons for refusals).
- Track number of intakes completed
- Track 1:1 and group sessions provided, per patient

*Self-Report*
- Diabetes Distress Scale (pre/post)
### Identified Community Need: Behavioral Health

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<td>Scripps Memorial Hospital Encinitas</td>
<td>County Mental Health Department</td>
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Tracking encounters and not patients as patients can be seen several times and want to avoid measuring duplicate patients.
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| Psychiatric Liaison Team (PLT) | The Psychiatric Liaison Team will help to accurately access patients and provide them with best and safest community resources in order to enhance the continuity of care for every patient. The goal is to reduce rates of re-admission to the hospital, help people adhere to treatment plans, bring about the relief of symptoms and ensure the long-term stabilization of individual’s health. **The Psychiatric Liaison Team is a mobile psychiatric assessment team with clinicians providing mental health evaluation and triage services. Although based at Scripps Mercy Hospitals, the team travels countywide serving all Scripps Hospitals.** | Scripps Memorial Hospital La Jolla | County Mental Health Department | Continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and urgent care settings.                                                                                                                                                                                                                     | The PLT clinicians are a resource to the acute care and urgent care settings with a primary responsibility to; perform a psychosocial evaluation upon receipt of a physician order, serve as liaisons between the system-wide patients care settings, Scripps Mercy Hospital’s Behavioral Health Unit and provide community behavioral health resources. Information will be retrieved from the Midas Data Base for all patients seen by the Psychiatric Liaison Team 1. Track number of encounters (visits) referred to inpatient setting  
   a. Behavioral Health Mercy  
   b. Other inpatient facilities  
   c. Crisis Residential Placement  
2. Track the number of encounters referred to an outpatient setting  
   a. Patient given outpatient referrals  
   b. Family Health Centers  
   c. Outpatient psychiatrist  
   d. Detox  
   e. Shelter  
3. Track visits to the behavioral health unit within 90 days.                                                                                                                                                                                                                     |
### Identified Community Need: Behavioral Health

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<tr>
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   b. Family Health Centers  
   c. Outpatient psychiatrist  
   d. Detox  
   e. Shelter  
3. Track visits to the behavioral health unit within 90 days. |

*The Psychiatric Liaison Team is a mobile psychiatric assessment team with clinicians providing mental health evaluation and triage services. Although based at Scripps Mercy Hospitals, the team travels countywide serving all Scripps Hospitals.*

Tracking encounters and not patients as patients can be seen several times and want to avoid measuring duplicate patients.
## Identified Community Needs: Behavioral Health

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<tr>
<td><strong>Scripps Drug and Alcohol Resource Nurses</strong></td>
<td>Patients presenting with mental health and drug and alcohol will be identified to the appropriate level of care including community clinics. Providers will have an increased ability to provide treatment to those who are unfunded or underfunded.</td>
<td><strong>Scripps Memorial Hospital Encinitas</strong></td>
<td>Volunteers of America (VOA) Volunteers of America has long served populations with co-occurring disorders of substance abuse and mental illness.</td>
<td>Through a contract with the Volunteers of America, Scripps provides safe detox up to five patients per week with Case Management from the Scripps Drug and Alcohol Resource Nurses to help them into community based programs. The role of the Resource Nurse is to work directly with the nursing staff at each of the hospitals in search of patients who may be at risk for alcohol/drug withdrawal. The proactive approach involves daily discussions with the Charge Nurse characteristics of an addicted patient as well as specific diagnosis common to those with substance</td>
<td>The VOA uses intensive wrap-around approaches to provide clients with top-quality clinical services, as well as the support they need to best manage their behavioral health. An enhanced case management approach is used, promoting intensive coordination and communication with Scripps staff. The following metrics are tracked with this program:  - Track number of referrals sent to VOA</td>
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| Scripps Drug and Alcohol Resource Nurses | Patients presenting with mental health and drug and alcohol will be identified to the appropriate level of care including community clinics. Providers will have an increased ability to provide treatment to those who are unfunded or underfunded. | Scripps Green Hospital | Volunteers of America (VOA) Volunteers of America has long served populations with co-occurring disorders of substance abuse and mental illness. | Through a contract with the Volunteers of America, Scripps provides safe detox up to five patients per week with Case Management from the Scripps Drug and Alcohol Resource Nurses to help them into community based programs. The role of the Resource Nurse is to work directly with the nursing staff at each of the hospitals in search of patients who may be at risk for alcohol/drug withdrawal. The proactive approach involves daily discussions with the Charge Nurse characteristics of an addicted patient as well as specific diagnosis common to those with substance abuse and mental illness. | The VOA uses intensive wrap-around approaches to provide clients with top-quality clinical services, as well as the support they need to best manage their behavioral health. An enhanced case management approach is used, promoting intensive coordination and communication with Scripps staff. The following metrics are tracked with this program:  
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- Track number of referrals sent to VOA |
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</table>
| Mi Puente/My Bridge | *Mi Puente* applies an RN plus volunteer approach, and builds upon a strong collaborative partnership between inpatient (“referring”) and outpatient (“receiving”) care settings. *Mi Puente* aims to improve continuity of care and address the (physical and behavioral) health needs of the at-risk Hispanic population. This program holds promise for impactful expansion to other conditions and underserved populations. | Scripps Mercy Hospital                | San Ysidro Health Center                             | *Mi Puente* includes in-hospital coaching visit(s) from a Behavioral Health RN, and post-discharge supportive telephone calls from the RN (week 1) and a specially-trained Volunteer Peer Mentor (weeks 1-4). | Individuals of low socioeconomic (SES) and ethnic minority status, including Hispanics, the largest U.S. ethnic minority group, are disproportionately burdened by chronic cardiovascular and metabolic conditions (“cardiometabolic” e.g., obesity, diabetes, hypertension, heart disease). High levels of unmet behavioral health in this population contribute to the striking disparities in disease prevalence and outcomes. This program will compare *Mi Puente* (“My Bridge”, n=260) to Usual Care (n=260) in a total of 560 Hispanics adults, hospitalized with multiple cardiometabolic conditions and 1+ behavioral health concern(s) at Scripps Mercy Chula Vista.  
Track Number of Patients  
- Track number of eligible patients  
- Track number of enrolled patients  
- Track number of patients who decline |
### Identified Community Need: Behavioral Health

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<th>Evaluation Methods and Measureable Targets</th>
</tr>
</thead>
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<tr>
<td>Scripps Mercy &amp; Family Health Centers Behavioral Health Partnership</td>
<td>With the expansion of Medi-Cal and Covered California, a large number of individuals with coverage are looking to access behavioral health care. The goal is to strengthen behavioral health services in the community and ensure patients are seen in a timely access to medically necessary care at community clinics and through hospital outpatient services before their behavioral health issues become acute and that they do not return to the Emergency Department.</td>
<td>Scripps Mercy Hospital</td>
<td>Family Health Centers of San Diego</td>
<td>Scripps Mercy will establish a stronger integration of care with Family Health Centers of San Diego (FHCSD) to prevent hospitalizations and ensure ongoing care upon discharge. Scripps Mercy and Family Health Centers will work on a seamless transition post discharge with mental health intake centers. Scripps will partner with FHCSD to ensure behavioral health patients transition into appropriate outpatient care when discharged from Scripps Mercy. Parties will form a Joint Operating Committee between both parties to study, address and improve patient flow (including establishing baseline metrics for reporting outcomes).</td>
<td>• Track the number of referrals to FHCSD. • Track the number of referrals for medical follow up (Referrals are made to the transition clinic for medical follow up when patients leave the ED) • Track the number of patients referred using ER Connect and expect a 10% increase from year prior. ER Connect is software program that tracks appointments, and no-show rates and other useful data.</td>
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</tbody>
</table>
### Identified Community Need: Behavioral Health

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</table>
| Behavioral Health Integration Program in Diabetes | Behavioral Health Integration Program (BHIP) in Diabetes is an integrated, interdisciplinary approach to managing the emotional and behavioral needs of individuals with type 1 and type 2 diabetes. The co-location of medical and behavioral health services in the same facility allows for convenient, warm hand-off from physician to behavioral health specialist. It also affords opportunities for physicians, diabetes educators, and others to receive consultation on behavioral health concerns, and in turn, more comprehensively address the multi-faceted needs of their patients with diabetes. | Scripps Memorial Hospital La Jolla & Scripps Green Hospital | Scripps Whittier Diabetes Institute (SWDI) Alliant International University (AIU) | The BHIP service is delivered by a Scripps Whittier Diabetes Institute licensed clinical health psychologist and supervised, AIU pre-doctoral clinical psychology trainees at the Scripps Clinic Anderson Medical Pavilion (AMP) facility. The clinical staff does not currently bill for these services as this is supported though philanthropy. The BHIP team receives referrals and warm hand-offs from physicians, diabetes educators, and other providers in order to support patients who are facing challenges related to health behaviors, adjustment/coping, and/or emotional well-being in the context of diabetes. Patient-facing services include intake assessment, and 1:1 and group treatment sessions. | Process/Utilization Measures  
- Track number of referrals received (% completed, and reasons for refusals).  
- Track number of intakes completed  
- Track 1:1 and group sessions provided, per patient  
Self-Report  
- Diabetes Distress Scale (pre/post) |
Obesity

Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have an adverse effect on health. Overweight and obesity ranges are determined using weight and height to calculate a number known as “body mass index” (BMI). An adult with a BMI between 25 and 29.9 is considered overweight, while an adult who has a BMI of 30 or higher is considered obese. For children and adolescents aged 2–19, overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex, while obese is defined as a BMI at or above the 95th percentile for children of the same age and sex. Obesity is an important health need due to its high prevalence in the U.S. and San Diego and its contribution to the development of other chronic conditions. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.

**Adults:** 36.3% of adults aged 18 and older self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight) in SDC. An additional 20.1% of adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in SDC. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. High levels of body fat are linked to obesity, heart disease, diabetes, and other health issues.

**Youth:** FITNESSGRAM is the required physical fitness test that school districts must administer to all California students in Grades 5, 7, and 9. The percentage of children in grades 5, 7, and 9 ranking within the “health risk” category (overweight) for body composition on the FITNESSGRAM physical fitness test was 17.7% in San Diego County for the years 2013–2014. Furthermore, approximately 15.9% of children in grades 5, 7, and 9 were ranked within the “high risk” category (obese). Rates of overweight and obese youth were highest among Hispanic/Latino and African American youth.

---

Obesity is largely categorized as a secondary diagnosis in hospital discharge data. An analysis of the primary diagnoses associated with a secondary diagnosis of an obesity-related ICD-9 code in 2013 was used to provide an overview of the main reasons individuals with abnormal weight seek care by age group. In addition, local program data were summarized to provide additional perspective on the impact of obesity on morbidity in San Diego. A summary of the trends found were as follows:

When examining inpatient hospital discharge data with obesity as a secondary diagnosis, it was found that the most common primary diagnosis of those patients were nonspecific chest pain in ages 25–64, abdominal pain for those age 15–24, and for those over 65 years their primary diagnosis was osteoarthritis, septicemia followed by congestive heart failure.

### Table 11. Adult and Youth Overweight and Obese Indicators

<table>
<thead>
<tr>
<th></th>
<th>San Diego County</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Adults Overweight</td>
<td>36.28%</td>
<td>35.85%</td>
<td>35.78%</td>
</tr>
<tr>
<td>Percent Adults with BMI &gt; 30.0 (Obese)</td>
<td>20.10%</td>
<td>22.32%</td>
<td>27.14%</td>
</tr>
<tr>
<td>Percent Youth Overweight</td>
<td>17.74%</td>
<td>19.30%</td>
<td>NA</td>
</tr>
<tr>
<td>Percent Youth Obese</td>
<td>15.89%</td>
<td>18.99%</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
**The thresholds for youth overweight and obese are based on the CDC's BMI-for-age growth charts, which define an individual as overweight when his or her weight is between the “85th to less than the 95th percentile”.

### Table 12. Obesity San Diego County Trends Over Time, 2009–2013

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Obese (Adults 18–64 years old)</td>
<td>21.9%</td>
<td>22.1%</td>
<td>23.1%</td>
</tr>
</tbody>
</table>

*Defined as body mass index (weight [kg]/height [m2]) greater than or equal to 30.0

*Source: California Health Interview Survey, 2009, 2011-2012, and 2012-2013
Community input was also collected on the most common health issues that contribute significantly to overall morbidity through key informant interviews and community partner discussions. The results for obesity are summarized in Table 13.

**Table 13. Summary Of Community Input On Common Obesity-Related Issues, HASD&IC 2016 CHNA**

<table>
<thead>
<tr>
<th>Summary of Obesity-Related Responses*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the most common health issues or needs?</td>
</tr>
<tr>
<td>• High obesity prevalence</td>
</tr>
<tr>
<td>• Issue for acculturating refugees, Native Americans, older veterans and low-income individuals</td>
</tr>
<tr>
<td>• Lack of physical activity</td>
</tr>
<tr>
<td>• Nutrition and diet</td>
</tr>
<tr>
<td>• Orthopedic issues</td>
</tr>
<tr>
<td>• Physical education avoidance due to body image and anxiety</td>
</tr>
<tr>
<td>• Starts in youth</td>
</tr>
</tbody>
</table>

*Based on feedback during Key Informant Interviews and Community Partner Discussions

An assessment of health needs by HHSA region found that obesity was consistently cited as being among the top five most important health problems across all the regions, though it ranked highest in East and South region. Obesity and its contribution to other chronic and co-occurring diseases was found to be a significant area of need in San Diego County.

Scripps Health is addressing obesity through the following programs and interventions:

1. **Diabetes Prevention Program (DPP)**

Congress authorized the Center for Disease Control to establish the NATIONAL DIABETES PREVENTION PROGRAM (National DPP) [www.cdc.gov/diabetes/prevention](http://www.cdc.gov/diabetes/prevention) — a public-private initiative to offer evidence-based, cost effective interventions in communities across the United States to prevent type 2 diabetes. There are 86 million people with diabetes and this lifestyle change program has been shown to be cost effective and can be cost saving. The Diabetes Prevention Program is a scientifically validated lifestyle intervention based model. The Centers for Disease Control and National Institutes of Health promote widespread adoption of the DPP due to its demonstrated effectiveness. Without weight loss and moderate physical activity 15-30% of people with prediabetes will develop type 2 diabetes within 5 years. Research shows structured lifestyle interventions can cut the risk of type 2 diabetes in half.

Scripps aims to decrease the incidence of type 2 diabetes by managing a major diabetes risk factor, obesity in underserved, ethnically diverse populations by testing the effectiveness of a lifestyle curriculum. Scripps aims to examine the effectiveness of the DPP program in reducing BMI and weight. Scripps also aims to examine the effectiveness of the DPP program in improving behavioral & psychological risk profiles.
Strategies
Scripps will offer an intensive lifestyle intervention program that has been validated by
the NIH and CDC. Empower patients with pre-diabetes to take charge of their health
and wellbeing. The individuals will meet in groups with a community health promoter/
lifestyle coach for 16 weeks, 1-hour sessions and 6-8 monthly follow up sessions.

Evaluation Methods and Measurable Targets

Pre measures only:
• Track socio-demographics (age, race/ethnicity, socioeconomic status, marital status)

Pre/Post measures:
• Track number of individuals that attend/complete the program
• Track weight
• Track Healthful Change Rulers (participation rate importance of readiness, and
  confidence in making healthful changes)
• Track health behaviors (nutrition, exercise, smoking, alcohol use)
• Track stress

*This is a yearlong intensive program. Program participants will begin the program
at different times throughout the year. Data will be reported as cohorts complete the
yearlong program. At the end of the three years we will have comprehensive and
complete data.

Post measures only:
• Track participant evaluation (participants’ rate satisfaction/acceptability).

2. Healthy Living Program

It is estimated that there are 20,000 people with diabetes in the Scripps ambulatory
population and 13,000 admissions to Scripps hospitals annually. Prediabetes affects
86 million Americans. People with diagnosed diabetes will have health care costs 2.3
times higher than if they didn’t have the disease. Philanthropic funds awarded to the
Scripps Diabetic Prevention Care Line are focused on promoting healthy lifestyles and
preventing diabetes and obesity among high risk populations. Scripps will use these
funds as well leverage other monies as philanthropic investment capital, and transition to
a cost effective and sustainable healthy lifestyles and diabetes prevention program that
promises to support Scripps’ effort to deliver population health while managing its costs.

Strategies
Scripps will encourage participants to adopt three health behaviors (nutritious diet,
physical activity & not smoking) to prevent cancer, type 2 diabetes, cardiovascular
disease and respiratory disease that causes 50% of all deaths in San Diego and the
underserved population. Participants will learn how to make healthy food choices using low cost options, make physical activity part of their daily life and learn how to stay motivated and maintain healthy habits. Scripps will implement a series of 3 free sessions that encourage participants to identify and adopt practical ways to improve their health habits. Sessions will be offered throughout San Diego County in English and Spanish, with special emphasis on the Latino and underserved communities. Sessions will include health screenings, healthy cooking tips and mindful eating and practice sessions.

**Evaluation Methods and Measurable Targets**

*Pre Measures Only*
- Track Socio-demographics (age, race/ethnicity, socioeconomic status, marital status)
- Track diabetes risk survey (patients at high risk for prediabetes are referred to the Diabetes Prevention Project (DPP)).

*Pre/Post Measures*
- Track the number of individuals that attend/complete the program
- Track Healthful Change Rulers (participants’ rate importance of readiness, and confidence in making healthful changes — completed prior to first class, and at the end of every class).

*Post Measure Only*
- Track participant evaluation (participants’ rate satisfaction/acceptability) completed at the end of every class.

**3. Promise Neighborhood (Reducing Childhood Obesity in South Bay)**

Scripps is a partner with the Promise Neighborhood Initiative and the goals are to implement and coordinate activities specific to 5210 (5 Fruits or More a day, 2 hours or less of Screen time, One hour of Physical Activity a day and 0 surgery juices). These messages are tailored to school staff, parents and the students. Promise Neighborhood has also developed a wellness committee composed of the school principal, teachers, parents and Scripps staff that will sustain strategies campus wide that support healthy eating and active living. The program provides a series of five wellness classes (10 sessions each) to 120 youth participants in the 4th and 5th grade classes at Castle Park Elementary. Sessions begin in the second quarter of the school year. Since 2013, over 400 children and over 100 parents have participated in wellness activities on campus. As a result of implementing wellness activities, lesson plans and advocacy in healthy living at the school and surrounding community, the amount of physical activity and consumption of fruits and vegetables has increased by over 50% of the children, school staff and parents.
Strategies
1. Scripps will partner with local elementary schools to implement and coordinate activities specific to 5210 and healthy lifestyles. 5210 message (5 Fruits or More a day, 2 hours or less of Screen time, One hour of Physical Activity a day and 0 surgery juices).
2. Administer the 5210 Health Assessment Survey and Healthy Plan to the 4th and 5th grade classes before the 10 sessions are introduced to evaluate knowledge on the 5210 messages. In addition, support physical activities for students to pass the yearly State fitness test exam. Pre survey is administered in the second quarter of the school year.
3. Administer 5210 Pre and Post goal setting plan to 4th and 5th grade classes on the last day of the 10 sessions in an effort to have students set long term goals. Goal setting survey is administered in the third quarter of the school year.
4. After the 10 sessions, a summary report on the health assessment survey and goal plan is developed. The report compares responses from the previous school year 4th grade classes to current 5th grade classes to evaluate changes in behavior. The summary report is completed at the end of the school year.
5. Scripps will organize school-wide wellness fair for parents and students and invite local service organizations to provide additional resources for parents and facilitated activities promoting the 5210 message.
6. Implement wellness activities/classes with community partners, Scripps Family Medicine Residents and Resident Leadership Academy.

Evaluation Methods and Measurable Targets
• Track total number of youth participants
• Administer pre and post survey knowledge and post goal setting plan and 5210 educational data
• Provide summary report
• Wellness Committee meetings documented

The metrics are reported once a year at the end of the school year (May)
Identified Community Need: Obesity

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Objectives</th>
<th>Hospitals</th>
<th>Partners</th>
<th>Action Items</th>
<th>Evaluation Methods and Measurable Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Prevention Program (DPP)</td>
<td>Decrease the incidence of type 2 diabetes by managing a major diabetes risk factor, obesity in underserved, ethnically diverse populations by testing the effectiveness of a lifestyle curriculum.</td>
<td>Scripps Memorial Hospital Encinitas</td>
<td>Community Housing Works</td>
<td>Offer an intensive lifestyle intervention program that has been validated by the NIH and CDC. Empower patients with pre-diabetes to take charge of their health and wellbeing. The individuals will meet in groups with a community health promoter/lifestyle coach for 16 weeks, 1-hour sessions and 6-8 monthly follow up sessions.</td>
<td>The Diabetes Prevention Program is a scientifically validated lifestyle intervention based model. The Centers for Disease Control (CDC) and National Institutes of Health (NIH) promote widespread adoption of the DPP due to its demonstrated effectiveness.</td>
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<tr>
<td></td>
<td><em>This is a yearlong intensive program. Program participants will begin the program at different times throughout the year. Data will be reported as the cohorts complete the program. At the end of the 3 years there will be comprehensive complete data.</em></td>
<td></td>
<td>Scripps Clinic - Vista</td>
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<tr>
<td></td>
<td><strong>Aim 1</strong> – Examine the effectiveness of the DPP program in reducing BMI and weight.</td>
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<tr>
<td></td>
<td><strong>Aim 2</strong> – To examine the effectiveness of the DPP program in improving behavioral &amp; psychological risk profiles.</td>
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<tr>
<td></td>
<td><strong>Pre measures only:</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>● Sociodemographic (age, race/ethnicity, socioeconomic status, marital status)</td>
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<tr>
<td></td>
<td><strong>Pre/Post measures:</strong></td>
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<tr>
<td></td>
<td>● Number of individuals that attend/complete the program</td>
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<tr>
<td></td>
<td>● Weight</td>
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# Identified Community Need: Obesity

## Program Name

**Diabetes Prevention Program (DPP)**

## Objectives

- Decrease the incidence of type 2 diabetes by managing a major diabetes risk factor, obesity in underserved, ethnically diverse populations by testing the effectiveness of a lifestyle curriculum.

**Aim 1** – Examine the effectiveness of the DPP program in reducing BMI and weight.

**Aim 2** – To examine the effectiveness of the DPP program in improving behavioral & psychological risk profiles.

## Hospital Sites

- **Scripps Green Hospital**

## Partners

- Partners TBD

## Action Items

- Offer an intensive lifestyle intervention program that has been validated by the NIH and CDC. Empower patients with pre-diabetes to take charge of their health and wellbeing. The individuals will meet in groups with a community health promoter/lifestyle coach for 16 weeks, 1-hour sessions and 6-8 monthly follow up sessions.

## Evaluation Methods and Measurable Targets

The Diabetes Prevention Program is a scientifically validated lifestyle intervention based model. The Centers for Disease Control (CDC) and National Institutes of Health (NIH) promote widespread adoption of the DPP due to its demonstrated effectiveness.

**Pre measures only:**
- Sociodemographic (age, race/ethnicity, socioeconomic status, marital status)

**Pre/Post measures:**
- Number of individuals that attend/complete the program
- Weight
- Healthful Change Rulers (participation rate importance of readiness, and confidence in making healthful changes)
- Health behaviors (nutrition, exercise, smoking, alcohol use)
- Stress

**Post measures only:**
Participant evaluation (participants’ rate satisfaction/acceptability).

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*This is a yearlong intensive program. Program participants will begin the program at different times throughout the year. Data will be reported as the cohorts complete the program. At the end of the 3 years there will be comprehensive complete data.*
**Identified Community Need: Obesity**

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| **Diabetes Prevention Program (DPP)**       | Decrease the incidence of type 2 diabetes by managing a major diabetes risk factor, obesity in underserved, ethnically diverse populations by testing the effectiveness of a lifestyle curriculum.                           | Scripps<br>Memorial<br>Hospital<br>La Jolla | Partners TBD  | Offer an intensive lifestyle intervention program that has been validated by the NIH and CDC. Empower patients with pre-diabetes to take charge of their health and wellbeing. The individuals will meet in groups with a community health promoter/lifestyle coach for 16 weeks, 1-hour sessions and 6-8 monthly follow up sessions | The Diabetes Prevention Program is a scientifically validated lifestyle intervention based model. The Centers for Disease Control (CDC) and National Institutes of Health (NIH) promote widespread adoption of the DPP due to its demonstrated effectiveness.  
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# Identified Community Need: Obesity

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<td><strong>Scripps Memorial Hospital Encinitas</strong></td>
<td>Community Clinics, Nurseries, Local Schools, Senior Apartments, YMCA’s, Faith based organizations, Community Housing Works</td>
<td>Implement a series of 3 free sessions that encourage participants to identify and adopt practical ways to improve their health habits. Sessions are offered throughout San Diego County in English and Spanish, with special emphasis on the Latino and underserved communities. Sessions include health screenings, healthy cooking tips and mindful eating and practice sessions.</td>
<td>The Healthy Living Program will support Scripps’ efforts at cost containment in the short and long term. The anticipated impact will be to prevent at-risk individuals from getting diabetes, thereby avoiding the 2.3 times higher healthcare costs of a person with diabetes.</td>
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**Pre measures only**
- Sociodemographic (age, race/ethnicity, Socioeconomic status, marital status)
- Diabetes risk survey (patients at high risk for prediabetes are referred to the Diabetes Prevention Project (DPP)).

**Pre/Post Measures**
- Number of individuals that attend/complete the program
- Healthful Change Rulers (participants’ rate importance of readiness, and confidence in making healthful changes – completed prior to first class, and at the end of every class).

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<td>Scripps Mercy Hospital</td>
<td>Community Clinics, Nurseries, Local Schools, Senior Apartments, YMCA’s, Faith based organizations, Community Housing Works, Casa Familiar</td>
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| Promise Neighborhood (Reducing Childhood Obesity in South Bay) | Increase education and awareness related to healthy lifestyles for elementary aged children, parents and school staff. Improve behaviors related to nutrition and physical activity. | Scripps Mercy Hospital | Scripps Family Medicine Residency, Castle Park Elementary School, South Bay Community Services | 1. Scripps will partner with local elementary schools to implement and coordinate activities specific to 5210 and healthy lifestyles. 5210 message (5 Fruits or More a day, 2 hours or less of Screen time, One hour of Physical Activity a day and 0 surgery juices). 2. Administer the 5210 Health Assessment Survey and Healthy Plan to the 4th and 5th grade classes and support Physical Activities for students to pass the yearly State fitness test exam. 3. Scripps will organize school-wide wellness fair for parents and students and invite local service organizations to provide additional resources for parents and facilitated activities promoting the 5210 message. 4. Implement wellness activities/classes with community partners, Scripps Family Medicine Residents and Resident Leadership Academy. | • Track total number of youth participants  
• Administer Pre and Post-Test knowledge and 5210 educational data  
• Provide summary report  
• Wellness committee meetings documented |
Evaluation Plans

Scripps will monitor and evaluate the strategies listed in this document for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor will be tailored to each strategy and will include the collection and documentation of tracking measures as listed above and more detailed in its corresponding table metric tool documents. As stated earlier, Scripps Health anticipates the implementation strategies may evolve due to the fast pace at which the community and health care industry change. Therefore, a flexible approach is best suited for the development of its response to the Scripps Health Community Health Needs Assessment (CHNA).