Scripps Health FY 2017– 2019 Implementation Plan

In Support of the 2016 San Diego Community Health Needs Assessment

Updated
September 2019

Scripps Health
10140 Campus Point Drive
San Diego, CA 92121

scripps.org

2018 Scripps Health Implementation Plan

Table of Contents

Health Issues

Scripps Health 2018 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: Address of Hospital Organization:	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 Torrey Pines Road San Diego, CA 92037 080000139 Scripps Memorial Hospital Encinitas 354 Santa Fe Drive La Jolla, CA 92037 080000148

Scripps Health 2018 Implementation Plan

About Scripps Health

Founded in 1924 by philanthropist Ellen Browning Scripps, Scripps Health is a $3.2 billion not-for-profit integrated health system based in San Diego, California. Scripps treats more than 700,000 patients annually through the dedication of 3,000 affiliated physicians and more than 15,000 employees among its five acute-care hospital campuses, home health care services, and an ambulatory care network of physician offices and 29 outpatient centers and clinic. Scripps also offers payer products and population health services through Scripps Accountable Care Organization, Scripps Health Plan and customized narrow network plans in collaboration with third-party payers

Today, the health system extends from Chula Vista to Oceanside and is dedicated to improving community health while advancing medicine. Recognized as a leader in disease and injury prevention, diagnosis and treatment, Scripps is also at the forefront of clinical research, 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 five times as one of the nation's best health care systems by Truven Health Analytics division of IBM Watson Health. Its hospitals are consistently ranked by U.S. News & World Report among the nation's best and Scripps is regularly recognized by Fortune magazine, 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.

SCRIPPS FACILITIES/DIVISIONS

Scripps Memorial Hospital Encinitas
Scripps Green Hospital
Scripps Memorial Hospital La Jolla
Scripps Clinic
Scripps Mercy Hospital
*San Diego & Chula Vista Campuses

Scripps Clinical Research Services
Scripps Coastal Medical Center
Scripps Home Health Care
Scripps Whittier Diabetes Institute

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 do not 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 an 18-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, CHNA Report.

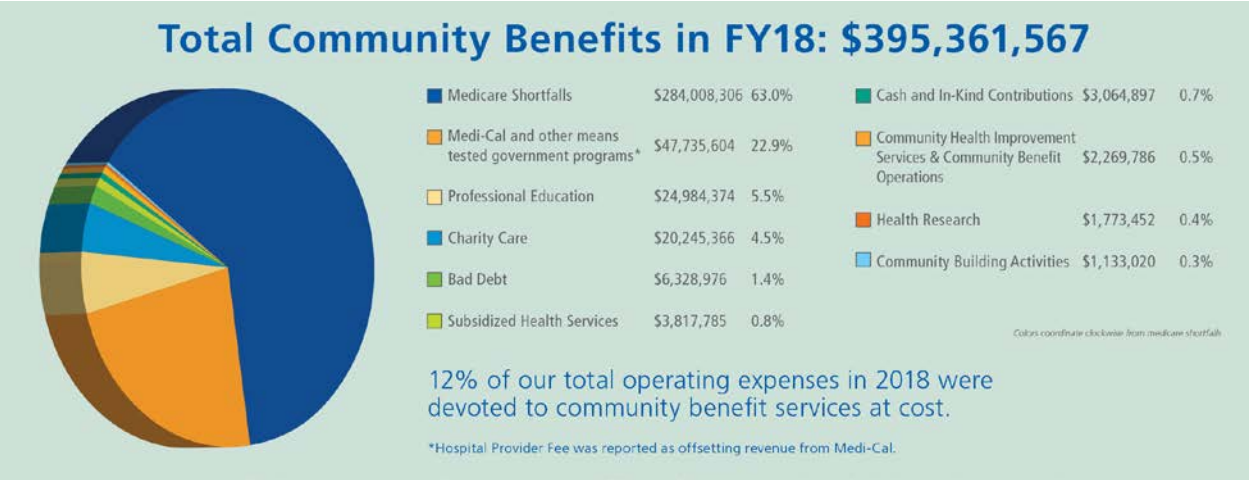
About Scripps Health Community Benefit

In addition to the CHNA and Implementation Plan, Scripps Health continues to meet community needs by providing charity care and uncompensated care, professional educational 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.

In FY 2018 Scripps documented more than $395 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.



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 regions of San Diego. Community outreach efforts are focused in those areas with proximity to a Scripps facility. Scripps hosts, sponsor and participates in many community-building events throughout the year.

SCRIPPS HEALTH			
HOSPITAL/HEALTH CARE SYSTEM*	LOCATION		
Scripps Memorial Hospital La Jolla	9888 Genesee Ave.	La Jolla	92037
Scripps Mercy Hospital	4077 5th Ave.	San Diego	92103
Scripps Green Hospital	10666 N. Torrey Pines Road	La Jolla	92037
Scripps Memorial Hospital Encinitas	354 Santa Fe Drive	Encinitas	92024
Scripps Mercy Hospital Chula Vista	435 H St.	Chula Vista	91910

*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 inpatient discharge years 2013-2016 (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 2013-2016 from which the Top 70% of Scripps Patients Originate

CITY	2013	2014	2015	2016
San Diego	37%	37%	36%	36%
Chula Vista	8%	8%	8%	7%
Carlsbad	5%	6%	6%	6%
Oceanside	5%	5%	5%	6%
Encinitas	3%	3%	3%	3%
National City	3%	2%	2%	2%
La Jolla	3%	2%	2%	2%
San Marcos	2%	2%	2%	2%
Vista	2%	2%	2%	3%
El Cajon	2%	2%	2%	2%
Grand Total	**70%**	**70%**	**70%**	**70%**

Figure 1 – Scripps Health Service Area

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 one 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 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 plan to commit to address the health need.
- Describe any planned collaboration between hospital facilities and other facilities or organizations in addressing the health need.

Or

- The significant health needs the hospital does not intend to meet, explaining why the hospital does not intend to meet the health need.

Scripps Implementation Plan Strategy Team

The Scripps Implementation Strategy Team included the following individuals:

Scripps Executives

- Carl Etter, Corporate Senior VP, Regional Chief Executive
- Tom Gammiere, Corporate Senior VP, Regional Chief Executive
- June Komar, Corporate Executive, Vice President Strategy and Administration

Clinical Care Line Leaders

- Jerry Gold, Administrator, Behavioral Health Clinical Care
- Athena Philis-Tsimikas, Corp VP, Scripps Whittier Institute
- Chris Walker, Senior Director, Scripps Whittier Institute

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
- Kimberly Luu, Research Assistant, Scripps Whittier Institute, Administration
- Addie Fortmann, Manager, Diabetes Care Line Research, Scripps Whittier Institute, Administration
- George Hayes, Manager, Market Outreach
- Karen McCabe, Director, Community Benefits
- Kimberly Roberts, Director, Clinical Services, Community Health & Advocacy, Scripps La Jolla
- Zachary Mayoras, Complex Care Manager, Nursing Administration
- Monica Ruiz, Supervisor, Community Program & Research, Scripps Whittier Institute
- Kristine Osborne, Data Analyst, PLT Team
- Marilen Collins, Director, Patient Care, Nursing Administration, Encinitas
- Mark Zangrando, Senior Director, Mission Integration

Scripps Health Implementation Plan Summary

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 movement, 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 with 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.

In addition to the health outcome needs that were identified in the CHNA ten social determinants of health needs were also a key theme and referenced in all of the community engagement activities. These ten social determinants of health needs were outlined in order of priority. Food Insecurity and Access to Healthy Food, Access to Care or Services, Homelessness/Housing, Physical Activity, Education/Knowledge, Cultural Competency, Transportation, Insurance Issues, Stigma, and Poverty.

Some of these social determinants of health needs are addressed within the four health conditions identified in this report such as access to care, physical activity, and education/knowledge through various program interventions. The other social determinants of health needs were not addressed in detail in the Scripps Implementation Plan due to limited financial and staffing constraints and/or a lack of expertise or competency to effectively address the needs. In addition, some of these issues are being addressed by other providers in the San Diego community who have

more expertise. Scripps Health remains committed to the care and improvement of health for all San Diegans and will look to the exploration of new opportunities and new partnerships to address these needs and future needs identified.

With the 2016 CHNA completed 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 in 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 modification as needed.

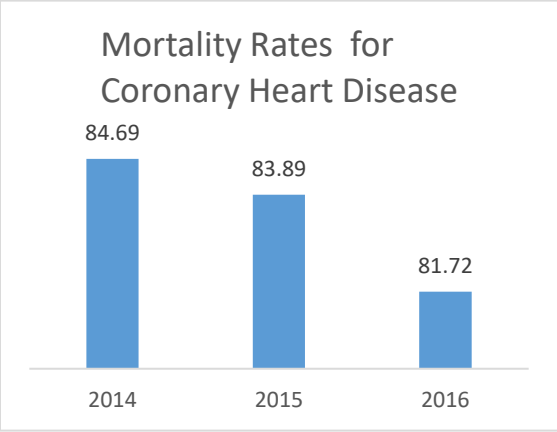
In response to identified unmet health needs in the 2016 Community Needs Assessment, during FY17–FY19 Scripps Health is focusing on the strategies and initiatives, their measures of implementation and the metrics used to evaluate their effectiveness described in the report.

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 event 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 fourth, and 'Essential (primary) Hypertension and Hypertensive Renal Disease' ranked tenth. The overall death rate from coronary heart disease decreased by 3.5% from 2014-2016 but increased among Black (8.7%) and American Indian/Alaska Native (29.4%) individuals.[1]

Figure 2 – Mortality Rates for Coronary Heart Disease

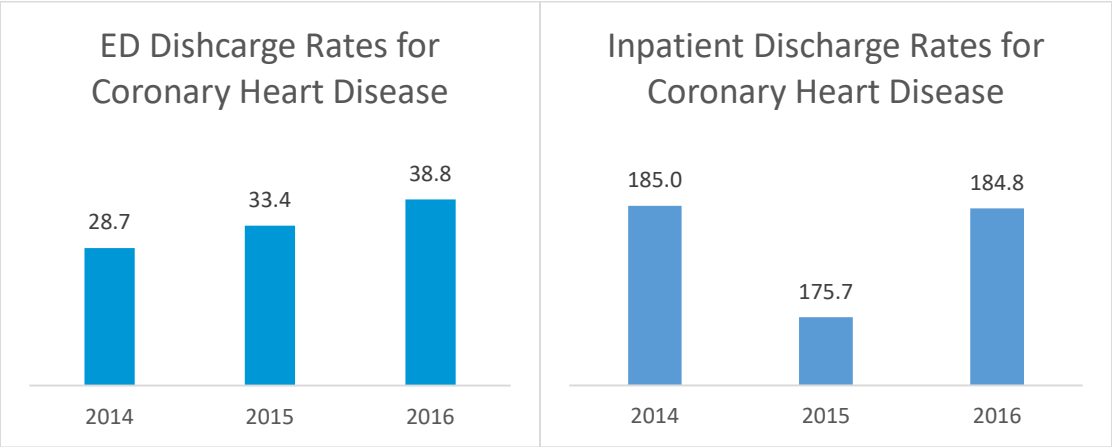


According to data presented in the Scripps 2016 CHNA, high blood pressure, high cholesterol and smoking are all risk factors that could lead to cardiovascular disease and stroke. About half of all Americans (47 percent) have at least one of these three risk factors. Additional risk factors include alcohol use, obesity, physical inactivity, poor diet, diabetes and genetic factors (CDC, 2015).

[1] County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html

Rates of ED discharge for *Coronary Heart Disease* increased by 35.3% from 2014-2016. The steepest increases were for those 45-64 years old (41.9%) and Asian/Pacific Islanders (55.1%). Inpatient discharge rates decreased slightly (by 0.1%). [2]

Figure 3 – Hospital Discharge Rates for Coronary Heart Disease, 2014-2017



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 Live Foundation. Eric was a healthy Steel 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 which provides free screenings to youth in order to identify cardiac anomalies that may lead to SCA, with the ultimate goal of standardizing cardiac screenings among the youth. This program helps 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 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.

[2] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Sudden cardiac arrest is the leading cause of death on school campuses and the number one killer of student athletes. While studies show that 1 in 300 youth has an undetected heart condition, heart screenings are not part of regular well-child exams or pre-participations sports physicals, even though the first symptom of sudden cardiac arrest could be death. Free youth heart screenings provided by the Eric Paredes Save A Life Foundation are non-invasive and include a cardiac risk assessment, and EKG, a consultation with a cardiologist and if indicated, an echocardiogram. Since 2010, the foundation has screened 29,610 youth, finding 476 with cardiac abnormalities requiring follow-up serious enough to put the youth at risk for sudden cardiac arrest. In 2018, 81 percent of youth screened participated in school or community sports programs. More than half of youth screened represent diverse ethnicities, while 39% were from extremely low to moderate income households. Nearly 250 youth indicated they did not have a regular pediatrician, while four percent were uninsured. Of parents surveyed, 61 percent indicated they were not aware of the need to actively prevent SCA in youth, while unaware of warning signs and risk factors. 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 physician.

Strategies

Scripps partners with local San Diego schools to administer and read electrocardiograms and if warranted an echocardiogram screening by Scripps physicians (cardiologist) before high school students participate in organized sport 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

Table 2 – Results: Eric Paredes Save A Life Foundation

Objective(s): 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.		
Performance Measures	2017	2018
In the total number of adolescent Screenings, 6% of the 4,915 were uninsured adolescents.	3,533	4,915
Total number of adolescents with positive finding of heart abnormalities.	35	32
Total number of high risk adolescents identified.	13	23

2. Adults Screening in Conjunction with the EP Save A Life "Screen Your Teen" Events

Strategies

Scripps Health empowers community members with cardiovascular screenings, education and support. Scripps promotes 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

Table 3 – Results: Adult Screenings: Eric Paredes Save A Life Foundation

Objective(s): Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.		
Performance Measures	2017	2018
Track number of cardio check tests for adults screened	20	36
Track number of adults found at risk	0	8
Track number of referrals	0	8

Challenges

In FY18, Scripps continued to experience some limited staffing resources. The program manager was the only staff person conducting the screening program and his main role was market outreach. We were not able to provide the full lipid panel/glucose screening but blood pressure screenings were conducted.

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

Scripps Health prevents 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 partners 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 assist with the screenings. Metrics are collected via surveys bi-annually and insurance information is collected via surveys at injury clinics. Two injury clinics were held on 8/18/18 and

9/15/18. The sports physicals are conducted once a year before students participate in organized sports. Refer to table 4 for performance measures.

Evaluation Methods and Measurable Targets

Table 4 - Sweetwater Union High School District Pre-Participation Sports Screening Assessment

Objective(s): To prevent Sudden Cardiac Arrest (SAC) and death in South Bay/Chula Vista high school students by increasing education and awareness related to cardiovascular screenings and healthy lifestyles.		
Performance Measures	2017	2018
Total number of youth screened	814	1,025
Number of youth with heart abnormalities	1	2
Percentage of individuals that are underserved *(based on enrollment in school lunch program)*	51.9%	51.9%
Number of injury clinics held during football season. Dates: 8/18/18 and 9/15/18	2	2

4. Su Corazon, Su Vida / Your Heart, Your Life – Scripps Mercy Hospital, Chula Vista

Scripps Health supports 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, and underserved community along the US/Mexico border region.

Strategies

Scripps implements 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 are followed up weekly via phone for five consecutive weeks. These calls are focused on motivational support and encouragement. An educational packet is given to support the initial educational seminar that includes information from the *Your Heart, Your Life* curriculum. Refer to table 8 for performance measures

Evaluation Methods and Measurable Targets

- Participants receive an initial heart health educational session that includes review of daily-self assessment, salt avoidance, and exercise and medication adherence.
- Outcomes explored include decreased hospitalizations and improved biometric measures including weight and blood pressure pre and post.

- Readmissions related to heart failure are tracked in each participant. (The number of times a patient is admitted to the hospital for a condition related to heart disease is tracked over the course of the intervention).
- Each participant is given a “Health Habits” pre-test and post-test to measure behavior change.

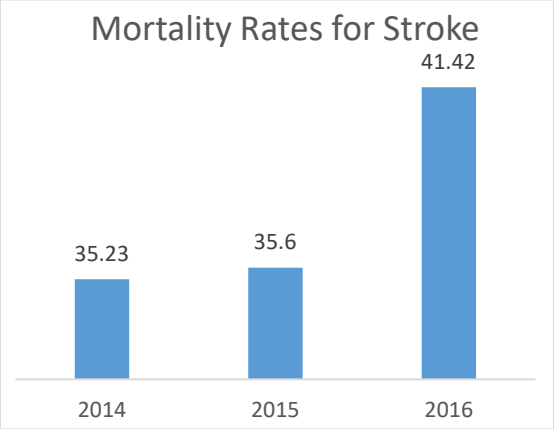
Table 5 - Su Corazon, Su Vida – Your Heart, Your Life

Objective(s): Empower Latina women to manage their heart health through a community intervention program which decreases the readmission rates for heart failure patients and improves their quality of life in the underserved population in South Bay, San Diego, and underserved communities along the U.S./Mexico border region.					
Performance Measures		2017		2018	
Number of initial Heart Health Education participants		66		33	
Overall Unhealthy Behavior		Pre	Post	Pre	Post
		21%	11%	81%	19%
Overall Healthy Behavior		Pre	Post	Pre	Post
		79%	98%	69%	31%
Pre	Post	178.5	177.3	171.3	170.3
Pre	Post	134/75	132/75	126/77	125/76
Number of Heart Failure Readmissions		2		9	

5. Stroke Risk Program

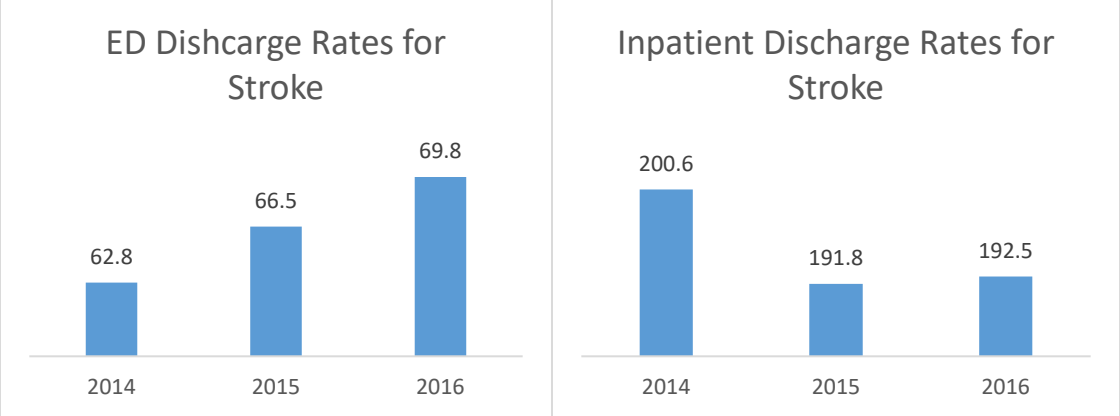
Stroke was the fourth leading cause of death in San Diego County in 2016. Death rates for stroke increased by 17.6% from 2014–2016. The increase was steepest for Hispanics (28.5%).[3]

Figure 4 – Mortality Rates for Stroke, 2014-2016



Rates of ED discharge for *stroke* increased by 11.0% from 2014–2016. The steepest increases were for those 27–44 (20%) and for people who identify their race as "Other" (28.9%). Rates of Inpatient discharge for stroke decreased by 4.1%.[4]

Figure 5 – Hospital Discharge Rates for Stoke



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

[3] County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html

[4] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

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 educates and engages 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 emergency room physician and was designed to be an integral part of training package for ambulance staff. The FAST test is an 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 **F**acial drooping, **A**rm weakness, **S**peech difficulties and **T**ime.

- **F**acial 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.
- **A**rm weakness: The inability to raise one's arm fully.
- **S**peech difficulties: An inability or difficulty to understand or produce speech.
- **T**ime: If any of the symptoms above are showing, time is of the essence, call the emergency services or go to the hospital.

In FY18, The Scripps Stroke Team and their community partners worked on the vision to make San Diego a heart attack 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 stroke. The following are the events the Stroke Team participated in:

Annual Coronado Fire Department Open House

The Scripps Health Stoke Team participated in the Coronado Fire and Police Departments annual open house. Stroke Team members provided community outreach through stroke risk screenings as well as education on stroke to the public. Informational provided to the community included education on stroke signs and symptoms, risk factors, healthy life style promotions, and calling 911 for someone with symptoms of stroke.

This event was held at the Coronado Fire Department. The event is open for all San Diego County residents to attend but primarily serves residents of Central San Diego City and those on Coronado Island.

Annual Imperial Beach Fire Department Open House

The Scripps Health Stoke Team participated in the Imperial Beach Fire Department's annual open house. Stroke Team members provided community outreach through stroke risk screenings as well as education on stroke to the public. Informational provided to the community included education on stroke signs and symptoms, risk factors, healthy life style promotions, and calling 911 for someone with symptoms of stroke.

This event was held at the Imperial Beach Fire Department. The event is open for all San Diego County residents to attend but primarily serves residents of Southern and South Bay San Diego City.

Strike Out Stroke

Strike Out Stoke is a national fundraising and community awareness campaign to educate the public about the urgency as well as the signs and symptoms of stroke. The simple mission of Strike Out Stroke is to spread the F.A.S.T message across the country and greatly increase the number of stroke survivors who get to the hospital in time to get life-saving treatment. The San Diego event was held on April 18th, 2018 in collaboration with the San Diego County Stroke Consortium in which donors attend a game at PETCO Park to see the Padres play. The Stoke Team had an informational booth that provided community outreach through stroke risk screenings and education on stroke. Education included signs and symptoms of stroke, risk factors, healthy life style promotions, and calling 911 for someone with symptoms of stroke.

This event was held at PETCO Park in Downtown San Diego. The event is open for all San Diego County residents that buy a ticket and attend the baseball game. Although the event is in downtown San Diego given the nature of the event the population served is generalized county wide.

Evaluation Methods and Measureable Targets

Table 6– Stroke Risk Factor Program

Objective(s): 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 attacks and strokes.		
Performance Measures	2017	2018
Total number of community events	5	3
Total number of completed risk factor score cards	118	117
Number of high risk individuals identified	31	11
Number of referrals made	15	11
Number of individuals that are uninsured/underserved	13	0

Throughout the three events 11 individuals were identified as high risk for stroke. This is a decrease from 31 in FY17. The largest difference between the two fiscal years occurred at the Imperial Beach Fire Department event where, although a similar number of individuals were screened for risks there was a significant decrease in the number identified as high risk. The reason for the decrease is unknown but may be related to the population attending the event or increased awareness regarding stroke throughout the county.

For FY18, 11 referrals were made throughout the three events, which is a few less than FY17. This may be due to the fact that there were two fewer events in FY18 than in FY17 when the additional referrals occurred.

There is also a noticeable difference in the number of identified uninsured individuals between FY17 and FY18. FY18 had zero reported uninsured individuals screened, including at the event where the majority of high risk individuals are identified, whereas FY17 had 13 uninsured individuals identified. The reason for the difference is unknown. The response by the individual to the question of insurance at the time of screening is voluntary and so the number of uninsured individuals screened may be inaccurate. The difference may also be related to the population of attendees or stroke awareness throughout the county.

Cardiovascular Programs Broken Out By Hospital

Scripps Encinitas, Green, La Jolla and Mercy Hospitals

1) Eric Paredes Save A Life Foundation (Screenings)
2) Adult Screening in Conjunction with EP Save A Life Screen you Teen Events
3) Sweetwater Union High School District Pre-participation Sports Screening Assessments (Mercy Chula Vista)
4) Su Corazon, Su Vida (Mercy Chula Vista)
5) Stroke Risk Factor Program

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
Mission Hills High School • Number of teens screened — **860** • Number of teens with heart abnormalities — **13** • Number of teens found at risk — **6** • Number of uninsured — **4%** (According to survey of onsite parents.) • Number who do not have a pediatrician — **26** • Number who check they use a community clinic — **26** • *Families that surveyed as extremely low to moderate income — **54%** (According to survey of onsite parents.)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the Sand Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
MISSION HILLS HIGH SCHOOL • Number of blood pressure screenings – **25**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Green Hospital
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
DEL NORTE HIGH SCHOOL • Number of teens screened — **720** • Number of teens with heart abnormalities — **4** • Number of teens found at risk — **6** • Number of uninsured — **4%** (According to survey of onsite parents.) • Number who do not have a pediatrician — **20** • Number who check they use a community clinic — **28** • *Families that surveyed as extremely low to moderate income — **17%** • (According to survey of onsite parents.)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the San Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Green Hospital
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
DEL NORTE HIGH SCHOOL • Number of blood pressure screenings — *No adult screenings were conducted due to resources.*	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
UNIVERSTY OF CALIFORNIA SAN DIEGO • Number of teens screened — **540** • Number of teens with heart abnormalities — **0** • Number of teens found at risk — **1** • Number of uninsured – **16%** (according to survey of onsite parents) • Number who do not have a pediatrician — **36** • Number who check they use a community clinic — **34** • * Families that surveyed as extremely low to moderate income — **95%** (According to survey of onsite parents)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the Sand Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult Screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
UNIVERSITY OF CALIFORNIA SAN DIEGO • Number of blood pressure screenings — **0** *No adult screenings were conducted due to resources.*	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
TORREY PINES HIGH SCHOOL • Number of teens screened — **867** • Number of teens with heart abnormalities — **4** • Number of teens found at risk — **5** • Number of uninsured **— 4%** (according to survey of onsite parents) • Number who do not have a pediatrician **— 29** • Number who check they use a community clinic **— 31** • * Families that surveyed as extremely low to moderate income — **15%** (According to survey of onsite parents)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the Sand Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult Screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
TORREY PINES HIGH SCHOOL • Number of blood pressure screenings — **10**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Mercy Hospital
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
Otay Ranch High School • Number of teens screened — **750** • Number of teens with heart abnormalities — **10** • Number of teens found at risk — **1** • Number of uninsured — **6%** (according to survey of onsite parents) • Number who do not have a pediatrician — **53** • Number who check they use a community clinic — **34** • * Families that surveyed as extremely low to moderate income — **65%** (According to survey of onsite parents)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the Sand Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult Screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Mercy Hospital
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
OTAY RANCH HIGH SCHOOL • Number of blood pressure screenings — **0** *No adult screenings were conducted due to resources.*	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Mercy Hospital
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
PATRICK HENRY HIGH SCHOOL • Number of teens screened — **566** • Number of teens with heart abnormalities **— 5** • Number of teens found at risk **— 2** • Number of uninsured **— 2%** (according to survey of onsite parents) • Number who do not have a pediatrician **— 21** • Number who check they use a community clinic **— 10** • * Families that surveyed as extremely low to moderate income **— 25%** (According to survey of onsite parents)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the Sand Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult Screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Mercy Hospital
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
PATRICK HENRY HIGH SCHOOL • Number of blood pressure screenings — **0** *No adult screenings were conducted due to resources.*	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Eric Paredes Save A Life Foundation (Screenings)**
Hospital Site	Scripps Mercy Hospital
Partners	Local Schools Countywide
Objective: To prevent sudden cardiac arrest and death in high school aged children, including underserved areas in San Diego County through awareness, education and action.	
Action Items: Partner with local San Diego high schools to administer and read electrocardiograms and if warranted an echocardiogram screening by a Scripps physician (cardiologist) before high school students participate in organized sports and activities.	
Evaluation Methods and Measurable Targets	
SOUTHWEST HIGH SCHOOL • Number of teens screened **— 612** • Number of teens with heart abnormalities — **6** • Number of teens found at risk **— 3** • Number of uninsured **— 7%** (according to survey of onsite parents) • Number who do not have a pediatrician **— 75** • Number who check they use a community clinic **— 89** • * Families that surveyed as extremely low to moderate income **— 64%** (According to survey of onsite parents)	

*The majority of students in the San Diego Unified School District meet the poverty guidelines. 153 schools in the Sand Diego Unified School District receive Federal Title I funds as set forth in the Elementary and Secondary Act (ESEA). Title I Elementary and Secondary Education Act (ESEA) School is defined as a school enrolling at least 40 percent of children from low-income families.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Adult Screenings** in conjunction with Eric Parades Save A Life "Screen Your Teen" Event
Hospital Site	Scripps Mercy Hospital
Partners	Local Schools Countywide
Objective: Empower community members with cardiovascular screenings, education and support. Promote accountability and behavior change through education on chronic disease self-management.	
Action Items: 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" events.	
Evaluation Methods and Measurable Targets	
SOUTHWEST HIGH SCHOOL • Number of blood pressure screenings — **0** *No adult screenings were conducted due to resources.*	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease & Stroke*

Program Name	**Sweetwater Union High School District Pre-Participation Sports Screening Assessment**
Hospital Site	Scripps Mercy Hospital
Partners	Southwest Sports Foundation Scripps Family Medicine Residency Sweet Water Union High School
Objective: Prevent sudden cardiac arrest (SCA) and death in South Bay/Chula Vista high school students by increasing education and awareness related to cardiovascular screenings and healthy lifestyles.	
Action Items: 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.	
Evaluation Methods and Measurable Targets	
1. Cardiac Screenings • Total number of youth screened — **1025** • Number of youth with heart abnormalities — **2** • Number of referrals made **— 2** • Percentage of individuals that are underserved — **52% (***based on enrollment in school lunch program.)* ***2.*** **Injury Clinics** • Number of injury clinics held during football season — **2** Clinics were held on 8/11/18 and 9/15/18.	

*In order to qualify for school lunch program students must meet the low-income criteria.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease*

Program Name	**Su Corazon, Su Vida – Your Heart, Your Life**
Hospital Site	Scripps Mercy Hospital
Partners	Local South Bay clinics. Scripps Whittier Institute for Diabetes. Center for Disease Control (CDC). National Heart, Lung, Blood Institute.
Objective: Empower Latina women to manage their heart health through a community intervention program which decreases the readmission rates for heart failure patients and improves their quality of life in underserved population in the South Bay San Diego, and underserved community along the U.S./Mexico border region.	
Action Items: 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 are followed up weekly via phone for five consecutive weeks. These calls will be focused on motivational support and encouragement. 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.	
Evaluation Methods and Measurable Targets	
Participants receive an initial health educational session that includes a review of daily-self assessment, salt avoidance, medication adherence and exercise. Outcomes explored include decreased hospitalizations and improved **biometric measures** including weight and blood pressure pre and post. **Continued on next page**	

Readmissions related to heart failure are tracked in each participant. (The number of times a patient is admitted to the hospital for a condition related to heart disease was tracked over the course of the intervention). Each participant is given a "Health Habits" pre-test and post-test to measure behavior change.

- Number of Initial Heart Health Education Participants — **33**
- Baseline Health Habit Pre-Test — **81%** overall unhealthy behaviors — **19%** overall healthy behaviors
- Baseline Health Habit Post-Test — **99%** of participants maintained or improved behaviors.
- Average Pre/Post Weight (after 12-month period) Pre- **171.3 lbs**. — Post **170.3 lbs**.
- Average Pre/Post Blood Pressure – Pre **126/77** — Post **125/76**
- Number of Heart Failure Readmissions — **1**

Scripps

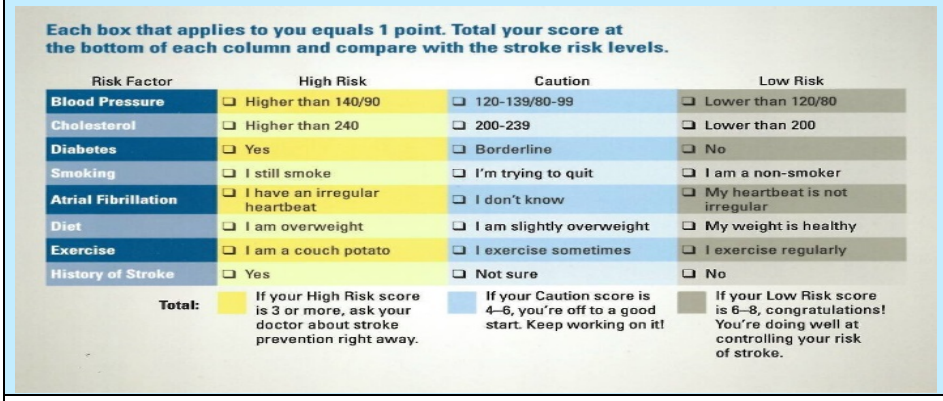
Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease & Stroke*

Program Name	**Stroke Risk Factor Program**
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Strike Out Stroke Event – Partnered with the San Diego County Stroke Consortium and the San Diego Padres.

Objective: Stroke is the fourth leading cause of death in San Diego County. 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 San Diego County 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 attacks and strokes.

Action Items: 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.



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	High Risk	Caution	Low Risk
Blood Pressure	❑ Higher than 140/90	❑ 120-139/80-99	❑ 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
Atrial Fibrillation	❑ 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
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 good start. Keep working on it!	If your Low Risk score is 6–8, congratulations! You're doing well at controlling your risk of stroke.

The acronym stands for—
Facial drooping,
Arm weakness,
Speech difficulties
Time.

Evaluation Methods and Measurable Targets

No events were conducted in this region due to limited resources.

Scripps

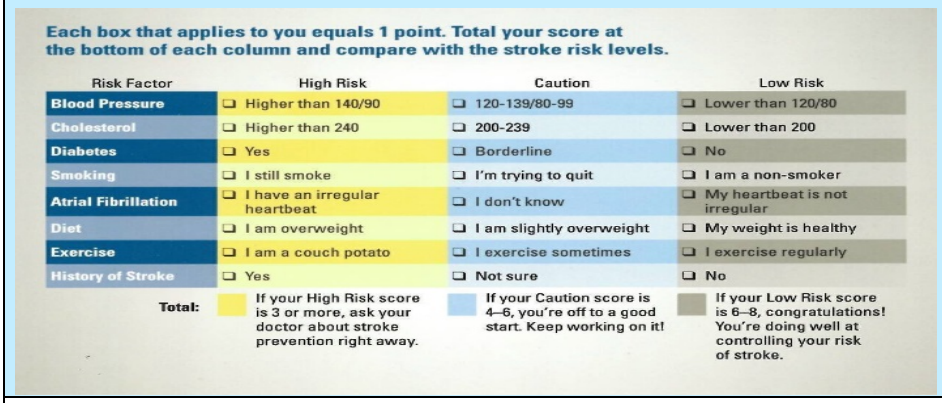
Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease & Stroke*

Program Name	**Stroke Risk Factor Program**
Hospital Site	Scripps Green Hospital
Partners	Be There San Diego.

Objective: Stroke is the fourth leading cause of death in San Diego County. 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 San Diego County 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 attacks and strokes.

Action Items: 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.



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	High Risk	Caution	Low Risk
Blood Pressure	❑ Higher than 140/90	❑ 120-139/80-99	❑ 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
Atrial Fibrillation	❑ 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
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 good start. Keep working on it!	If your Low Risk score is 6–8, congratulations! You're doing well at controlling your risk of stroke.

The acronym stands for—
Facial drooping,
Arm weakness,
Speech difficulties
Time.

Evaluation Methods and Measurable Targets

No events were conducted in this region due to limited resources.

Scripps

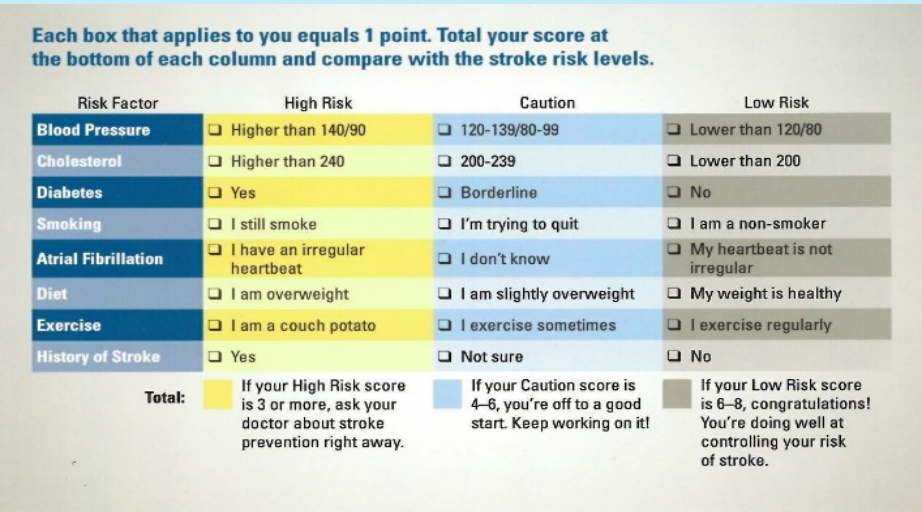
Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease & Stroke*

Program Name	**Stroke Risk Factor Program**
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Strike Out Stroke Event partners with the San Diego County Stroke Consortium and San Diego Padres

Objective: Stroke is the fourth leading cause of death in San Diego County. 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 San Diego County 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 attacks and strokes.

Action Items: 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.



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	High Risk	Caution	Low Risk
Blood Pressure	❑ Higher than 140/90	❑ 120-139/80-99	❑ 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
Atrial Fibrillation	❑ 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
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 good start. Keep working on it!	If your Low Risk score is 6–8, congratulations! You're doing well at controlling your risk of stroke.

The acronym stands for—
Facial drooping,
Arm weakness,
Speech difficulties
Time.

Continued on next page

Evaluation Methods and Measurable Targets
Strike Out Stroke • Total number of completed risk factor scored cards **— 27** • Number of high risk individuals identified — **0** • Number of referrals made — **0** • Number of individuals that uninsured/underinsured — **0**

Scripps

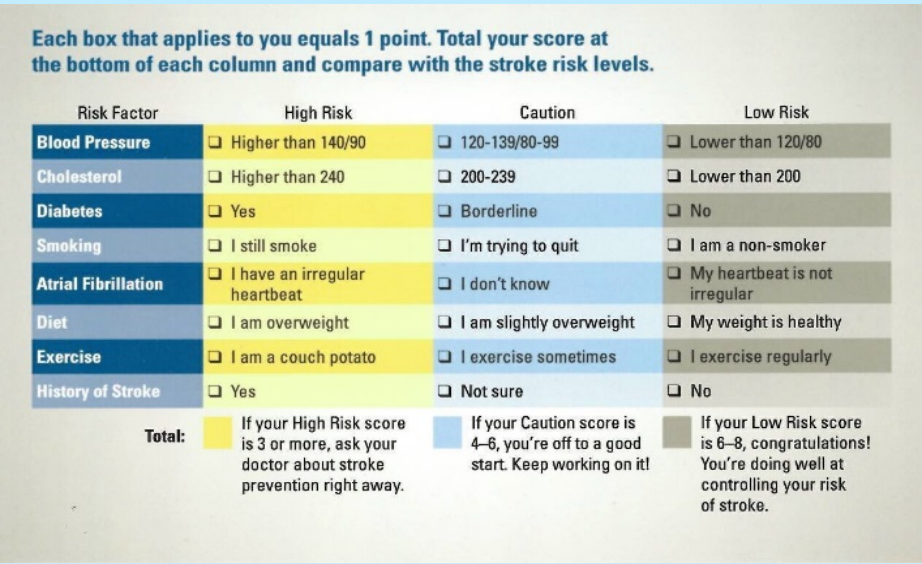
Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Cardiovascular Disease & Stroke*

Program Name	**Stroke Risk Factor Program**
Hospital Site	Scripps Mercy Hospital
Partners	Coronado Fire Department. Imperial Beach Fire Department. County of San Diego.

Objective: Stroke is the fourth leading cause of death in the San Diego County. 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 San Diego County 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 attacks and strokes.

Action Items: 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.



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	High Risk	Caution	Low Risk
Blood Pressure	❑ Higher than 140/90	❑ 120-139/80-99	❑ 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
Atrial Fibrillation	❑ 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
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 good start. Keep working on it!	If your Low Risk score is 6–8, congratulations! You're doing well at controlling your risk of stroke.

The acronym stands for—
Facial drooping,
Arm weakness,
Speech difficulties
Time.

Continued on next page

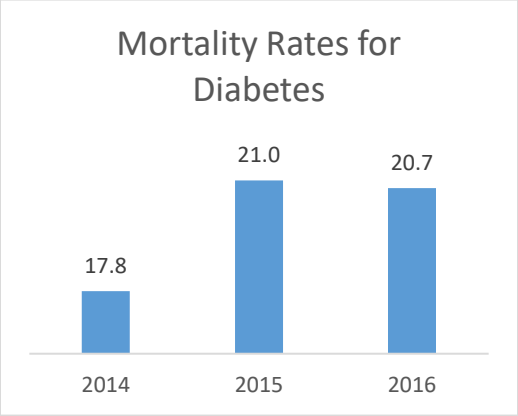
Evaluation Methods and Measurable Targets
Coronado Fire Dept Open House • Total number of completed risk factor scored cards **— 52** • Number of high risk individuals identified **— 9** • Number of referrals made **— 9** • Number of individuals that uninsured/underinsured — **0** **Imperial Beach Fire Dept Open House** • Total number of completed risk factor scored cards **— 38** • Number of high risk individuals identified **— 2** • Number of referrals made **— 2** • Number of individuals that uninsured/underinsured **— 0**

Diabetes (Type 2)

There are 29 million people with diabetes in the United States and 382 million worldwide, and the rates are the 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 prediabetes and at high risk of developing diabetes. A summary of the magnitude and prevalence of diabetes is described below.

Diabetes is an important health need because of its prevalence and its potential to have a devastating impact on morbidity and mortality. Diabetes is also largely preventable; rates of diabetes are, therefore, potentially amenable to health promotion efforts. Diabetes was the seventh leading cause of death in San Diego County in 2016. The age-adjusted death rate for diabetes increased 16.3% from 2014–2016. Increases were steepest for Hispanics (53.0%) and those who identify as “Other” (35.0%).[5]

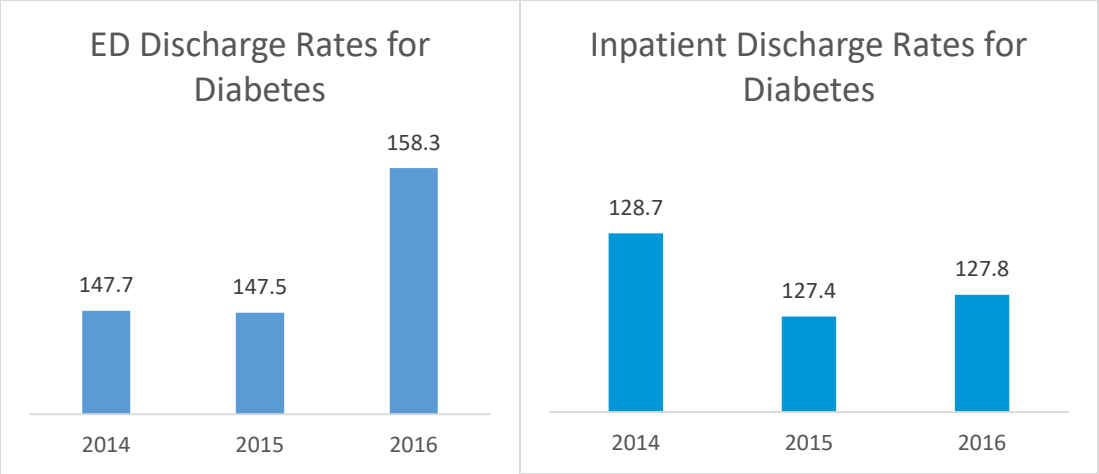
Figure 6 – Mortality Rate for Diabetes in San Diego County



[5] County of San Diego Health and Human Services Agency Public Health Services, Regional & Community Data. https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html

In San Diego County, in 2017, 9.4% of adults had diabetes.[6] ED discharges for diabetes increased 7.2% stable from 2014–2016; increases in discharge rates were highest (13.9%) or those 27– 44 years old and for Asian/Pacific Islander (16.3%) and Black individuals (15.1%). Inpatient discharge rates for diabetes decreased slightly (0.7%) from 2014–2016 but increased for Asian/Pacific Islanders (28.6%) and for people 11–17 years old (15.7%) and for people 18–26 years old (28.8%).[7]

Figure 7– Discharge Rates for Diabetes



During focus groups, health care personnel working in clinics and hospital settings discussed diabetes and its management as one of the “biggest health issues” they face; they also indicated that the public seems unaware about how to prevent the onset of diabetes. Community residents also identified diabetes management as a significant health problem for San Diego County. In particular, the cost of insulin was cited as a significant barrier to care for diabetes management, and because insulin needs to be refrigerated, diabetes management was noted as especially challenging for those without a refrigerator, such as those who are homeless.

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 7.

[6] California Health Interview Survey, 2013 to 2017, UCLA Center for Health Policy Research. California Health Interview Survey, 2013 to 2017, UCLA Center for Health Policy Research. Rates indicate the percentage of people who had a diagnosis of diabetes in 2017.

[7] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

Table 7 – Summary of Community Input on Common Diabetes (Type 2) Issues, HASD&IC 2016 CHNA

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

**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 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 improved 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 provides 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 is 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 saving 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 Measureable Targets

Table 8 – The Scripps Diabetes Care Retinal Screening Program

Objective(s): Improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population.		
Program Measures	**2017**	**2018**
Total Screening Events	24	25
Total Patients Screened	542	534
Percentage of Positive Screens	28%	33.5%
Percentage of individuals referred to Primary Care Physician	100%	100%
Percentage of individuals referred to Retinal Specialist	6%	5.8%

Challenges

One of the successes of the retinal screening program is having a solid relationship with a clinical partner for follow up and providing referrals for individuals found at risk. Without this link to a clinical home we risk patients not having navigation to treatment. In FY18, Scripps continued to experience some limited staffing resources. The program manager was the only staff person conducting the screening program. His main role was market outreach and currently he is only allocated 16 hours a month to the retinal program. Therefore, screenings were only held at Encinitas, La Jolla and Mercy hospitals for FY18.

2. Project Dulce Care Management

The Project Dulce program has been fighting the diabetes epidemic for more than 20 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 the 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 improves self-management education for underserved population living with diabetes. It offers a comprehensive, culturally sensitive diabetes self-management program for underserved and uninsured populations. These educators, “Promotoras”, 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. Refer to table 9 for program measures.

Evaluation Methods and Measurable Targets

Intake Forms/New Patients

Table 9 – Project Dulce Care Management Program

Objective(s): Improve self-management education for underserved population living with diabetes.		
Program Measures	**2017**	**2018**
*Total number of new patients cared for by clinical team.	1,258	5,165

*Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be traced through the Implementation Plan.

While there was a larger increase in people served in FY18 at Mercy Hospital there was a significant decline at the other hospital sites. In FY18 there was an overall reduction of Diabetes Health Educators (DHE’s). An internal strategic decision was made at Scripps Whittier Diabetes Institute to shift resources to Scripps Whittier Diabetes, Diabetes Self-Management Education and Support (DSME) program and as a result the Project Dulce community classes were reduced significantly. In FY18, Scripps adopted the role of Diabetes Health Educator (DHE - community health workers) to deliver T2 DSME programs with its payer population. This resulted in less available staff to continue efforts in the community with Project Dulce classes. In the summer of 2018, two new Diabetes Health Educators were hired. They were officially signed off to teach Project Dulce classes in December, 2018. These new staffing resources will allow the Whittier Diabetes Institute to re-initiate the Project Dulce Community classes. For FY19, an

additional 1.0 FTE DHE will be hired and the Whittier is committed to offering a minimum of 10 Project Dulce class series in FY19.

Pre/Post Survey metrics described on pages 55–68

- Track knowledge of diabetes recommendations
- Track diabetes distress
- Track support for diabetes management
- Track diabetes self-care behaviors (fruit/vegetable consumption, exercise, blood glucose monitoring, medication adherence, foot checks).

3. Medical Assistant Health Coaching (MAC) for Diabetes in Diverse Primary Care Settings – Scripps Hospital Encinitas

Diabetes affects nearly 29 million individuals in the U.S, and if current trends continue, one of three 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.

In 2015, the National Institute of Diabetes and Digestive and Kidney Diseases (NIH/NIDDK) granted Scripps Whittier Diabetes Institute $2.1 million to fund the MAC Trial, which is studying an innovative team care approach that trains medical assistants (MAs) to provide health coaching in the primary care setting to patients with poorly controlled Type 2 diabetes, help them problem solve, and improve their diabetes-related health outcomes. The goals include improving diabetes self-management and clinical outcomes, such as blood glucose levels, cholesterol and blood pressure. The study is being conducted in two diverse settings: a Scripps Health primary care practice, and a community health center, Neighborhood Healthcare. The MAC program offers a potential solution to the burgeoning primary care demand capacity imbalance that can be applied in diverse healthcare setting to better address the needs of the growing number of individuals with Type 2 diabetes management.

Strategies

The program takes place within the 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 Usual Care (UC) (Scripps Coastal Carlsbad, n-150, Neighborhood Healthcare Escondido, n=150). In addition to Usual Care, MAC clinic

patients receive brief, targeted self-management support from the MA Health Coach. The MA incorporates 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, Medical Assistants coordinate brief phone follow-up to review progress and problem-solve barriers. Refer to table 10 for program measures.

Evaluation Methods and Measurable Targets

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

Table 10 – Medical Assistant Health Coaching (MAC)

Objective(s): 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 assistant (MA)) can be trained as health coaches to work in tandem with primary care providers to deliver self-management support.		
Program Measures	**2017**	**2018**
Number of eligible patients	482	489
Number of enrolled patients	59*	34*
Number patients declined	4	7

***Maximum class size is 390. Classes start on different cycles throughout the 12 month period. New patients enroll as openings occur.

Diabetes Programs Broken Out By Hospital

Scripps Encinitas, Green, La Jolla and Mercy

1) Scripps Diabetes Care Retinal Screening Program
2) Project Dulce Care Management[8]
3) Medical Assistant Health Coaching (MAC) (Scripps Encinitas)

[8] While there was a larger increase in people served in FY18 at Mercy Hospital there was a significant decline at the other hospital sites. In FY18 there was an overall reduction of Diabetes Health Educators (DHE's). An internal strategic decision was made at Scripps Whittier Diabetes Institute to shift resources to Scripps Whittier Diabetes, Diabetes Self-Management Education and Support (DSME) program and as a result the Project Dulce community classes were reduced significantly. In FY18, Scripps adopted the role of Diabetes Health Educator (DHE - community health workers) to deliver T2 DSME programs with its payer population. This resulted in less available staff to continue efforts in the community with Project Dulce classes. In the summer of 2018, two new Diabetes Health Educators were hired. They were officially signed off to teach Project Dulce classes in December, 2018. These new staffing resources will allow the Whittier Diabetes Institute to re-initiate the Project Dulce Community classes. For FY19, an additional 1.0 FTE DHE will be hired and the Whittier is committed to offering a minimum of 10 Project Dulce class series in FY19. Therefore, only Scripps Mercy performance measures are presented for the Project Dulce Care Management Program in FY18.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	The Scripps Diabetes Care Retinal Screening Program
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Neighborhood Healthcare — Escondido
Objective: Improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population.	
Action Items: Retinal Screenings: With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program provides low-cost and or free screenings to the community. Scripps partners with either community clinics or not-for-profit organization to read the images and provide the necessary follow up. After the screenings are interpreted, follow-up care is arranged as needed.	
Evaluation Methods and Measurable Targets	
Number of Retinal Screening events and individuals seen: • Number of Events — **21** • Number of Patients — **516** • Percentage of individuals that screen positive **— 34%** • Percentage of individuals that are self-referred to Primary Care Physician **— 100%** • Percentage of Retinal Specialist Referrals **— 6%**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	The Scripps Diabetes Care Retinal Screening Program
Hospital Site	Scripps Green Hospital
Partners	
Objective: Improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population.	
Action Items: Retinal Screenings: With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program provides low-cost and or free screenings to the community. Scripps partners with either community clinics or not-for-profit organization to read the images and provide the necessary follow up. After the screenings are interpreted, follow-up care is arranged as needed.	
Evaluation Methods and Measurable Targets	
• No retinal screenings were conducted due to limited resources.	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	The Scripps Diabetes Care Retinal Screening Program
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	
Objective: Improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population.	
Action Items: Retinal Screenings: With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program provides low-cost and or free screenings to the community. Scripps partners with either community clinics or not-for-profit organization to read the images and provide the necessary follow up. After the screenings are interpreted, follow-up care is arranged as needed.	
Evaluation Methods and Measurable Targets	
Number of retinal screening events and individuals seen: • Number of Events — **3** • Number of Patients — **10** • Percentage of individuals that screen positive — **10%** • Percentage of individuals that are self-referred to Primary Care Physician — **100%** • Percentage of Retinal Specialist Referrals — **0%**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	The Scripps Diabetes Care Retinal Screening Program
Hospital Site	Scripps Mercy Hospital
Partners	Chula Vista Scripps Diabetes Center
Objective: Improve identification of diabetic retinopathy (vision complications because of diabetes) through preventions, early diagnosis and appropriate treatment in the underserved population.	
Action Items: Retinal Screenings: With early diagnosis and appropriate treatment, 95% of blindness can be prevented. The Scripps Diabetes Care Retinal Screening Program provides low-cost and or free screenings to the community. Scripps partners with either community clinics or not-for-profit organization to read the images and provide the necessary follow up. After the screenings are interpreted, follow-up care is arranged as needed.	
Evaluation Methods and Measurable Targets	
Number of Retinal Screening events and individuals see: • Number of Events **— 1** • Number of patients **— 8** • Percentage of individuals that screen positive — **50%** • Percentage of individuals that are self-referred to Primary Care Physician — **100%** • Percentage of Retinal Specialist Referrals — **13%**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	Project Dulce Care Management
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Neighborhood Healthcare — Escondido
Objective: Improve self-management education for underserved population living with diabetes.	
Action Items: 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	
• *Total number of new patients cared for by clinical team – **582** *Does not include retinal screenings.* • **Pre/Post Survey -** While there was a larger increase in people served in FY18 at Mercy Hospital there was a significant decline at the other hospital sites. (See footnote 8 on page 54 for a detailed explanation).	

**Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be tracked through this Implementation Plan.*

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	Project Dulce Care Management
Hospital Site	Scripps Green Hospital
Partners	TBD: Faith Community
Objective: Improve self-management education for underserved population living with diabetes.	
Action Items: 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	
• *Total number of new patients cared for by clinical team – **0** *Does not include retinal screenings* • **Pre/Post Survey -** While there was a larger increase in people served in FY18 at Mercy Hospital there was a significant decline at the other hospital sites. (See footnote 8 on page 54 for a detailed explanation).	

**Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be tracked through this Implementation Plan.*

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	Project Dulce Care Management
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	TBD: Faith Community
Objective: Improve self-management education for underserved population living with diabetes.	
Action Items: 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	
• *Total number of new patients cared for by clinical team – **0** *Does not include retinal screenings* • **Pre/Post Survey -** While there was a larger increase in people served in FY18 at Mercy Hospital there was a significant decline at the other hospital sites. (See footnote 8 on page 54 for a detailed explanation).	

**Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be tracked through this Implementation Plan.*

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	Project Dulce Care Management
Hospital Site	Scripps Mercy Hospital
Partners	TBD: Faith Community
Objective: Improve self-management education for underserved population living with diabetes.	
Action Items: 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	
• *Total number of new patients cared for by clinical team – **559** *Does not include retinal screenings* • **Pre/Post Survey** (See following pages for metrics)	

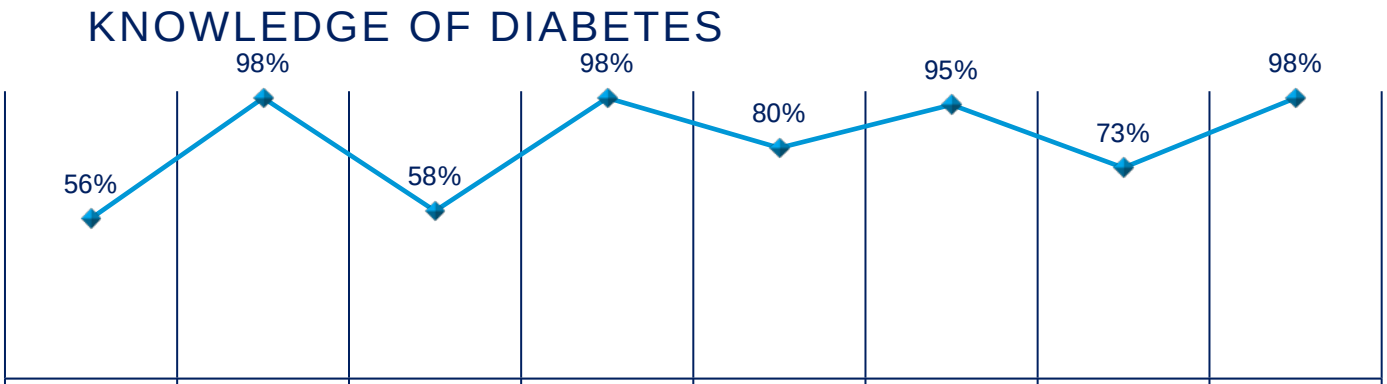
**Individuals with more chronic needs will be referred for the Project Dulce Clinical component and will not be tracked through this Implementation Plan.*

Site: Mercy – Project Dulce Care Management

I. Knowledge of Diabetes Recommendations

Participants were asked four different questions that measured their knowledge of diabetes recommendations prior to starting the Project Dulce series (pre-test) and after completion (post-test). Ideally, we would want to see the percentage (of participants who answered each question correctly) **increase** from the pre-test to the post-test.

Question 1: How does exercise affect your blood?
Question 2: Which is the best way to take care of your feet?
Question 3: What is a retinal exam?
Question 4: Carbohydrates (starches and sweets) break down in your body to what?



	Pre Question 1	Post Question 1	Pre Question 2	Post Question 2	Pre Question 3	Post Question 3	Pre Question 4	Post Question 4
N answered question	61	43	60	43	61	43	60	42
N answered question correctly	34	42	35	42	49	41	44	41
Percentage	56%	98%	58%	98%	80%	95%	73%	98%

Note: *Filling out the survey is voluntary. As a result there can be a variation in sample size of pre/post data.*

Site: Scripps Mercy Hospital—Project Dulce Care Management—Pre/Post Surveys

Diabetes Distress

Participants were asked two different questions that measured their diabetes distress prior to starting the Project Dulce series (pre-test) and after completion of the series (post-test). Ideally, we should want to see the mean response to each of these two questions **decrease** from the pre-test to the post-test since a lower score indicates less diabetes distress.

Question 1: How often in the last week have you felt overwhelmed by living with diabetes?

Question 2: Do you know healthy ways to handle the stress related to diabetes?

Each question is based on a scale of 1 to 5.

Question 1: **1** = Never; **2** = Almost Never; **3** = Sometimes; **4** = Most of the time; **5** = Always

Question 2: **1** = Yes; **2** = Maybe; **3** = I don't know; **4** = I don't think so; **5** = No

Diabetes Distress				
Survey Question	Pre – Q1	Post – Q1	Pre – Q2	Post – Q2
Participants Responding	60	43	59	42
Scale (1-5)	1.7 (almost never)	1.6 (almost never)	2 (maybe)	1.2 (yes)

Site: Scripps Mercy Hospital—Project Dulce Care Management—Pre/Post Surveys

III. Support for Diabetes Management

Participants were asked three questions regarding the support they feel they received for their diabetes management. Participants were asked these questions prior to starting Project Dulce classes (pre-test) and after completion of the series (post-test). Ideally, we would want to see the mean response to each of these questions **decrease**, as a lower score is associated with an increased feeling of support for diabetes management.

Questions were asked on a scale of 1 to 5.

1 = Yes I can, **2** = Maybe I can, **3** = I don't know if I can, **4** = I don't think I can, **5** = No I can't

Question 1: When you need it, do you feel you can ask for support on how to live with and take care of diabetes?

Question 2: Do you feel you can ask your doctor questions about your treatment plan?

Question 3: Do you feel you can make a plan with goals that will help you control your diabetes?

Support for Diabetes Management						
Survey Question	Pre - Q1	Post - Q1	Pre - Q2	Post - Q2	Pre - Q3	Post - Q3
Participants Responding	58	42	59	43	57	42
Scale (1-5)	1.47 (Yes, I can)	1.10 (Yes, I can)	1.22 (Yes, I can)	1.16 (Yes, I can)	1.39 (Yes, I can)	1.07 (Yes, I can)

Site: Scripps Mercy Hospital—Project Dulce Care Management—Pre/Post Surveys

IV. Diabetes Self-Care Behaviors

Participants were asked five question regarding the diabetes self-care behaviors they perform on a weekly basis. These questions were asked prior to starting Project Dulce classes (pre-test) and after completion of the series (post-test). Ideally, we would want to see the mean number of days patients perform these behaviors to **increase** between the pre-test and the post-test since the more often they perform these behaviors, the better.

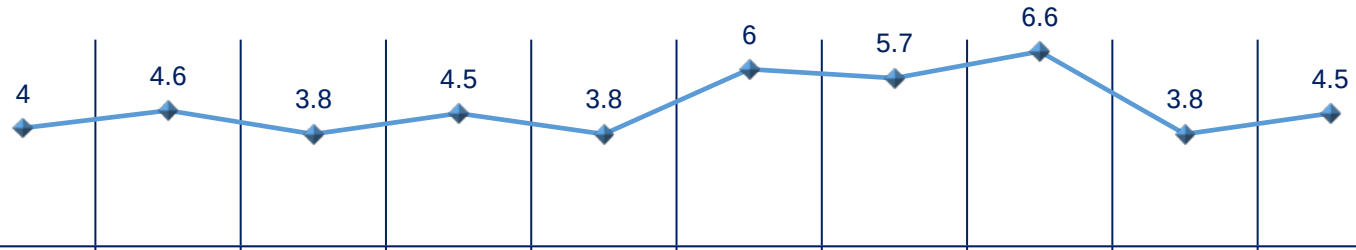
Question 1: In the last week, how many days did you eat three or more servings of vegetables low in carbohydrates?

Question 2: In the last week, how many days did you engage in some type of exercise for at least 30 minutes?

Question 3: In the last week, how many days did you test your blood sugar? (See Note)

Question 4: In the last week, how many days did you take your medications as ordered by your doctor? (See Note)

Question 5: In the last week, how many days did you check your feet?



	Pre Question 1	Post Question 1	Pre Question 2	Post Question 2	Pre Question 3	Post Question 3	Pre Question 4	Post Question 4	Pre Question 5	Post Question 5
N = answered question	59	43	58	41	34	22	30	20	59	40
Mean number of days	4	4.6	3.8	4.5	3.8	6	5.7	6.6	3.8	4.5

Note: *1.Anyone who marked that they "do not check blood sugar" or "do not take diabetes medication" were excluded from analyses, which is why the N value for these questions may be significantly smaller.*

2. Filling out the survey is voluntary. As a result there can be a variation in sample size of pre/post data.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Diabetes*

Program Name	Medical Assistant Health Coaching (MAC)
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Neighborhood Health Care — FQHC. San Diego State University.

Objective: One of every 3 U.S. 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 assistant (MA)) 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 health care setting to better address the needs of the growing number of individuals with Type 2 diabetes management.

Action Items: The program takes place within primary care clinics of two health systems that serve large, ethnically/racially, and socioeconomically diverse populations in San Diego County: Neighborhood Healthcare (AFQHC) and Scripps. One clinic within each system is designated to MAC (Scripps Encinitas, n=150; Neighborhood Healthcare Temecula, n-150), and on to Usual Care (UC) (Scripps Coastal Carlsbad, n-150; Neighborhood Healthcare Escondido, n=150).

In addition to usual care, MAC clinic patients receive brief, targeted self-management support from the MA Health Coach. The MA incorporates 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 coordinate brief phone follow-up to review progress and problem-solve barriers.

Continued on next page

Evaluation Methods and Measurable Targets
Electronic health records were used to identify eligible patients and to examine changes in clinical outcomes over 12 months. Phone surveys were 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: **<u>Track number of Patients</u>** • Eligible — **489** • Enrolled — **34*** • Declined — **7**

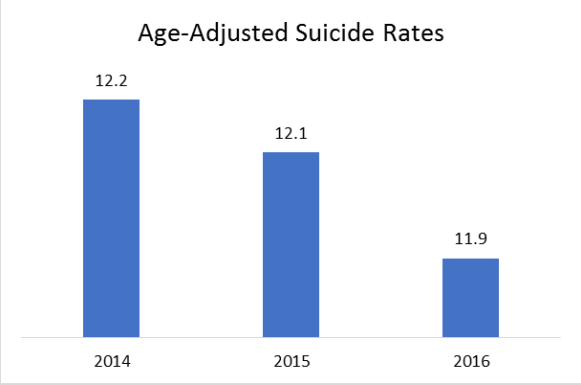
*Maximum class size is 390. Classes start on different cycles throughout the 12 month period. New patients enroll as openings occur.

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.

An analysis of mortality data in San Diego County found that in 2016, intentional self-harm (suicide) was the ninth leading cause of death. In 2016, the age-adjusted suicide rate in San Diego was 11.9 per 100,000. Rates were highest among Whites (18.7), followed by Blacks (11.5), Asian Pacific Islanders (8.2) and Hispanics (5.3). While the rate of suicide decreased slightly (1.3%) from 2014–2016, the rates of suicide for people who identify as Asian/Pacific Islander, Black, and “other,” increased in those same years by 13.3%, 47.2%, and 93.0% respectively.[9]

Figure 8 – Age Adjusted Suicide Rates in San Diego County

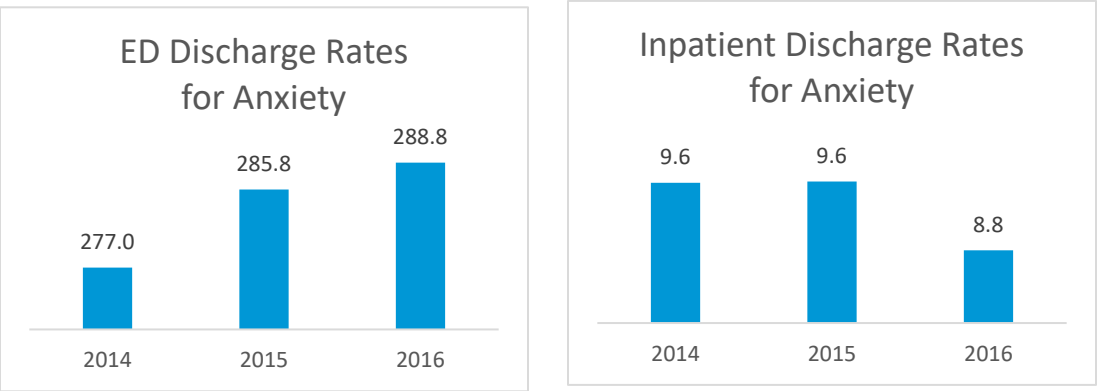


Mental health issues affect nearly 1 in 5 people, and when left untreated, are a leading cause of disability, are associated with chronic disease, and may lead to premature mortality. In San Diego County, 12.4 people per every 100,000 die from suicide annually, and approximately 10% of all adults seriously consider committing suicide. While the rate of suicide decreased slightly (1.3%) from 2014–2016, the rates of suicide for people who identify as Asian/Pacific Islander, Black, and “other,” increased in those

[9] Live Well San Diego. Live Well San Diego Data Access Portal. Injury. https://data.livewellsd.org/

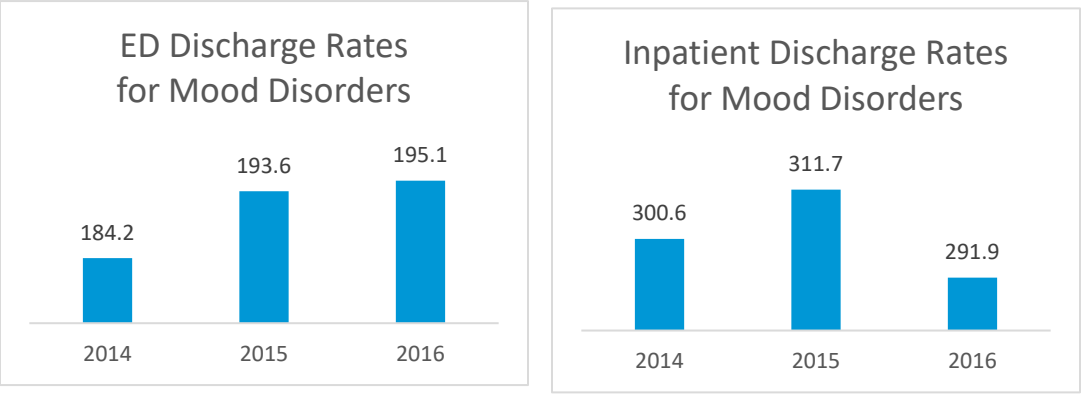
same years (13.3%, 47.2%, 93.0%). In addition, more people are being discharged emergency departments for anxiety than in the past – rates increased by 4.3% between 2014–2016, while rates of inpatient discharges for anxiety decreased by 7.9% during the same time period. People who identify as "other race" and Black/African American had the highest rates of ED and hospital discharge for anxiety.[10]

Figure 9 – Hospital Discharge Rates for Anxiety



ED discharges for mood disorders also increased (5.9%) from 2014–2016, while inpatient discharges for mood disorders decreased by 2.9%. Discharge rates for mood disorders were higher for people who identify their race as Black/African American than for any other race.[11]

Figure 10 - Hospital Discharge Rates for Mood Disorders



In the community engagement process, residents described the desperation of people who need but cannot get quality, timely mental health services; they emphasized that while accessing services is hard for everyone, for people who may be at the highest risk

[10] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©
[11] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

for trauma related mental illness – like veterans, refugees, and the LGBTQ community, and for those who are uninsured, access to this care seems nearly impossible.

Substance and opioid misuse. Substance use, particularly opioid misuse, is a health crisis that has reached epidemic proportions both nationally and locally. In San Diego County, ED discharges for opioid misuse increased by 267.2% from 2014–2016, while inpatient discharges increased by 239.3%. The steepest increases in both discharge rates were among people 65+, who experienced a 1,734.4% increase in ED discharges and an 863.1% increase in hospital discharges.[12]

Heavy alcohol consumption is also problem in San Diego County. Nearly 20% of adults ages 18 and older self-report excessive alcohol use. Participants in the community engagement process discussed the link between mental health and substance misuse, arguing that the failure to provide preventive and acute mental health services often leads to self-medicating with drugs and alcohol. They also an insufficient supply of substance use disorder outpatient and in-patient drug treatment programs as a critical need in San Diego County.

Community input was also collected on the most common health issues that contribute significantly to overall morbidity through key informant interview and community partner discussion. The results for behavioral health are summarized in Table 11.

Table 11 – Summary of Community Input on Common Behavioral Health Issues, HASD&IC 2016 CHNA

Summary of Behavioral Health-Related Responses*	
1. What are the most common health issues or needs?	
Anxiety	Lack of training in schools
Behavioral health affects all other diseases	Problems with compliance/coverage
Depression	Self-injury/suicidal ideation in youth
Dementia and Alzheimer's in seniors	Smoking
Homelessness	Social media/bullying
Increase in developmental disorders in children	Stress
Lack of psychiatrists	Substance Abuse — Drugs/alcohol

**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

[12] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. 2014-2016. SpeedTrack©

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) helps to accurately access patients and provide them with the 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 the individual's health. Scripps will continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and urgent care settings (Ranch 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 is retrieved from the Midas Data Base, for all patients seen by the Psychiatric Liaison Team. Refer to table 12 for program measures.

Table 12 – Psychiatric Liaison Team (PLT)

Objective(s): The Psychiatric Liaison Team will help to accurately assess patients and provide them with the best and safest community resources in order to enhance the continuity of care for every patient.		
Programs Measures	2017	2018
Number of encounters (visits) referred to inpatient **setting**		
a. Discharge/ Transfer from ED to Mercy Behavioral Health Unit	1,227	1,233
b. Other Non-Scripps Inpatient Facilities	101	51
c. Crisis Residential Placement	37	1
	2017	2018
Number of encounters (visits) referred to an outpatient **setting**		
a. Patient given outpatient referrals	678	486
b. Family Health Centers	11	17
c. Outpatient Psychiatrist	74	43
d. Detox	17	14
e. Shelter	16	20

2. Scripps Drug and Alcohol Resources Nurses

Through a contract with 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. Note: Scripps will not be contracting with Volunteers of America in 2019 and will be looking to partner with other organizations. 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 on characteristics of an addicted patient as well as specific diagnosis common to those with substance abuse.

Strategies

Patients presenting with mental health, drug and alcohol complications are identified to the appropriate level of care including community clinics. Providers 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 the need to best manage their behavioral health. An enhanced case management approach is used, promoting intensive coordination and communication with Scripps staff. Refer to table 13 for program measures.

Table 13 – Scripps Drug and Alcohol Resource Nurse

Objective(s): Patients presenting with mental health, drug and alcohol abuse 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 uninsured or underinsured.		
Program Measures	2017	2018
Number of referrals sent to Volunteers of America (VOA)	110	73

3. Mi Puente: "My Bridge" to Better Cardiometabolic Health and Well Being Scripps Mercy Hospital, Chula Vista

Scripps Whittier Diabetes Institute received a $2.4 million study grant from the NIH's National Institute of Nursing Research in 2015 to evaluate Mi Puente, a program at Scripps Mercy Chula Vista hospital that uses a "nurse + volunteer" team approach to help hospitalized Hispanic patients with multiple chronic diseases reduce their hospitalizations and improve their day-to-day health and quality of life.

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 striking disparities in disease prevalence and outcomes.

A behavioral health nurse provides in-hospital coaching to patients, who are then followed after discharge by a volunteer community peer mentor to assist them in overcoming barriers that may interfere with achieving and maintaining good health.

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 compares Mi Puente ("My Bridge", n=260) in a total of 560 Hispanic adults, hospitalized with multiple cardiometabolic conditions and 1+ behavioral health concern(s) at Scripps Mercy Chula Vista. A thorough evaluation of this program will not be evaluated until the end of the study which will in 2020 when the program will be completed. The evaluation is being conducted by San Diego State University.

Table 14 – Mi Puente/My Bridge

Objective(s): Mi Puente applies 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.		
Program Measures	2017	2018
Number of eligible patients	214	202
Number of enrolled patients	153	147
Number of patients who declined	45	16

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 to 200 mental health visits a day in-house.[13]

Strategies

Scripps partners with FHCSD to help ensure behavioral health patient's transition into appropriate outpatient care when discharged from Scripps Mercy. Scripps Mercy and Family Health Centers work on a seamless transition post discharge with mental health intake centers. The two organizations have formed a Joint Operating Committee between both parties to study, address and improve patient flow (including establishing baseline metrics for reporting outcomes). Refer to table 15 for program measures.

[13] California Health Care Foundation, "San Diego: Major Providers Pursue Countywide Networks and New Patient Care Models", Mathematica Policy Research, July 2016.

Evaluation Methods and Measurable Targets

Table 15 – Scripps Mercy and Family Health Centers Behavioral Health Partnership

Objective(s): 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 outpatients services before their behavioral health issues become acute and they do not return to the Emergency Department.		
Program Measures	2017	2018
Number of referrals to FHCSD	213	378
Number of referrals for medical follow up. (Referrals are made to the transition clinic for medical follow up when patients leave the ED)	470	398
Track number of patients referred using ER Connect and expect a 10% increase from prior year. Number of patients referred in FY18 using ER Connect*.	173	536

*ER Connect is a software program that tracks appointments and no-show rates and other useful data.

5. Behavioral Health Integration Program (BHIP) in Diabetes

Many people find that the day-to-day tasks associated with having diabetes –testing one's blood sugar, planning meals, getting enough physical activity and remembering to take medications can be stressful. A common condition known as "diabetes distress" can be the result of feeling like it's all too much. Scripps Diabetes Care and Prevention has a Diabetes Behavioral Specialist on staff to help people manage their diabetes without being overwhelmed or unduly distressed. The 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 collocation of medical and behavioral health services in the same facility allow 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

Table 16 – Behavioral Health Program in Diabetes (BHIP)

Objective(s): Behavioral Health Integration Program (BHIP) 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 comprehensibly address the multi-faceted needs of their patients with diabetes.			
Program Measures	2017	2018	
Process/Utilization Measures			
Number of referrals received	153	221	
Number of intakes completed	131	100	
Number of 1:1 and group sessions provided per patient	67	251	
	2017	2018	
Self-Report			
Diabetes Distress Scale (Pre/Post)*	0	Pre	Post
		3	2.25

*The Diabetes Distress Scale was not provided in 2017 as BHIP was temporarily closed during Q2 & Q3 (due to transition in Interventionist)

Behavioral Health Programs Broken Out By Hospital

Scripps Encinitas, Green, La Jolla and Mercy

1) Psychiatric Liaison Team (PLT)
2) Scripps Drug & Alcohol Resource Nurse
3) Mi Puente/My Bridge
4) Scripps Mercy & Family Health Centers Behavioral Health Partnership
5) Behavioral Health Integration Program in Diabetes (BHIP) (Scripps La Jolla and Scripps Green)

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Psychiatric Liaison Team (PLT)
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	County Mental Health Department
Objective: The Psychiatric Liaison Team will help to accurately assess patients and provide them with the 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 endure the long-term stabilization of individual's health.	
Action Items: Continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and Urgent Care settings.	
Evaluation Methods and Measurable Targets	
The PLT clinicians are a resource to the acute care and urgent care setting 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 was 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. Discharge/ Transfer from ED to Mercy Behavioral Health Unit — **266** b. Other Inpatient Facilities — **3** c. Crisis Residential Placement — **0** 2. Track the number of encounters referred to an outpatient setting a. Patient given outpatient referrals — **35** b. Family Health Centers — **1** c. Outpatient psychiatrist — **4** d. Detox — **0** e. Shelter — **2**	

*Scripps is tracking encounters and not patients in order to avoid tracking duplicate patients.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Psychiatric Liaison Team (PLT)
Hospital Site	Scripps Green Hospital
Partners	County Mental Health Department
Objective: The Psychiatric Liaison Team will help to accurately assess patients and provide them with the 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 endure the long-term stabilization of individual's health.	
Action Items: Continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and Urgent Care settings.	
Evaluation Methods and Measurable Targets	
The PLT clinicians are a resource to the acute care and urgent care setting 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 was retrieved from the Midas Data Base for all patients seen by the Psychiatric Liaison Team. 1. Track number of encounters (visits) referred to <u>inpatient</u> setting d. Discharge/ Transfer from ED to Mercy Behavioral Health Unit — **2** e. Other Inpatient Facilities — **1** f. Crisis Residential Placement — **0** 2. Track the number of encounters referred to an <u>outpatient</u> setting f. Patient given outpatient referrals — **2** g. Family Health Centers — **0** h. Outpatient psychiatrist — **0** i. Detox — **0** j. Shelter — **0**	

*Scripps is tracking encounters and not patients in order to avoid tracking duplicate patients.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Psychiatric Liaison Team (PLT)
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	County Mental Health Department
Objective: The Psychiatric Liaison Team will help to accurately assess patients and provide them with the 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 endure the long-term stabilization of individual's health.	
Action Items: Continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and Urgent Care settings.	
Evaluation Methods and Measurable Targets	
The PLT clinicians are a resource to the acute care and urgent care setting 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 was retrieved from the Midas Data Base for all patients seen by the Psychiatric Liaison Team. 1. Track number of encounters (visits) referred to <u>inpatient</u> setting g. Discharge/ Transfer from ED to Mercy Behavioral Health Unit — **225** h. Other Inpatient Facilities — **2** i. Crisis Residential Placement — **0** 2. Track the number of encounters referred to an <u>outpatient</u> setting k. Patient given outpatient referrals — **25** l. Family Health Centers — **0** m. Outpatient psychiatrist — **4** n. Detox — **0** o. Shelter — **1**	

*Scripps is tracking encounters and not patients in order to avoid tracking duplicate patients.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Psychiatric Liaison Team (PLT)
Hospital Site	Scripps Mercy Hospital
Partners	County Mental Health Department
Objective: The Psychiatric Liaison Team will help to accurately assess patients and provide them with the 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 endure the long-term stabilization of individual's health.	
Action Items: Continue to provide a dedicated Psychiatric Liaison Team at all Scripps Hospitals Emergency Departments and Urgent Care settings.	
Evaluation Methods and Measurable Targets	
The PLT clinicians are a resource to the acute care and urgent care setting 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 was retrieved from the Midas Data Base for all patients seen by the Psychiatric Liaison Team. 1. Track number of encounters (visits) referred to <u>inpatient</u> setting j. Discharge/ Transfer from ED to Mercy Behavioral Health Unit — **740** k. Other Inpatient Facilities — **45** l. Crisis Residential Placement — **1** 2. Track the number of encounters referred to an <u>outpatient</u> setting p. Patient given outpatient referrals — **424** q. Family Health Centers — **16** r. Outpatient psychiatrist — **35** s. Detox — **10** t. Shelter — **17**	

*Scripps is tracking encounters and not patients in order to avoid tracking duplicate patients.

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Scripps Drug & Alcohol Resource Nurse
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Volunteers of America (VOA)
Objective: Patients presenting with mental health, drug and alcohol abuse 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.	
Action Items: 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.	
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 were tracked with this program: Number of referrals sent to VOA. — **6**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Scripps Drug & Alcohol Resource Nurse
Hospital Site	Scripps Green Hospital
Partners	Volunteers of America (VOA)
Objective: Patients presenting with mental health, drug and alcohol abuse 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.	
Action Items: 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.	
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 were tracked with this program: Number of referrals sent to VOA. — **0**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Scripps Drug & Alcohol Resource Nurse
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Volunteers of America (VOA)
Objective: Patients presenting with mental health, drug and alcohol abuse 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.	
Action Items: 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.	
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 were tracked with this program: Number of referrals sent to VOA. — **3**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Scripps Drug & Alcohol Resource Nurse
Hospital Site	Scripps Mercy Hospital
Partners	Volunteers of America (VOA)
Objective: Patients presenting with mental health, drug and alcohol abuse 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.	
Action Items: 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.	
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 were tracked with this program: Number of referrals sent to VOA. — **64**	

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Mi Puente/My Bridge
Hospital Site	Scripps Mercy Hospital
Partners	San Ysidro Health Center San Diego State University Chula Vista Community Collaborative Chula Vista Well Being Center
Objective: 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.	
Action Items: 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	
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 compared Mi Puente ("My Bridge", n=260) to Usual Care (n=260) in a total of 560 Hispanic adults, hospitalized with multiple cardiometabolic conditions and 1+ behavioral health concern(s) at Scripps Mercy Chula Vista. Metrics: • Number of eligible patients — **202** • Number of enrolled patients —**147** • Number patients who decline — **16**	

Note: A thorough evaluation of this program will not be evaluated until the end of the study which will be in 2020 when the program will be completed. The evaluation is being conducted by San Diego State University.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Behavioral Health*

Program Name	Scripps Mercy & Family Health Centers Behavioral Health Partnership
Hospital Site	Scripps Mercy Hospital
Partners	Family Health Centers of San Diego (FHCSD)
Objective: With the expansion of Medi-Cal and Covered California, a large number 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 outpatients services before their behavioral health issues become acute and they do not return to the Emergency Department.	
Action Items: Scripps Mercy established 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 partners with FHCSD to ensure behavioral health patients transition in appropriate outpatient care when discharged from Scripps Mercy. The two organizations have formed a Joint Operating Committee to study, address and improve patient flow (including establishing baseline metrics for reporting outcomes).	
Evaluation Methods and Measurable Targets	
• Number of referrals to FHCSD — **378** • Number of referrals for medical follow up — **398** (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. Number of patients referred in FY18 using ER Connect* — **536**.	

*ER Connect is a software program that tracks appointments and no-show rates and other useful data.

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

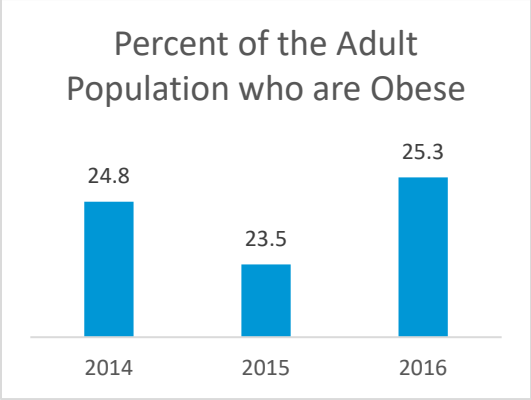
Identified Community Health Need: *Behavioral Health*

Program Name	Behavioral Health Integration Program In Diabetes (BHIP)
Hospital Site	Scripps Memorial Hospital La Jolla & Scripps Green Hospital
Partners	Scripps Whittier Diabetes Institute (SWDI) Alliant International University (AIU)
Objective: 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 comprehensibly address the multi-faceted needs of their patients with diabetes.	
Action Items: 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 at 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 • Number of referrals received — **221** • Number of intakes completed — **100** • Number of 1:1 and group sessions provided per patient — **251** Self-Report Diabetes Distress Scale – (pre/post) **Pre = 3 Post = 2.25**	

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.[14] 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.[15] Obesity is an important health needs 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. In 2016, 25.3% of adults were obese, a 2% increase from 2014.

Figure 11 – Percent of the Adult Populations who are Obese in San Diego County, 2014-2016



Source: California Health Interview Survey, 2014 to 2016, UCLA Center for Health Policy Research.

Adults: 36.3% of adults aged 18 and older self-report that they have a Body Mass Index (BMI) between 25 and 30 (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 (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.

[14] CDC. Defining Adult Overweight and Obesity. Retrieved from CDC.gov.
[15] Barlow SE and the Expert Committee. Expert Committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: summary report. Pediatrics 2007, 120 Supplement December 2007:S164 –S192.

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 (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 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, abnormal pain for those age 15–24, and for those over 65 years their primary diagnosis was osteoarthritis, septicemia followed by congestive heart failure.

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 17.

Table 17– Summary of Community Input on Common Obesity-Related Issues, HASD&IC 2016 CHNA

Summary of Obesity-Related Responses*	
High obesity prevalence	Orthopedic issues
Issue for acculturating refugees, Native Americans, older veterans and low-income individuals	Physical education avoidance due to body image and anxiety
Lack of physical activity	Starts in youth
Nutrition and diet	

**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 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 to establish the **National Diabetes Prevention Program** (National DPP) 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. The National DPP, a CDC-led lifestyle change program, has more than 1,300 sites nationwide, including county public health departments, YMCAs, community health centers, health care facilities, academic institutions, and community centers. There are 86 million people with diabetes and this lifestyle change program has been shown to be cost effective and a cost saving initiative for the organization. The Diabetes Prevention Program is a scientifically validated lifestyle intervention based model. The Center for Disease Control and the National Institute 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 five years. Research shows structured lifestyle interventions can cut the risk of Type 2 diabetes in half.

While the Scripps Whittier Diabetes Institute has been providing the best care for people with diabetes for decades, the Institute continued with the Scripps Diabetes Prevention Program (DPP), which is a yearlong intervention where people with prediabetes meet weekly for 16 weeks, then monthly thereafter. The Diabetes Prevention Program (DPP) is an intensive lifestyle intervention program that has been proven to prevent diabetes in large-scale national studies. The primary objective is to lose 5 to 7% of body weight through healthy eating and physical activity. The Diabetes Prevention Program has been thoroughly evaluated in NIH sponsored randomized controlled trials, and has been found to decrease the number of new cases of diabetes among those with prediabetes by 58%.

Strategies

Scripps offers an intensive lifestyle intervention program that has been validated by the NIH and CDC. The program empowers patients with pre-diabetes to take charge of their health and well-being. The individuals meet in groups with a community health promoter/lifestyle coach for 16 weeks, 1 hour sessions and 6–8 monthly follow up sessions for a total of 12 months.

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 and psychological risk profiles.

Evaluation Methods and Measurable Targets (See aggregate information for sociodemographic data on page115)

It takes an entire year to collect the surveys at baseline, month 6, and month 12. In FY17, there was only one cohort that had completed the full 12 months. Of the 14 participants who started in October 2016 for Cohort #1, only 5 completed through month 12 classes and survey data points at the end of year one. For this reason the baseline sample size (used for the "pre" analysis) was 14 participants, while month 12 sample size (used for the "post" analysis) was only 5 participants. This makes for an extremely small sample size which in turn skews the results of the post analyses. At the end of FY18, nearly 18 cohorts have completed the program which produces a much larger sample size and data that is interpretable. In addition, in FY18 an additional 9 cohorts were started and are aimed to complete various time points over the year in FY19. Now that the program is running to scale, the sample sizes will be significantly larger and therefore produce statistically significant outcomes and yield the pre and post analysis. In FY19, Scripps plans to start a minimum of 10 cohorts throughout San Diego County.

*Cohort definition: A cohort is a group of participants who attend DPP classes at the same time, on the same day of the week, at the same location, and with the same instructor over the course of the 1 year program. By utilizing the cohort format, the program aims to develop a group dynamic among participants which has been shown to increase motivation, participation, and feelings of support.

2. Healthy Living Program

In 2015, Scripps began Healthy Living classes which are open to anyone interested in learning about the benefits of good nutrition, physical activity, and avoiding tobacco. These behaviors can help to prevent the four chronic diseases (lung disease, cancer, Type 2 diabetes and, cardiovascular disease) that contribute to 50 percent of all the deaths in the US. The three-class series is held at locations throughout the community. Two hundred and eight people attended Healthy Living classes that were provided throughout the County, again with special attention to the Latino community of the South Bay.

Strategies

Scripps encourages participants to adopt three health behaviors (nutritious diet, physical activity and 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 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 implements a series of three 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 Latino and underserved communities. Sessions include health screenings, healthy cooking tips and mindful eating and practice sessions.

Evaluation Methods and Measurable Targets (See aggregate information for sociodemographic data on pages 132)

Pre/Post measures

Table 18 – Healthy Living Program

Objective(s): Encourage participants to adopt three health behaviors (nutritious diet, physical activity and 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.		
Program Measures	2017	2018
Number of individuals that attend/complete program		
Attended 1 class	89	29
Attended 2 classes	60	22
Attended 3 classes	47	22

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). Numbers of individuals were lower in FY18 due to less resources but this program will be revamped to increase outcomes for FY19. See pages 116 -133 for hospital site specific metrics.

Post-Measure Only

Table 19 – Healthy Living Program

Objective(s): Encourage participants to adopt three health behaviors (nutritious diet, physical activity and 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.				
Program Measures	2017		2018	
Track participants evaluation (participants' rate satisfaction/acceptability) completed at the end of each class.	Number of classes included in average	*Mean	Number of classes included in average	*Mean
Overall Quality of Session 1	17	3.75	15	3.81
Overall Quality of Session 2	13	3.25	15	3.85
Overall Quality of Session 3	12	3.83	12	3.83

*Mean number is based on a scale of 1 (Needs a lot of improvement) to 4 (Excellent)

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, **1** 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 more than 120 youth participants in the 4th and 5th grade classes at Castle Park Elementary. In FY18, 50 high school students from Chula Vista and Montgomery high schools participated in the program. 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 vegetable has increased by over 50% of the children, school staff and parents.

Strategies

1. Scripps partners with local elementary schools to implement and coordinate activities specific to 5210 and healthy lifestyles. 5-2-1-0 message (**5** fruits or more a day, **2** hours or less of screen time, **1** hour of physical activity a day and **0** surgery juices).

2. Scripps helps to administer the 5210 Health Assessment Survey and Health Plan to the 4th and 5th grade classes before the 10 sessions are introduced to evaluate knowledge on the 5210 message. In addition, support physical activities for students to pass the yearly State fitness exam. Pre-survey is administered in the second quarter of the school year.

3. Scripps helps to administer the 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 the current 5th grade classes to evaluate changes in behavior. The summary report is completed at the end of the school year.

5. Scripps organizes school-wide wellness fairs for parents and students and invite local service organizations to provide additional resources for parents and facilitated activities promoting the 5210 message.

6. Scripps implements wellness activities/classes with community partners, Scripps Family Medicine Residents and Resident Leadership Academy.

Summary Report

Background: Castle Park Elementary students from the 4th and 5th grade classes were introduced to the 5210 Health Assessment Survey in October 2016. The survey was administered prior to starting the 5210 nutritional education classes to learn about their knowledge of the 5210 message. Four sessions were offered to the 4th and 5th grade classes. Topics and activities included: reading nutrition labels, essential vitamins, screen time presentations, physical activity bingo, role playing, circuit training and measuring sugar in drinks. Their responses would give a better idea on the type of 5210 activities to include in each session. The nutritional education classes initiated the week after the survey was conducted in each class. Data was compared from the 4th grade classes' school year 2016-2017 to the 5th grade classes' school year 2017–2018.

Methodology: The pre-surveys were conducted face-to-face in the classroom with the support of the teachers and tutors at the beginning of the session. Scripps Mercy Hospital Chula Vista staff along with residents from the Scripps Family Residency Program assisted a total of students, 56, 4th grade students and 53, 5th grade students from academic year 2017-2018. The surveys consisted of nine questions focused on the 5210 message and were distributed at the first session and revisited at the

conclusion. Towards the end of the school year, Scripps will administer the Post survey with the same questions to compare responses and changes in behavior

Results: Student responses (154) showed that there was an increase in improvement from one grade level to the next in knowledge of the 5210 message related to the importance of nutrition and physical activity.

- Improvement rate for knowledge after participating in 5210 sessions – Pre 60% Post 79%.
- Improvement rate for behavior after participating in 5210 sessions – Pre 60.9% Post 62.5%.

Overall, the course conveys a positive message to get students interested in healthy behaviors and to be proactive with them while at a young age. According to the data, the kids are learning and remembering the different components of 5210, but they are having trouble executing the knowledge into their everyday life. Refer to table 29 for program measures.

Evaluation Methods and Measurable Targets

Table 20 - Promise Neighborhood (Reducing Childhood Obesity in South Bay)

Objective(s): Increase education and awareness related to health lifestyles for elementary aged children, parents and school staff. Improve behaviors related to nutrition and physical activity.				
Program Measures	2017*		2018*	
Total number of youth participants	100		159	
Improvement rate for ***knowledge*** after participating in 5210 sessions	Pre	Post	Pre	Post
	58%	80%	59.8%	79.2%
Improvement rate for ***behavior*** after participating in 5210 sessions	Pre	Post	Pre	Post
	20%	37.5%	60.9%	62.5%
Number of students who completed post goal setting plan and 5210 educational sessions	95		154	
Number of Wellness Meetings documented	9		9	

*The metrics are reported at the end of the school year (May).

Obesity Programs Broken Out By Hospital

Scripps Encinitas, Green, La Jolla & Mercy

1) Diabetes Prevention Program (DPP)
   (with aggregate sociodemographic data for all sites)
2) Healthy Living
   (with aggregate sociodemographic data for all sites)
3) Promise Neighborhood (Reducing Childhood Obesity in South Bay)
   (Mercy Chula Vista)

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Diabetes Prevention Program (DPP)
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Community Housing Works Scripps Coastal Medical Center—Vista
Objective: 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 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.	
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 well-being. The individuals meet in groups with a community health promoter/lifestyle coach for 16 weeks, one hour sessions and six to eight 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 Institute of Health (NIH) promotes 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 completed 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	

Note: 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 three years, Scripps will be able to show comprehensive and complete performance measures.

Scripps Encinitas Memorial Hospital — Diabetes Prevention Program – Pre/Post Measures

Number of Participants Completing Program – 17

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Median Score
Ruler 1 - Baseline	33	10
Ruler 1 – End of Program	17	10
Ruler 2 – Baseline	34	10
Ruler 2 – End of Program	17	9
Ruler 3 – Baseline	34	9.5
Ruler 3 – End of Program	17	9

Scripps Encinitas Memorial Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

NUTRITION

- Scores can range from 16-24.
- Lower scores indicate poor eating habits while higher scores indicate ideal eating habits.
- Ideally, you want to see scores **increase** by Month 12.

Nutrition: Pre (Baseline) and Post (Month 12) Scores on Food Behavior Checklist		
	Number of Respondents	**Mean Score**
Baseline	33	41
Month 12	17	43

EXERCISE

- Scores can range from 1 (sedentary) to 7 (active).
- Ideally, you want the scores to **increase** by Month 12.

Exercise: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: RAPA	33	4.5 (under-active regular)
Month 12: RAPA	17	5.6 (active)

Scripps Encinitas Memorial Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

STRESS

- Scores ranging from 0 – 13 would be considered low stress.
- Scores ranging from 14 – 26 would be considered moderate stress.
- Scores ranging from 27 – 40 would be considered high perceived stress.
- Ideally, you want to see scores **decrease** by Month 12.

Stress: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: Perceived Stress Scale	33	13.18 (moderate stress)
Month 12: Perceived Stress Scale	17	11 (low stress)

ALCOHOL USAGE

- Responses can range from 0 days to 31 days.
- Ideally, you want to see scores **decrease** by Month 12.

Alcohol: Pre (Baseline) and Post (Month 12) During the past month, on how many days did you drink any alcoholic beverages?		
	Number of Respondents	**Median Score**
Baseline: Alcohol use in past the month	34	0.5 days
Month 12: Alcohol use in the past month	17	0 days

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Diabetes Prevention Program (DPP)
Hospital Site	Scripps Green Hospital
Partners	Community Housing Works Scripps Coastal Medical Center—Vista
Objective: 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 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.	
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 well-being. The individuals meet in groups with a community health promoter/lifestyle coach for 16 weeks, one hour sessions and six to eight 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 Institute of Health (NIH) promotes 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 completed 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	

Note: 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 three years, Scripps will be able to show comprehensive and complete performance measures.

Scripps Green Hospital — Diabetes Prevention Program – Pre/Post Measures

Number of Participants Completing Program – 22

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Median Score
Ruler 1 - Baseline	32	10
Ruler 1 – End of Program	22	10
Ruler 2 – Baseline	32	9
Ruler 2 – End of Program	22	10
Ruler 3 – Baseline	32	8
Ruler 3 – End of Program	22	9

Scripps Green Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

NUTRITION

- Scores can range from 16-24.
- Lower scores indicate poor eating habits while higher scores indicate ideal eating habits.
- Ideally, you want to see scores **increase** by Month 12.

Nutrition: Pre (Baseline) and Post (Month 12) Scores on Food Behavior Checklist		
	Number of Respondents	**Mean Score**
Baseline	32	42
Month 12	22	47

EXERCISE

- Scores can range from 1 (sedentary) to 7 (active).
- Ideally, you want the scores to **increase** by Month 12.

Exercise: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: RAPA	32	4.9 (under-active regular)
Month 12: RAPA	22	5.7 (active)

Scripps Green Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

STRESS

- Scores ranging from 0 – 13 would be considered low stress.
- Scores ranging from 14 – 26 would be considered moderate stress.
- Scores ranging from 27 – 40 would be considered high perceived stress.
- Ideally, you want to see scores **decrease** by Month 12.

Stress: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: Perceived Stress Scale	32	17 (moderate stress)
Month 12: Perceived Stress Scale	21	14.6 (moderate stress)

ALCOHOL USAGE

- Responses can range from 0 days to 31 days.
- Ideally, you want to see scores **decrease** by Month 12.

Alcohol: Pre (Baseline) and Post (Month 12) During the past month, on how many days did you drink any alcoholic beverages?		
	Number of Respondents	**Median Score**
Baseline: Alcohol use in past the month	32	2 days
Month 12: Alcohol use in the past month	22	2.8 days

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Diabetes Prevention Program (DPP)
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Community Housing Works Scripps Coastal Medical Center—Vista
Objective: 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 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.	
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 well-being. The individuals meet in groups with a community health promoter/lifestyle coach for 16 weeks, one hour sessions and six to eight 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 Institute of Health (NIH) promotes 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 completed 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	

Note: 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 three years, Scripps will be able to show comprehensive and complete performance measures.

Scripps La Jolla Memorial Hospital — Diabetes Prevention Program – Pre/Post Measures

Number of Participants Completing Program – 21

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Median Score
Ruler 1 - Baseline	34	10
Ruler 1 – End of Program	21	10
Ruler 2 – Baseline	34	10
Ruler 2 – End of Program	21	10
Ruler 3 – Baseline	34	9.5
Ruler 3 – End of Program	21	10

Scripps La Jolla Memorial Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

NUTRITION

- Scores can range from 16-24.
- Lower scores indicate poor eating habits while higher scores indicate ideal eating habits.
- Ideally, you want to see scores **increase** by Month 12.

Nutrition: Pre (Baseline) and Post (Month 12) Scores on Food Behavior Checklist		
	Number of Respondents	**Mean Score**
Baseline	37	42
Month 12	21	45

EXERCISE

- Scores can range from 1 (sedentary) to 7 (active).
- Ideally, you want the scores to **increase** by Month 12.

Exercise: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: RAPA	36	4.6 (under-active regular)
Month 12: RAPA	21	5.8 (active)

Scripps La Jolla Memorial Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

STRESS

- Scores ranging from 0 – 13 would be considered low stress.
- Scores ranging from 14 – 26 would be considered moderate stress.
- Scores ranging from 27 – 40 would be considered high perceived stress.
- Ideally, you want to see scores **decrease** by Month 12.

Stress: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: Perceived Stress Scale	37	13.7 (moderate stress)
Month 12: Perceived Stress Scale	21	10.9 (low stress)

ALCOHOL USAGE

- Responses can range from 0 days to 31 days.
- Ideally, you want to see scores **decrease** by Month 12.

Alcohol: Pre (Baseline) and Post (Month 12) During the past month, on how many days did you drink any alcoholic beverages?		
	Number of Respondents	**Median Score**
Baseline: Alcohol use in past the month	37	0 days
Month 12: Alcohol use in the past month	21	0 days

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Diabetes Prevention Program (DPP)
Hospital Site	Scripps Mercy Hospital
Partners	Community Housing Works Scripps Coastal Medical Center—Vista
Objective: 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 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.	
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 well-being. The individuals meet in groups with a community health promoter/lifestyle coach for 16 weeks, one hour sessions and six to eight 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 Institute of Health (NIH) promotes 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 completed 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	

Note: 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 three years, Scripps will be able to show comprehensive and complete performance measures.

Scripps Mercy Hospital — Diabetes Prevention Program – Pre/Post Measures

Number of Participants Completing Program – 40

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Median Score
Ruler 1 - Baseline	61	10
Ruler 1 – End of Program	40	10
Ruler 2 – Baseline	61	10
Ruler 2 – End of Program	40	10
Ruler 3 – Baseline	61	10
Ruler 3 – End of Program	40	10

Scripps Mercy Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

NUTRITION

- Scores can range from 16-24.
- Lower scores indicate poor eating habits while higher scores indicate ideal eating habits.
- Ideally, you want to see scores **increase** by Month 12.

Nutrition: Pre (Baseline) and Post (Month 12) Scores on Food Behavior Checklist		
	Number of Respondents	**Mean Score**
Baseline	61	43
Month 12	40	51

EXERCISE

- Scores can range from 1 (sedentary) to 7 (active).
- Ideally, you want the scores to **increase** by Month 12.

Exercise: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: RAPA	61	5 (under-active regular)
Month 12: RAPA	40	6 (active)

Scripps Mercy Hospital — Diabetes Prevention Program – Pre/Post Measures

Healthy Behaviors Measurements

STRESS

- Scores ranging from 0 – 13 would be considered low stress.
- Scores ranging from 14 – 26 would be considered moderate stress.
- Scores ranging from 27 – 40 would be considered high perceived stress.
- Ideally, you want to see scores **decrease** by Month 12.

Stress: Pre (Baseline) and Post (Month 12) Scores on the Rapid Assessment of Physical Activity Scale		
	Number of Respondents	**Mean Score**
Baseline: Perceived Stress Scale	60	15 (moderate stress)
Month 12: Perceived Stress Scale	40	12 (low stress)

ALCOHOL USAGE

- Responses can range from 0 days to 31 days.
- Ideally, you want to see scores **decrease** by Month 12.

Alcohol: Pre (Baseline) and Post (Month 12) During the past month, on how many days did you drink any alcoholic beverages?		
	Number of Respondents	**Median Score**
Baseline: Alcohol use in past the month	61	0 days
Month 12: Alcohol use in the past month	40	0 days

Diabetes Prevention Program

Sociodemographic Aggregate Data Explanation for all Sites: Scripps Encinitas, Green, La Jolla & Mercy

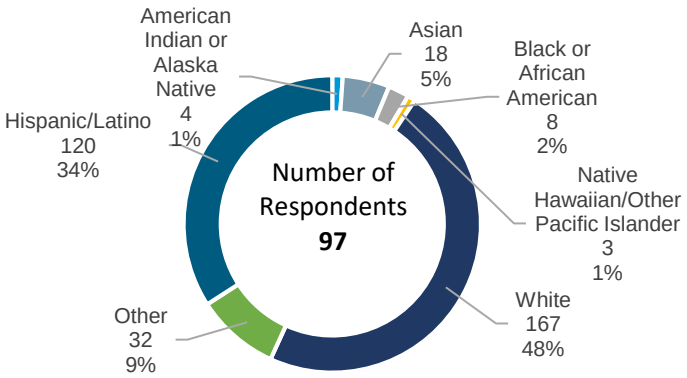
Age

Number who responded	Mean Age
227	57 years of age

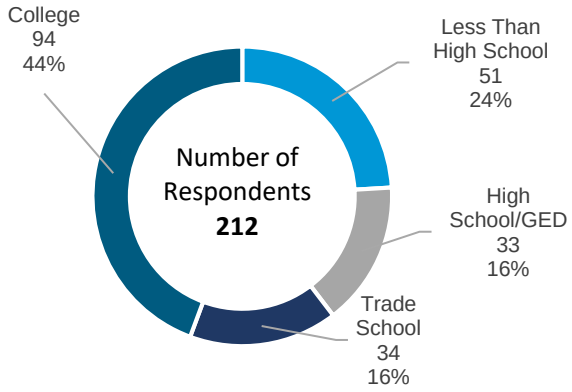
Income

Income Level	Number who responded
Less than $24,000	51
Greater than $24,000	167
Total	**218**

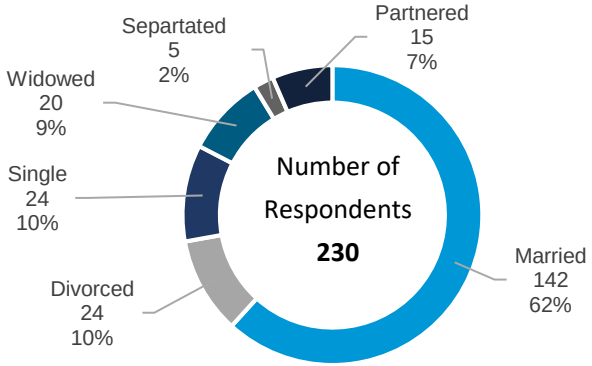
Race – *Note multiple boxes can be selected*



Education Level



Marital Status



Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Healthy Living Program
Hospital Site	Scripps Memorial Hospital Encinitas
Partners	Community Housing Works Community Clinics Nurseries Local Schools Senior Apartments Faith based organizations YMCA
Objective: Encourage participants to adopt three health behaviors (nutritious diet, physical activity and 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.	
Action Items: Implement a series of three 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.	
Evaluation Methods and Measurable Targets	
The Healthy Living Program supports 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. **Pre-Measures Only (see aggregate data)** • 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). **Continued on Next Page**	

Pre/Post Measures

- Number of individuals that completed 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).

Post-Measure only

- Participant Evaluation (participants' rate satisfaction/acceptability) completed at the end of every year.

Scripps Encinitas Hospital- Healthy Living Program—Pre/Post Measures

Number of participants – 11

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Average Score
Ruler 1 - Baseline	6	8.83
Ruler 1 – End of Program	2	9.50
Ruler 2 – Baseline	6	8.50
Ruler 2 – End of Program	2	9.50
Ruler 3 – Baseline	6	7.33
Ruler 3 – End of Program	2	9.00

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Scripps Encinitas Hospital- Healthy Living Program—Post Measures

Participants Evaluation

Participants were asked the following question at the end of each session. How would you rate the overall quality of today's class? This is based on a scale of **1** (needs a lot of improvement) to **4** (excellent).

At the Encinitas site, there were two Session 1 classes, two Session 2 classes and one Session 3 class held. All participants who attended a Session 1 class at Encinitas and responded to the question were included in the mean for "overall quality of Session 1". The means for the other two Sessions were calculated using the same method.

Overall Quality of	Number of classes included in average	Average Score
Session 1	1	3.67 (Excellent)
Session 2	1	3.50 (Excellent)
Session 3	1	3.67 (Excellent)

Scripps Employee Question – Note: 3 individuals out of the 11 did not answer this question.

Number participants who answered question	Scripps Employee	Non-Scripps Employee
6	1 (1/6 = 16.7%)	5 (5/6 = 83.3%)

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Healthy Living Program
Hospital Site	Scripps Green Hospital
Partners	Community Housing Works Community Clinics Nurseries Local Schools Senior Apartments Faith based organizations YMCA
Objective: Encourage participants to adopt three health behaviors (nutritious diet, physical activity and 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.	
Action Items: Implement a series of three 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.	
Evaluation Methods and Measurable Targets	
The Healthy Living Program supports 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. **Pre-Measures Only (see aggregate data)** • 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). **Continued on Next Page**	

Pre/Post Measures

- Number of individuals that completed 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).

Post-Measure only

- Participant Evaluation (participants' rate satisfaction/acceptability) completed at the end of every year.

Scripps Green Hospital - Healthy Living Program—Pre/Post Measures

Number of participants – 22

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale of 1 to 10.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Average Score
Ruler 1 - Baseline	24	9.12
Ruler 1 – End of Program	7	9.57
Ruler 2 – Baseline	24	8.46
Ruler 2 – End of Program	7	9.29
Ruler 3 – Baseline	23	8.00
Ruler 3 – End of Program	7	9.29

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Scripps Green Hospital - Healthy Living Program—Post Measures

Participants Evaluation

Participants were asked the following question at the end of each session. How would you rate the overall quality of today's class? This is based on a scale of **1** (needs a lot of improvement) to **4** (excellent).

At the Green site, there were two Session 1 classes, one Session 2 classes and one Session 3 class held. All participants who attended a Session 1 class at Green and responded to the question were included in the mean for "overall quality of Session 1". The means for the other two Sessions were calculated using the same method.

Overall Quality of	Number of classes included in average	Average Score
Session 1	4	3.62 (Excellent)
Session 2	2	3.90 (Excellent)
Session 3	3	3.50 (Excellent)

Scripps Employee Question

Number participants who answered question	Scripps Employee	Non-Scripps Employee
24	14 (14/24 = 58.3%)	10 (10/24 = 41.7%)

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Healthy Living Program
Hospital Site	Scripps Memorial Hospital La Jolla
Partners	Community Housing Works Community Clinics Nurseries Local Schools Senior Apartments Faith based organizations YMCA
Objective: Encourage participants to adopt three health behaviors (nutritious diet, physical activity and 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.	
Action Items: Implement a series of three 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.	
Evaluation Methods and Measurable Targets	
The Healthy Living Program supports 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. **Pre-Measures Only (see aggregate data)** • 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). **Continued on Next Page**	

Pre/Post Measures

- Number of individuals that completed 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).

Post-Measure only

- Participant Evaluation (participants' rate satisfaction/acceptability) completed at the end of every year.

Scripps Memorial Hospital La Jolla - Healthy Living Program—Pre/Post Measures

Number of participants – 20

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale of 1 to 10.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Average Score
Ruler 1 - Baseline	12	9.42
Ruler 1 – End of Program	1	9.00
Ruler 2 – Baseline	12	8.83
Ruler 2 – End of Program	1	9.00
Ruler 3 – Baseline	12	7.75
Ruler 3 – End of Program	1	7.00

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Scripps Memorial Hospital La Jolla - Healthy Living Program—Post Measures

Participants Evaluation

Participants were asked the following question at the end of each session. How would you rate the overall quality of today's class? This is based on a scale of **1** (needs a lot of improvement) to **4** (excellent).

At the La Jolla site, there were three Session 1 classes, two Session 2 classes and two Session 3 classes held. All participants who attended a Session 1 class at La Jolla and responded to the question were included in the mean for "overall quality of Session 1". The means for the other two Sessions were calculated using the same method.

Overall Quality of	Number of classes included in average	Average Score
Session 1	3	3.67 (Excellent)
Session 2	3	3.83 (Excellent)
Session 3	2	3.75 (Excellent)

Scripps Employee Question

Number participants who answered question	Scripps Employee	Non-Scripps Employee
12	1 (1/12 = 8.3%)	11 (11/12 = 91.7%)

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Healthy Living Program
Hospital Site	Scripps Mercy Hospital
Partners	Community Housing Works Community Clinics Nurseries Local Schools Senior Apartments Faith based organizations YMCA
Objective: Encourage participants to adopt three health behaviors (nutritious diet, physical activity and 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.	
Action Items: Implement a series of three 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.	
Evaluation Methods and Measurable Targets	
The Healthy Living Program supports 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. **Pre-Measures Only (see aggregate data)** • 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). **Continued on Next Page**	

Pre/Post Measures

- Number of individuals that completed 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).

Post-Measure only

- Participant Evaluation (participants' rate satisfaction/acceptability) completed at the end of every year.

Scripps Mercy Hospital- Healthy Living Program—Pre/Post Measures

Number of participants – 122

Healthful Change Measurements (Rulers)

Participants were asked to respond to the three healthful change ruler questions on the baseline survey which is collected at the participant's first class. Then, they were asked to fill out the same three ruler questions at the end of the last class they attended. These rulers assess the importance of making health changes, readiness to make such changes, and confidence that such changes can be made. Participants are asked to respond on a scale of 1 to 10.

1 (*not important/not ready/not confident*) to **10** (*very important/very ready/very confident*).

Ruler 1 question: How important is it to you to make healthy changes in your life?

Ruler 2 question: How ready are you to make healthy changes in your life?

Ruler 3 question: How confident are you that you can make healthy changes in your life?

Ruler Question	Number of participants that responded	Average Score
Ruler 1 - Baseline	29	9.66
Ruler 1 – End of Program	12	10.00
Ruler 2 – Baseline	29	9.59
Ruler 2 – End of Program	12	9.83
Ruler 3 – Baseline	29	9.48
Ruler 3 – End of Program	12	9.67

Note: Filling out the survey is voluntary. As a result there can be a variation in sample size of baseline and end of program data. Averages are taken across all participants who responded to the question.

Scripps Mercy Hospital- Healthy Living Program—Post Measures

Participants Evaluation

Participants were asked the following question at the end of each session. How would you rate the overall quality of today's class? This is based on a scale of **1** (needs a lot of improvement) to **4** (excellent).

At the Mercy site, there were ten Session 1 classes, eight Session 2 classes and eight Session 3 classes held. All participants who attended a Session 1 class at Mercy and responded to the question were included in the mean for "overall quality of Session 1". The means for the other two Sessions were calculated using the same method.

Overall Quality of	Number of classes included in average	Average Score
Session 1	6	4.00 (Excellent)
Session 2	6	3.95 (Excellent)
Session 3	6	3.92 (Excellent)

Scripps Employee Question – Note: 64 individuals out of the 122 did not answer this question.

Number participants who answered question	Scripps Employee	Non-Scripps Employee
27	1 (1/27 = 3.7%)	26 (26/27 = 96.3%)

Healthy Living Program

Sociodemographic Aggregate Data Explanation for all Sites: Scripps Encinitas, Green, La Jolla & Mercy

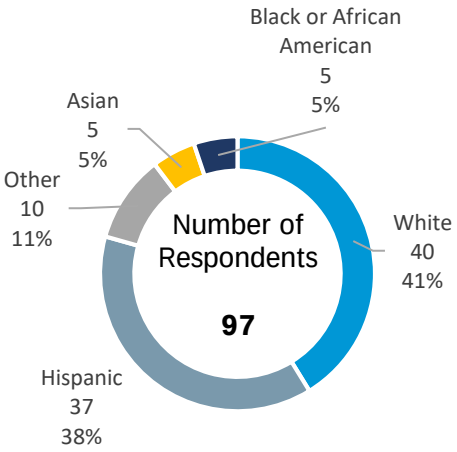
Age

Number who responded	Mean Age
66	55.74 years of age

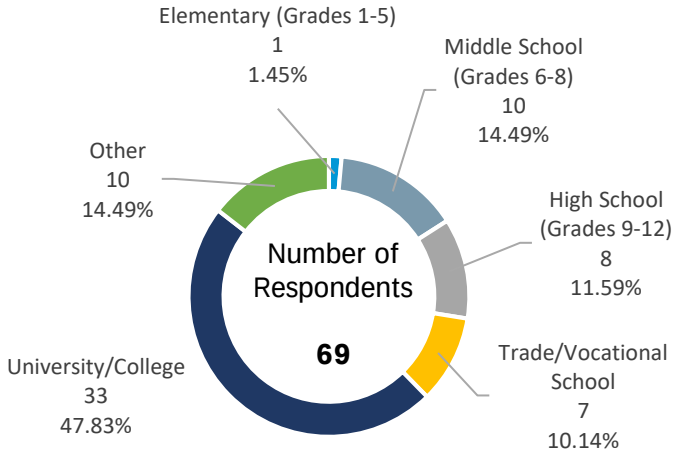
Income

Income Level	Number who responded
Less than $24,000	16
Greater than $24,000	41
Total	**57**

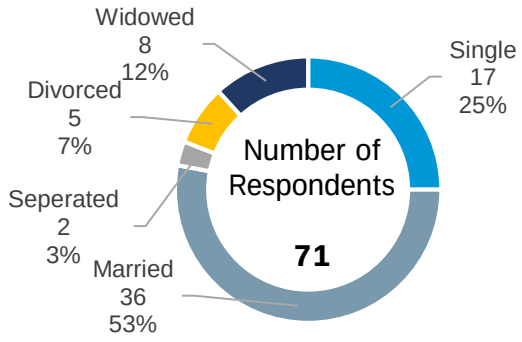
Race—*multiple boxes can be selected*



Education



Marital



Diabetes Risk Surveys

Positive Risk Test	Number who responded
Had positive risk test (score of 9 or greater)	51
Did not have a positive risk test	12
Total	**63**

Patients at a high risk of pre-diabetes are referred to the Diabetes Prevention Project (DPP)

Scripps Employee Question – Note: 93 individuals left this question blank.

Number of who answered the question	Number of Scripps Employee's	Number of Non-Scripps Employee's
69	17/69 = 24.6%	52/69 = 75.4%

Participants Satisfaction

*How would you rate the overall quality of today's class on a scale of **1** (needs a lot of improvement) to **4** (Excellent)*

Overall Quality of Sessions	Number of classes included in average	Scale
Session 1	15	3.81 (Excellent)
Session 2	15	3.85 (Excellent)
Session 3	12	3.83 (Excellent)

Number of individuals who completed the program	
Attended 1 class	29
Attended 2 classes	22
Attended 3 classes	22

Scripps

Community Health Needs Assessment—Implementation Plan
Fiscal Year 2018 (October 2017–September 2018)

Identified Community Health Need: *Obesity*

Program Name	Promise Neighborhood (Reducing Childhood Obesity in South Bay)
Hospital Site	Scripps Mercy Hospital
Partners	Scripps Family Medicine Residency Castle Park Elementary School South Bay Community Services
Objective: Increase education and awareness related to health lifestyles for elementary aged children, parents and school staff. Improve behaviors related to nutrition and physical activity.	
Action Items1. Scripps partners with local elementary schools to implement and coordinate activities specific to 5210 and health lifestyles. 5210 message is (**5** fruits or more a day, **2** hours or less of screen time, **1** hour of physical activity a day and **0** surgery juices). 2. Administer the 5210 Health Assessment Survey and Healthy Plan to 4th and 5th grade classes and support physical activities for students to pass the yearly State fitness test. 3. Scripps organizes school-wide wellness fairs 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.	
Evaluation Methods and Measurable Targets	
• Total number of youth participants — **159** • Improvement rate for knowledge after participating in 5210 sessions – Pre **60%** Post **79%** • Improvement rate for behavior after participating in 5210 sessions – Pre **61%** Post **63%** • Number of students who completed post goal setting plan and 5210 educational sessions — **154** • Number of Wellness committee meetings documented — **9**	

Evaluation Plans

Scripps monitors and evaluates 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 are tailored to each strategy and include the collection and documentation of tracking measures as listed in this report 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).