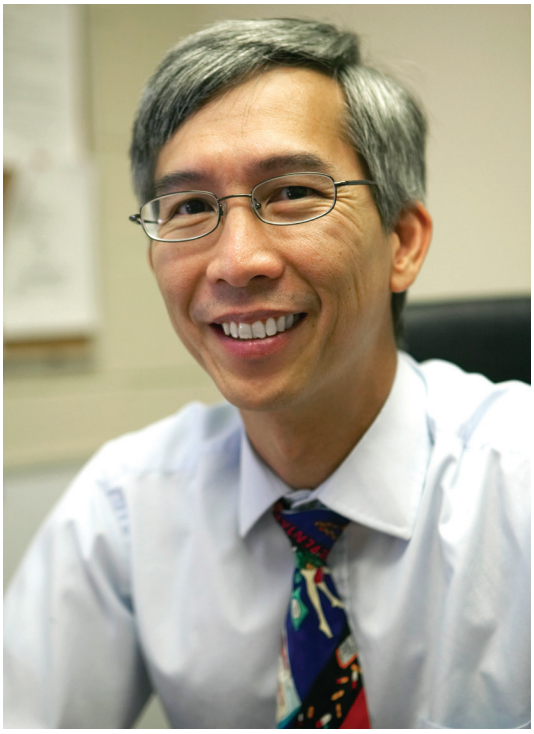
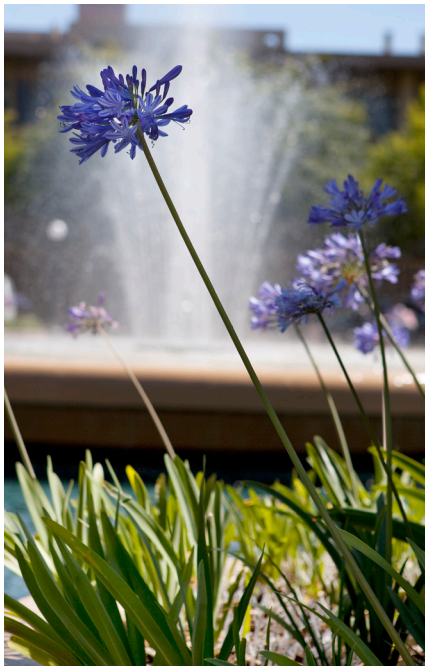
Stanford HEALTH CARE

Partnering to Improve

Stanford Health Care | Community Partnership Program

FY2017 – 2019 Implementation Strategy





FISCAL YEARS 2017 – 2019 IMPLEMENTATION STRATEGY

GENERAL INFORMATION

Contact Person:	Colleen Johnson
Years the Plan Refers to:	Fiscal years 2017-2019
Date Written Plan Was Adopted by Authorized Governing Body:	November 2, 2016
Authorized Governing Body that Adopted the Written Plan:	Finance Committee Stanford Health Care Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	Stanford Health Care EIN 94-6174066
Address of Hospital Organization:	Stanford Health Care 300 Pasteur Drive Stanford, CA 94305-5547

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[i] CHNA: Community Health Needs Assessment

I. ABOUT STANFORD HEALTH CARE

Stanford Health Care (SHC) seeks to heal humanity through science and compassion, one patient at a time, through its commitment to care, educate, and discover. Stanford Health Care delivers clinical innovation across its inpatient services, specialty health centers, physician offices, virtual care offerings, and health plan programs.

Stanford Health Care is part of Stanford Medicine, a leading academic health system that includes the Stanford University School of Medicine, Stanford Health Care, and Stanford Children's Health, with Lucile Packard Children's Hospital. Stanford Medicine is renowned for breakthroughs in treating cancer, heart disease, brain disorders, and surgical and medical conditions.

II. STANFORD HEALTH CARE'S SERVICE AREA

SHC draws patients from throughout California, across the country, and internationally. However, the majority of SHC's patients (nearly 65%) are residents of San Mateo or Santa Clara Counties. Therefore, for the purposes of its community benefit program, SHC has identified these two counties as its target community.

Located in the San Francisco Bay Area, both San Mateo and Santa Clara Counties include a mix of urban and suburban industrial, small business, and residential use. San Mateo County also includes a coastal area with significant agricultural, fishing, small business, and tourism land use. According to the U.S. Census, the estimated 2014 population across both of these counties was over 2.5 million.[ii] The service area is very ethnically diverse; about four in ten residents are of an ethnicity other than white, including sizeable Asian and Latino populations. In both counties, more than a third of residents are foreign-born.

The median income in Santa Clara County in 2014 was $93,854—the highest in California—and San Mateo was not far behind at $91,421. However, in that same year, one in ten Santa Clara County children and 14% of adults were living below the Federal Poverty Level (FPL).[iii] In addition, more Hispanic/Latino and Black/African-American Santa Clara County children were living in poverty compared to children of other racial/ethnic groups and the county overall.

[ii] 2014 data in this section are based on U.S. Census Bureau five-year estimates from the American Community Survey. This dataset is the most reliable dataset available as of August 2016. .
[iii] In 2014, the national FPL for a family of four was $23,850.

The cost of living in this area is high. A single parent with two children[iv] must earn over $90,000 annually to meet the family's basic needs, the equivalent of four full-time Santa Clara County minimum-wage jobs.

An additional point of concern is that the older population is increasing in this area. Currently, 16% of the population of Santa Clara County and 20% of San Mateo County are older adults (aged 65 years or older). These percentages are expected to rise to 23% and 31% respectively by the year 2050.

III. PURPOSE OF IMPLEMENTATION STRATEGY

This Implementation Strategy Report (IS Report) describes Stanford Health Care's planned response to the needs identified through the 2016 CHNA process. It fulfills Section 1.501(r)–3 of the IRS regulations governing nonprofit hospitals. Subsection (c) pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will address and a description of the health needs that the hospital will not address. Per these requirements, the following descriptions of the actions (strategies) Stanford Health Care intends to take include the anticipated impact of the strategies, the resources the hospital facility plans to commit to address the health needs, and any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs.

For information about Stanford Health Care's 2016 CHNA process and for a copy of the 2016 CHNA report, please visit https://stanfordhealthcare.org/about-us/community-partnerships.html.

IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2016 CHNA

The 2016 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. SHC's consultants used this primary qualitative input to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. The consultants compiled the statistical data and provided comparisons against Healthy People 2020 (HP2020) benchmarks[v] or, if such benchmarks were not available, statewide averages and rates.

In order to be considered a health need for the purposes of the 2016 CHNA, the need had to be supported by community input and/or by data from at least two secondary sources, and at least one indicator had to miss a benchmark (HP2020 or state average). A total of 21 health needs were

[iv] One infant and one preschool-aged child.

[v] Healthy People (www.healthypeople.gov) is an endeavor of the U.S. Department of Health and Human Services, which has provided 10-year national objectives for improving the health of Americans based on scientific data for 30 years. Healthy People sets objectives or targets for improvement for the nation. The most recent objectives are for the year 2020 (HP2020), and they were updated in 2012 to reflect the most accurate population data available.

identified in the 2016 CHNA. The health need prioritization and selection process is described in Section VI of this report.

Table 1. 2016 Community Health Needs List by Prioritization Category

SHC PRIORITIZED	CHNA IDENTIFIED HEALTH NEEDS
YES (met all five prioritization criteria)[vi]	**Behavioral Health**
	Cancer
	Diabetes/Obesity
	Health Care Access & Delivery
	Infectious Diseases
NO (did not meet all five prioritization criteria)	**Alzheimer's Disease & Dementia**
	Arthritis
	Birth Outcomes
	Cerebrovascular Diseases
	Climate Change
	Diet/Fitness/Nutrition
	Economic Security
	Housing & Homelessness
	Learning Disabilities
	Oral/Dental Health
	Respiratory Conditions
	Sexual Health
	Tobacco Use
	Transportation & Traffic
	Unintentional Injuries
	Violence & Abuse

V. WHO WAS INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) DEVELOPMENT

The SHC Community Partnership Program Steering Committee (CPPSC) selected the health needs to address. Actionable Insights, LLC provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health strategy. Actionable Insights is a consulting firm whose principals have experience conducting Community Health

[vi] The prioritization criteria may be found in Section VI of this report.

Needs Assessments and providing expertise on implementation strategy development and IRS reporting for hospitals.

VI. HEALTH NEEDS THAT STANFORD HEALTH CARE PLANS TO ADDRESS

A. Process and Criteria Used to Select Health Needs

In February 2016, the CPPSC met to review the information collected for the 2016 CHNA. The purpose of the meeting was to prioritize the identified significant health needs and then select the needs SHC would address, which would form the basis for SHC's FY2017-2019 community benefit plan and implementation strategies.

The CCPSC prioritized the 21 health needs documented in the 2016 CHNA by applying the following five criteria:

- The need cuts across both San Mateo and Santa Clara Counties (impacts SHC's target community).
- Community input identified the health need as a priority.
- SHC has the required expertise and resources to make an impact on this need.
- The need affects a large number of individuals (magnitude/scale).
- Health disparities or inequities exist regarding this need.

The CPPSC came to consensus on addressing the five health needs that met all of the criteria. While not rising to the threshold of significant health needs as documented in the 2016 CHNA, two additional needs (community emergency response and older adult health) were added based on SHC's knowledge of the community it serves. These needs are further described in the next section.

B. Descriptions of Health Needs that Stanford Health Care Plans to Address

Behavioral Health

This health need includes mental health, well-being (such as stress, depression, and anxiety), and substance abuse.

In San Mateo County (SMC), there was a rise between 1998 and 2013 in the percentage of self-reported mental and emotional problems. Suicide was the tenth leading cause of death in SMC in 2013. There is also a higher percentage of students in middle school and high school with depressive symptoms compared to their counterparts in the state as a whole. Countywide, depression is more common among Latinos, low-income residents, and those with a high school diploma or less. There are also disparities among surveyed adults who reported feeling worried, tense, or anxious, with Black, Latino, and low-income residents reporting these feelings most often. Finally, among surveyed county adults, difficulty with feeling satisfied with one's life and

with relationships to family members has been getting worse over time. With regard to alcohol and substance use, the level of binge drinking among young adult males in SMC rose between 1998 and 2013, and excessive alcohol consumption among all adults is higher in SMC than in the state. The community reported there is a limited supply of mental health care providers and substance abuse treatment options in SMC as well as inadequate insurance coverage for these behavioral health benefits among those who are insured. Participants in SMC expressed concerns about behavioral health for populations of all ages, from teens to adults and older adults. The SMC community identified a variety of factors that cause stress and thus have a negative impact on well-being, including lack of affordable housing, inadequate green spaces, commuting long distances, experiencing food insecurity, being unemployed/under-employed or having multiple jobs, living in an unsafe neighborhood, facing family conflict up to and including domestic violence, having undocumented status, experiencing economic disparities, and being the subject of racism, sexism, or gender inequality. The community also indicated that the level of stigma associated with behavioral health issues may make it harder for individuals with such issues to seek and obtain help, and that these individuals experience frequent discrimination in their communities and in health care settings.

In Santa Clara County (SCC), the community prioritized behavioral health as a top need. Many adults in the county reported having poor mental health, especially those who are LGBTQI. The community discussed the stigma that persists for those who experience mental illness. They also expressed concern about older adults, LGBTQI residents, and those of particular ethnic cultures where stigma is worse. Community feedback indicated that there is a lack of health insurance benefits for those who do not have formal diagnoses and insufficient services for those who do. Providers of behavioral health services cited poor access to such services when funding does not address the co-occurring conditions of addiction and mental illness. The community expressed concern about the documented high rates of youth marijuana use and rising youth methamphetamine use. While the magnitude of binge drinking among adults and youth is low, it is a contributor to liver disease/cirrhosis, the ninth leading cause of death in the county.

Cancer

In San Mateo County (SMC), cancer was the second leading cause of death in 2013. Cancer mortality rates are higher among Black and Pacific Islander SMC residents than HP2020 objective. The incidence rate of colorectal cancer and mortality rate of female breast cancer are both higher in SMC than HP2020 targets. Cervical, colorectal, lung, and prostate cancer disproportionately affect Black residents of SMC. Cervical cancer also disproportionately affects SMC's Latino residents. The health need is likely impacted by health behaviors such as rates of adult smoking that surpass the HP2020 target among various county populations, including men and low-income individuals. Alcohol consumption is also associated with higher risk of certain cancers, and the rates of binge drinking among adults is higher in SMC than in the state. Participants reported particular concern about smoking as a cause of cancer.

Cancer is the top leading cause of death in Santa Clara County (SCC). Data show that incidence rates of prostate and colorectal cancer are higher than HP2020 targets. Breast and cervical cancer both disproportionately affect White residents, lung cancer disproportionately affects Black residents, and a high proportion of Vietnamese residents have liver cancer. Black residents have higher overall cancer mortality rates compared with other racial/ethnic groups. Hepatitis B, a driver of liver cancer, is higher in SCC compared to the state. Asian and Pacific Islander residents are more likely to have hepatitis B than other racial/ethnic groups and are therefore at higher risk of liver cancer. In addition, public health experts have expressed concern about youth tobacco use, as smoking has also been shown to have an impact on various types of cancer.

Diabetes/Obesity

In San Mateo County (SMC), there was a rise between 1998 and 2013 in the percentage of self-reported diabetics. The overall adult diabetes rate in SMC, based on self-report, is higher than the HP2020 target, with Black and low-income residents disproportionately reporting being diabetic. Diabetes was the eighth leading cause of death in SMC in 2013. With regard to obesity, there are slightly higher rates of overweight and obese 2- to 4-year-olds countywide, and slightly higher rates of overweight youth in fifth, seventh, and ninth grades in the northern part of SMC, compared to state averages. There are disproportionalities among youth in SMC, with Black and Latino youth more likely to be obese or overweight and to be physically inactive than youth overall. Rates of diabetes management are slightly lower in SMC than in the state. There was a substantial drop over time in the percentage of SMC adults who exhibit a set of healthy behaviors (do not smoke, are not overweight, exercise adequately, and eat adequate fruits and vegetables). Adult and child fruit and vegetable consumption in the county is not much better than the state average, with disproportionate percentages of low-income, Black, and Latino county adults reporting fair or poor access to affordable fresh produce. Fitness among county adults improved between 2001 and 2013 but is still far from optimal. Smaller percentages of county seventh graders met the fitness standards than in prior years, with Latino, Black, and American Indian students disproportionately not meeting the standards. Few children walk or bike to school on a regular basis in the county. Community concerns included the relative availability of fast food restaurants compared to healthy/fresh foods, the cost of healthy food, inadequate access to grocery stores in low-income neighborhoods, not enough nutrition education, and neighborhoods with few safe places to play. With respect to diabetes specifically, the community expressed concern about the complications that can result from diabetes, the magnitude of the problem (more people living with and dying from chronic conditions such as diabetes than from acute conditions), and the relative lack of doctors and caregivers available to treat chronic diseases such as diabetes.

In Santa Clara County (SCC), the proportion of obese children younger than six is higher than the state and HP2020 targets. SCC's Latino and Black adolescents are more likely to be overweight and obese, and these rates fail Healthy People 2020 targets. While overall adult obesity is not worse in the county than in the state, Latino and Black adult obesity rates fail HP2020 targets.

While adult diabetes rates in SCC are no worse than in California overall, community perception was that childhood diabetes diagnoses are increasing (which is not confirmed with extant data).

Health Care Access and Delivery

In San Mateo County (SMC), disproportionalities in the population of insured residents illustrate the health need. For example, there are greater proportions of uninsured Latinos and those of "some other race" in SMC than in the state overall. In addition, the proportion of county residents who report visiting a doctor for a routine checkup has been trending down, while the proportion who report that the cost of care prevents them from visiting the doctor has been trending up. Low-income, Latino, and Black residents disproportionately experience transportation as a barrier to seeing a doctor. The percentage of the population in SMC that lives within one-half mile of a transit stop is lower than in the state overall; coastside residents cited this as particularly problematic. Access to both dental insurance and mental health services are also getting worse in SMC. Community participants indicated that more individuals are enrolled in health insurance but do not use it and continue to visit the ER or community clinics instead due to issues of affordability, a lack of primary and specialty practitioners who accept their insurance, and long wait times to obtain an appointment. Residents and providers both indicated that patients need help navigating the health care system. The community identified discrimination and lack of cultural competence as delivery barriers that affect minority populations in SMC.

In Santa Clara County (SCC), the proportion of Latino residents who are less likely to be insured, less likely to see a primary care physician, and more likely to go without health care due to cost is worse than the county overall. The community indicated that health care access is a top priority; specifically, affordability of insurance is an issue for those who do not qualify for Covered California subsidies. The lack of general and specialty practitioners, especially in community clinics, results in long wait times for appointments. The community also lacks health system literacy and is in need of patient navigators and advocates (especially immigrants). The community reported access to health care for those experiencing homelessness as a concern, especially behavioral health treatment and treatment for conditions that require rehabilitation and follow-up care. The LGBTQI and Black communities cited a lack of culturally competent providers as an access barrier. In addition, linguistic isolation is a concern in the county, which also impacts health care access.

Infectious Diseases

In San Mateo County (SMC), the health need is evident in the rise in the incidence rate of tuberculosis (TB) and rising numbers of deaths from pneumonia and influenza over the past decade. The latter two diseases combined were the sixth leading cause of death in SMC in 2013. The TB incidence rate is higher in SMC than the state. Disparities by race in TB incidence occur among county Asian/Pacific Islander residents. Also, the incidence rates of campylobacteriosis (a gastrointestinal illness) and salmonella have been trending upward in SMC in recent years. Older adults in SMC are vaccinated against influenza and pneumonia in smaller proportions than the

HP2020 target dictates. The community expressed concern about overcrowding in homes, as infectious diseases spread faster in crowded environments.

Infectious diseases are a health need in Santa Clara County (SCC) as evidenced by high rates of hepatitis B (which is worse than the state) and TB (which fails to meet the HP2020 target). Ethnic disparities are also seen in tuberculosis rates, with the rate for Asian and Pacific Islander residents more than double that of the county overall. Specifically, Vietnamese residents comprise a large proportion of all TB cases. The community expressed concern about the lack of screenings for these diseases, especially among Asian immigrants who come from countries where TB is more common than in the U.S. In addition, professionals cited the lack of referrals and follow-up with patients who are diagnosed with TB and/or hepatitis B. Finally, it is also concerning that influenza is the eighth leading cause of death in SCC.

Additional Needs Identified by SHC

Community Emergency Response

SHC plays a key role in disaster planning for the community. Through the Office of Emergency Management (OEM), SHC collaborates with local municipalities, county government, and other hospitals to coordinate planning, mitigation, response, and recovery activities for events that could adversely impact the community. The goal of these activities is to minimize the impact on life, property, and the environment from catastrophic events such as pandemic flu, earthquakes, and other disasters. Although emergency preparedness was not identified as a health need in the 2016 CHNA, it is part of the HP2020 objectives.[vii] As such, SHC believes it is important to continue its support of community emergency response.

Older Adult Health

According to the 2016 CHNA, the median age of the population in both San Mateo County (SMC) and Santa Clara County (SCC) is higher than the state. The 2016 CHNA also states that in the next 10 years, nearly one in five SCC residents will be 65 years or older. SMC's Public Health Officer has estimated that the proportion of older adults in the population in the next several decades will continue to be higher than the state average. Although older adult health was not identified as a health need in the 2016 CHNA, these existing data and projections suggest that it is an emerging issue. SHC believes that it can most effectively serve the needs of this growing population by continuing to provide fall prevention, chronic disease management, and subsidized safety programs, such as Lifeline, to the community through Aging Adult Services and Trauma Services.

[vii] https://www.healthypeople.gov/2020/topics-objectives/topic/preparedness.

VII. STANFORD HEALTH CARE'S IMPLEMENTATION STRATEGY

This plan represents a continuation of a multi-year strategic investment in community health. SHC believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2016 CHNA process.

Strategy Research

SHC developed strategies to address the health needs by reviewing literature on evidence-based and promising practices.

References to these sources are provided in numbered endnotes found at the end of this report.

A. Behavioral Health

Long-Term Goal: Improve behavioral health among San Mateo and Santa Clara Counties community members, including mental health, substance abuse, and well-being (such as stress, depression, and anxiety).

Intermediate Goal A.1: Improve community members' access to coordinated behavioral health care.

Goal A.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or Federally Qualified Health Centers (FQHCs) for efforts such as:

- Supporting coordination of behavioral health care and physical health care at MayView Clinic and Asian Americans for Community Involvement (AACI).[1] Supported practices could include the following:
  - Collaborative care for the management of depression using case managers to connect primary care providers, patients, and mental health specialists.[2]
  - Clinic-based depression care management, including active screening for depression, measurement-based outcomes, trained depression care managers, case management, a primary care provider and patient education, antidepressant treatment and psychotherapy, and a supervising psychiatrist.[3]
  - Staff-assisted depression care supports to ensure increased screening, accurate diagnosis, effective treatment, and follow-up.[4]
- Supporting local programs that provide appropriate medical care and supportive, social services for homeless individuals transitioning out of acute care hospitals,[5] such as funding the Medical Respite Program (MRP).[6]

Goal A.1 Anticipated impact:

- Improved access to behavioral health services among community members.
- Improved access to coordinated care among underserved populations.
- Improved clinical and community support for active patient engagement in treatment goal-setting and self-management.
- Among providers, increased knowledge of the importance of and approaches for routine screening and diagnosis of depression and related disorders.

Intermediate Goal A.2: Expand access to behavioral health services for vulnerable community members in both counties.

Goal A.2 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Integrated mental health and substance abuse services, treatment, and service provision to support recovery from co-occurring mental illness and substance abuse through a single agency or entity.[7]

Participate in collaboration and partnerships to address mental health in the community such as:

- Partnering with San Mateo Santa Clara Counties' Behavioral Health Departments on efforts to address behavioral health in the community.

Goal A.2 Anticipated impact:

- Improved access to behavioral health services among community members.

B. Cancer

Long-Term Goal: Increase community knowledge about cancer and support of those who are affected by cancer.

Intermediate Goal B.1: Increase access to cancer education, services, clinical trials, and programs, especially among minority and underserved populations.

Goal B.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Partnering with the Stanford Cancer Institute, a National Cancer Institute-designated cancer center, to identify and support community-appropriate cancer education programs and supportive services for minorities, women, and underserved populations that raise awareness, increase knowledge, and encourage positive attitudes and behavioral changes regarding cancer.[8]
- Supporting the Stanford Cancer Supportive Care Program (SCSCP) to provide non-medical services (e.g., support groups, classes, and workshops) to cancer patients, family members, and caregivers regardless of where patients receive treatment.[8]
- Partnering with the Stanford University School of Medicine to provide a cancer clinical trials information website, phone line, email query service, information kiosk, and clinical trial search app in support of community outreach/education on cancer clinical trials.[9]

Goal B.1 Anticipated impact:

- Increased opportunity for the community to become aware of cancer clinical trials.
- Increased opportunity for community members, particularly minority community members, with cancer to be linked to appropriate clinical trials.
- Increased access to cancer education and services.
- Increased knowledge about cancer.

C. Diabetes/Obesity

Long-Term Goal: Reduce obesity and diabetes incidence among adults in both counties.

Intermediate Goal C.1: Increase healthy behaviors among adults in both counties.

Goal C.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Intensive behavioral counseling interventions with adults to promote a healthful diet and physical activity.[10]

Participate in collaboration and partnerships to promote healthy behaviors such as:

- Get Healthy San Mateo County.
- The Bay Area Nutrition and Physical Activity Collaborative (BANPAC) policy or program initiatives focused on nutrition and physical activity.
- Center for Chronic Disease and Injury Prevention of Santa Clara County.

Goal C.1 Anticipated impact:

- Increased physical activity.
- Increased consumption of healthy foods.
- Reduced time spent on sedentary activities.
- Reduced consumption of unhealthy foods.
- More policies/practices that support increased physical activity and improved access to healthy foods.

Intermediate Goal C.2: Improve diabetes management and weight control among adults in both counties.

Goal C.2 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Samaritan House's Diabetes Care Day program or similar activities to improve diabetes self-management.[11]

Goal C.2 Anticipated impact:

- Improved diabetes self-management.
- Increased physical activity.
- Increased consumption of healthy foods.
- Reduced time spent on sedentary activities.
- Reduced consumption of unhealthy foods.

D. Health Care Access and Delivery

Long-Term Goal: Increase the number of people who have access to appropriate health care services.

Intermediate Goal D.1: Improve access to quality health care services for at-risk community members.

Goal D.1 Strategies:

Allocate resources to support:

- Participation in government-sponsored programs for low-income individuals.
- Providing Charity Care to ensure low-income individuals obtain medical services needed.

- Partnership among SHC's Emergency Department Registration Unit, Santa Clara County, and San Mateo County to deliver a program designed to link uninsured pediatric patients treated in the emergency department with assistance programs such as Medi-Cal, Healthy Families and Healthy Kids.[12]
- Partnership between SHC's Office of Research and Stanford University's School of Medicine in conducting and facilitating research studies and clinical trials to improve the health and treatment of patients, wherever they receive their care.
- Professional health advocates in assisting uninsured, low-income patients to research health care options, including helping individuals research eligibility requirements, identify appropriate health insurance programs, complete applications, compile required documentation, and follow up with county case managers.[13]
- Ensuring that all branches of the Stanford Health Library (including library's collection and health lecture series) are accessible to all community members free of charge.[14]
- Partnership with the Stanford University School of Medicine to support summer youth programs that promote the representation of ethnic minority and low-income groups in the health professions, such as the Stanford Medical Youth Science Program (SMYSP).[15]
- Providing the setting (hospital and clinics) and partial funding for Stanford University's School of Medicine medical residents, interns, and other health professionals to be trained to provide health care.[16]
- LifeFlight, a helicopter air medical and critical care ground transport program available 365 days/year, 24 hours/day, serving Northern CA in the transport of critically ill and injured adult, pediatric, and neonatal patients to definitive care, regardless of the patient's ability to pay.[17]

Provide grants, sponsorships, or in-kind support to community health centers, clinics, or FQHCs (e.g., AACI) for efforts such as:

- Partnering with the Stanford University School of Medicine to provide free lab and pathology tests to Cardinal Free Clinics, including chemistry, hematology, microbiology, and virology, as well as imaging services and screening for diseases such as hepatitis B.[18]
- Collaborating with Ravenswood Family Health Center (RFHC), Lucile Packard Children's Hospital Stanford, and the Stanford University School of Medicine to identify RFHC patients who frequently use Stanford's emergency department (ED) and develop appropriate interventions to address these patients' needs (such as improved chronic disease care and management) while reducing unnecessary ED visits.[19]

Goal D.1 Anticipated impact:

- Increased access to health insurance and health care services.
- Improved access to appropriate care.
- Improved care coordination among underserved populations.
- Increased pipeline of diverse health care providers.

E. Infectious Diseases

Long-Term Goal: Prevent infectious diseases such as hepatitis B, tuberculosis, influenza and pneumonia among community members in San Mateo and Santa Clara Counties.

Intermediate Goal E.1: Improve detection of cases of hepatitis B among community members.

Goal E.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Partnering with the Stanford University School of Medicine to provide free lab and pathology tests to Cardinal Free Clinics, including chemistry, hematology, microbiology, and virology, as well as imaging services and screening for diseases such as hepatitis B.[20]
- Partnering with the Stanford University School of Medicine Asian Liver Center on community-oriented programs related to hepatitis B.

Goal E.1 Anticipated impact:

- Reduced transmission rates of hepatitis B due to timelier detection.

Intermediate Goal E.2: Increase the number of residents vaccinated against hepatitis B.

Goal E.2 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs (e.g., Peninsula Healthcare Connection) for efforts such as:

- Universal hepatitis B vaccination in settings in which a high proportion of adults have risk factors for hepatitis B virus (HBV) infection.[21]
- Education of primary and specialty care physicians regarding implementation of standing orders to identify adults recommended for hepatitis B vaccination and administer vaccination as part of routine services.[23]
- Vaccination against hepatitis B of all previously unvaccinated adults aged 19 through 59 years with diabetes mellitus (type 1 and type 2).[22]

Participate in collaboration and partnerships to address hepatitis B in the community such as:

- Hep B Free Santa Clara County.

- Other partnership opportunities with San Mateo and Santa Clara Counties' Departments of Public Health, including potential collaboration around improved case management/follow-up for community members diagnosed with hepatitis B.

Goal E.2 Anticipated impact:

- Increased knowledge among providers regarding hepatitis B vaccination.
- Increased community knowledge regarding hepatitis B vaccination.
- Increased hepatitis B vaccination rates.

Intermediate Goal E.3: Improve rates of completion of treatment for those with active TB infections in San Mateo and Santa Clara Counties.

Goal E.3 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, local public health departments, or FQHCs for efforts such as:

- Improving case management for community members diagnosed with active TB, especially—but not exclusively—for homeless community members.[23]

Participate in collaboration and partnerships to address TB in the community such as:

- Working with county/local jurisdictions to explore leveraging funds from the California Department of Health and U.S. Department of Housing & Urban Development earmarked for temporary housing of persons with TB to provide more temporary housing for TB patients while they complete treatment (as patients must be "noninfectious before discharge to a congregate living setting").[25]

Goal E.3 Anticipated impact:

- Increased efforts among case managers to link TB patients (especially, but not exclusively, homeless TB patients) with behavioral health services and social services.
- Increased amount of temporary housing for TB patients during treatment.

Intermediate Goal E.4: Increase rates of detection and successful treatment of latent TB infection (LTBI) in San Mateo and Santa Clara Counties.

Goal E.4 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs (e.g., Peninsula Healthcare Connection) for efforts such as:

- Supporting case detection among foreign-born persons, including: [25]

- Appropriate, "targeted public education for foreign-born populations at high risk to explain that TB is a treatable, curable disease."
- "[B]etter access to medical services, especially for recently arrived immigrants and refugees."

- Improving case management for those whose primary language is not English by supporting:[25]
  - Adequate access to "reliable and competent medical translation."
  - Improved understanding among healthcare providers of "cultural attitudes towards TB."

Participate in collaboration and partnerships to address TB in the community such as:

- Working with Breathe California of the Bay Area (located in Santa Clara County) and Breathe California Golden Gate Public Health Partnership.
- Partnering with San Mateo and Santa Clara Counties' Departments of Public Health TB Control Programs.

Goal E.4 Anticipated impact:

- Increased knowledge among foreign-born residents about TB and local services and approaches related to TB.
- Increased access to medical services for foreign-born residents.
- Increased knowledge among providers about diagnosis and management of TB and various cultural attitudes towards TB.
- Increased access among foreign-born residents to reliable and competent medical translation in more languages.

Intermediate Goal E.5: Reduce incidence of influenza and pneumonia in San Mateo and Santa Clara counties.

Goal E.5 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs (e.g., Peninsula Healthcare Connection) for efforts such as:

- Implementing or expanding patient and/or provider vaccination reminder system.[24]
- Reducing physical barriers to vaccination such as "inconvenient clinic hours for working patients or parents, long waits at the clinic, or the distance patients must travel" by offering pneumonia vaccinations at senior centers and/or senior health fairs and/or via home visits.[26]
- Conducting educational sessions (e.g., on the importance of pneumococcal and influenza vaccinations and the effectiveness of strategies to improve documentation of vaccination status and increase vaccination rates) with medical staff and/or nursing/quality improvement staff.[25]

Participate in collaborations and partnerships to address influenza in the community such as:

- Working with Breathe California.
- Partnering with San Mateo and Santa Clara Counties' Departments of Public Health on influenza prevention and control efforts.

Goal E.5 Anticipated impact:

- Increased knowledge of the importance of and access to influenza and pneumonia vaccinations, among community members.
- Increased knowledge of the importance of and approaches to increasing pneumococcal and influenza vaccination rates, among medical staff and/or nursing/quality improvement staff.

Intermediate Goal E.6: Improve response to adult infectious disease in rural San Mateo County southern coastside communities.

Goal E.6 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Building the capacity of local community-based clinics such as Puente to focus on adult infectious disease prevention, detection, and treatment.[26]

Goal E.6 Anticipated impact:

- Increased adult vaccination rates for infectious diseases.
- Reduced incidence rates of infectious disease in rural San Mateo County southern coastside communities.

F. Community Emergency Response[viii]

Long-Term Goal: Improve the community's ability to "prevent, prepare for, respond to, and recover from a major health incident."[27]

Intermediate Goal F.1: "Strengthen and sustain health and emergency response systems" in San Mateo and Santa Clara Counties.[10]

[viii] While not rising to the threshold of a significant health need as documented in the 2016 CHNA, SHC added Community Emergency Response as a need to be addressed based on its knowledge of the community it serves.

Goal F.1 Strategies:

Participate in collaboration and partnerships to address community emergency response such as:[28]

- Collaborating, through the Office of Emergency Management (OEM), with local municipalities, county government, and other hospitals to coordinate planning, mitigation, response, and recovery activities for events that could adversely impact the community.
- Through OEM, working with Emergency Medical Services (EMS) in both San Mateo and Santa Clara Counties on joint disaster exercises, disaster planning and mitigation, and best practices.
- Through OEM, maintaining caches of emergency medical equipment and supplies for ready access and deployment in San Mateo and Santa Clara Counties in the case of disaster or emergencies. OEM also provides regular inventory review and 24/7 security to ensure that these EMS supplies are service-ready at all times.

Goal F.1 Anticipated impact:

- Sustained community disaster preparedness.

G. Older Adult Health[viii]

Long-Term Goal: Improve the health and well-being of older adults in San Mateo and Santa Clara Counties.

Intermediate Goal G.1: Improve older adults' access to critical prevention and health-promotion services.

Goal G.1 Strategies:

Provide grants, sponsorships, or in-kind support to community-based organizations, community health centers, clinics, or FQHCs for efforts such as:

- Exercise and educational programs that help older adults increase strength, balance, and mobility, and reduce their risk of falling, such as A Matter of Balance (MOB), Stepping On, Healthy Moves for Aging Well, or Strong for Life.[29]
- The Chronic Disease Self-Management Program (CDSMP), a behaviorally-oriented program that teaches participants how to manage their chronic conditions and helps them develop confidence in managing their health.[29]

[viii] While not rising to the threshold of a significant health need as documented in the 2016 CHNA, SHC added Older Adult Health as a need to be addressed based on its knowledge of the community it serves.

- A falls prevention program such as Farewell to Falls, including medication review, home visits, review and remediation of in-home falls risk factors, home modifications, in-home exercise program, and regular follow-up.[30]
- Reduced-rate or subsidized in-home medical alert service, Stanford Lifeline, for low-income older adults.[31]

Goal G.1 Anticipated impact:

- Increased physical activity.
- Reduced time spent on sedentary activities.
- Increased awareness of risk factors related to falls.
- Reduced age-adjusted falls hospitalization and mortality rates.

VIII. EVALUATION PLANS

SHC will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, SHC will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

IX. HEALTH NEEDS THAT STANFORD HEALTH CARE DOES NOT PLAN TO ADDRESS

As described in Section VI(A) of this report, SHC will address the five health needs that met all of the prioritization/selection criteria, as well as two additional needs that were not identified through the 2016 CHNA. SHC will not address the following identified health needs:

- The two needs of **Arthritis** and **Climate Change** were not chosen because they did not meet any of the five prioritization/selection criteria.
- The five needs of **Diet/Fitness/Nutrition**, **Learning Disabilities**, **Tobacco Use**, **Transportation & Traffic**, and **Unintentional Injuries** were not chosen because they each met only one of the five prioritization/selection criteria.
- The **Sexual Health** need was not chosen because it met only two of the five prioritization/selection criteria.
- The four needs of **Alzheimer's Disease & Dementia**, **Birth Outcomes**, **Economic Security**, and **Violence & Abuse** were not chosen because they each met only three of the five prioritization/selection criteria.

- Although the four needs of **Cerebrovascular Diseases**, **Housing & Homelessness**, **Oral/Dental Health**, and **Respiratory Conditions** each met four of the five prioritization/selection criteria, they were not chosen because:
    - **Cerebrovascular Diseases** and **Respiratory Conditions** did not meet the criterion of community prioritization; the community did not deem these needs of sufficient priority.
    - **Housing & Homelessness** and **Oral/Dental Health** did not meet the criterion of SHC expertise/resources.

APPENDIX: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST

Section §1.501(r)(3)(c) of the Internal Revenue Service code describe the requirements of the Implementation Strategy Report.

Federal Requirements Checklist	Regulation Subsection Number	Report Section
The Implementation Strategy is a written plan which includes:		
(2) Description of **how the hospital facility plans to address** the health needs selected, including:	(c)(2)	VII
Actions the hospital facility intends to take and the anticipated impact of these actions	(c)(2)(i)	VII
Resources the hospital facility plans to commit	(c)(2)(ii)	VII
Any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need	(c)(2)(iii)	VII or N/A
(3) Description of why a hospital facility is **not addressing** a significant health need identified in the CHNA. *Note: A "brief explanation" is sufficient. Such reasons may include resource constraints, other organizations are addressing the need, or a relative lack of expertise to effectively address the need.*	(c)(3)	IX
(4) For those hospital facilities that adopted a joint CHNA report, a **joint implementation strategy** may be adopted which meets the requirements above. In addition, the joint implementation strategy must:	(c)(4)	N/A
Be clearly identified as applying to the hospital facility;	(c)(4)(i)	N/A
Clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and	(c)(4)(ii)	N/A
Include a summary or other tool that helps the reader easily locate those portions of the strategy that relate to the hospital facility.	(c)(4)(iii)	N/A
(5) An authorized body **adopts the implementation** strategy on or before January 15th, 2017, which is the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.	(c)(5)	November 2, 2016
Exceptions: Our hospital does not qualify for any exception described in Section (D) for acquired, new, transferred, and terminated facilities.	(d)	N/A
Transition Rule: Our hospital conducted our first CHNA in fiscal year 2013 (and not in either of the first two years beginning after March 23, 2010). Therefore, the transition rule does not apply to our hospital facility.	(e)	N/A

ENDNOTES

[1] Unützer, J., Harbin, H, Schoenbaum, M. & Druss, B. (2013). *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*. Retrieved from https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf.

[2] Community Preventive Services Task Force. (2012). *Recommendation from the Community Preventive Services Task Force for Use of Collaborative Care for the Management of Depressive Disorders*. Retrieved from http://www.thecommunityguide.org/mentalhealth/CollabCare_Recommendation.pdf.

[3] Guide to Community Preventive Services (2008). *Interventions to reduce depression among older adults: clinic-based depression care management*. Retrieved from http://www.thecommunityguide.org/mentalhealth/depression-clinic.html.

[4] U.S. Preventive Services Task Force (2014). *Final Recommendation Statement: Depression in Adults: Screening*. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening.

[5] O'Connell, J. J., Oppenheimer, S. C., Judge, C. M., Taube, R. L., Blanchfield, B. B., Swain, S. E., & Koh, H. K. (2010). The Boston Health Care for the Homeless Program: A Public Health Framework. *American Journal of Public Health*, *100*(8): 1400–1408. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2901289/.

[6] Medical Respite Program: 20 bed respite unit located in a homeless shelter in San Jose that provides a safe, supportive environment for homeless patients discharged from acute care hospitals.

[7] Blandford, A. & Osher, F. (2012). A Checklist for Implementing Evidence-Based Practices and Programs (EBPs) for Justice-Involved Adults with Behavioral Health Disorders. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2013/04/SAMHSA-GAINS.pdf. For more information on Integrated Mental Health and Substance Abuse Services, visit http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367 and http://gainscenter.samhsa.gov/pdfs/ebp/IntegratingMentalHealth.pdf.

[8] Guide to Community Preventive Services. (2009). Increasing cancer screening: group education for clients. Retrieved from http://www.thecommunityguide.org/cancer/screening/client-oriented/GroupEducation.html; Underwood, J.M., Lakhani, N., Finifrock, D., Pinkerton, B., Johnson, K., Mallory, S.H., Santiago, P.M., & Stewart, S.L. (2015). *Evidence-Based Cancer Survivorship Activities for Comprehensive Cancer Control.* Retrieved from http://www.ajpmonline.org/article/S0749-3797%2815%2900485-7/pdf; see also http://www.cancersupportcommunity.org/publications-presentations; and http://www.cscpasadena.org/about-us/our-history/evidence-based-research.

[9] Baquet, C. R., Henderson, K., Commiskey, P., & Morrow, J. N. (2008). Clinical Trials – The Art of Enrollment. *Seminars in Oncology Nursing*, 24(4): 262–269.. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3262589/.

[10] U.S. Preventive Services Task Force. (2015). *Final Update Summary: Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling.*

Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd.

[11] Vachon, G. C., Ezike, N., Brown-Walker, M., Chhay, V., Pikelny, I., & Pendergraft, T. B. (2007). Improving access to diabetes care in an inner-city, community-based outpatient health center with a monthly open-access, multistation group visit program. *Journal of the National Medical Association*, 99(12): 1327.

[12] Acosta, C., Dibble, C., Giammona, M., & Wang, N.E. (2009). A model for improving uninsured children's access to health insurance via the emergency department. *Journal of Health Care Management,* March/April; 54(2):105-116.

[13] Addresses strategies under U.S. Department of Health and Human Services' Strategic Goal 1, Objective A, to "extend affordable coverage to the uninsured," including identified strategies such as "Maximize the participation of…eligible individuals in affordable health insurance coverage by helping them understand insurance options" and "…provide outreach and enrollment assistance…," http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj_a

[14] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Retrieved from http://health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf (strategies include health library collections).

[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2006). *The Rationale for Diversity in the Health Professions: A Review of the Evidence.* Retrieved from http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/rationalefordiversity.pdf; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, and U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health. (2009). *Pipeline Programs to Improve Racial and Ethnic Diversity in the Health Professions: An Inventory of Federal Programs, Assessment of Evaluation Approaches, and Critical Review of the Research Literature.* Retrieved from http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/pipelinediversityprograms.pdf; also addresses Healthy People 2020 emerging health issue of "increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities:" https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[16] Addresses Healthy People 2020 emerging health issue of "increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities." https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[17] **Used as primary transport:**

Baxt, W.G. & Moody, P. (1983). The impact of a rotorcraft aeromedical emergency care service on trauma mortality. *Journal of the American Medical Association* 249:3047-3051.

Baxt, W.G., Moody, P., Cleveland, H.C., et al. (1985). Hospital-based rotorcraft aeromedical emergency care services and trauma mortality: A multicenter study. *Annals of Emergency Medicine*, 14:859-864.

Cunningham, P., Rutledge, R., Baker, C.C., et al. (1997) A comparison of the association of helicopter and ground ambulance transport with the outcome of injury in trauma patients transported from the scene. *Journal of Trauma*, 43:940-946.

Used as secondary transport:

Boyd, C.R., Corse, K.M., Campbell, R.C. (1989). Emergency interhospital transport of the major trauma patient: Air versus ground. *Journal of Trauma*, 29:789-794.

Moylan, J.A., Fitzpatrick, K.T., Beyer, J.A. III, et al. (1988) Factors improving survival in multisystem trauma patients. *Annals of Surgery*, 207:679-685.

[18] Addresses Healthy People 2020 goal to "Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life," https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[19] New England Healthcare Institute. (2010). *A Matter of Urgency: Reducing Emergency Department Overuse*. Retrieved from http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf; U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services. (2014). *CMCS Informational Bulletin: Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings.* Retrieved from https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf; and Enard, K. R., & Ganelin, D. M. (2013). Reducing Preventable Emergency Department Utilization and Costs by Using Community Health Workers as Patient Navigators. *Journal of Healthcare Management / American College of Healthcare Executives*, 58(6): 412–428. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142498/.

[20] Addresses Healthy People 2020 goal to "Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life," https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[21] Centers for Disease Control and Prevention. (2006). *A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (AICP) Part II: Immunization of Adults.* MMWR 2006; 55 (No. RR-16):1-33. Retrieved from http://www.cdc.gov/mmwr/pdf/rr/rr5516.pdf; includes the following activities:

— Provide information to all adults regarding the health benefits of hepatitis B vaccination, including risk factors for HBV infection and persons for whom vaccination is recommended.

— Help all adults assess their need for vaccination.

— Vaccinate adults who report risks for HBV infection.

— Vaccinate adults requesting protection from HBV infection.

[22] Centers for Disease Control and Prevention. (2011). *Use of Hepatitis B Vaccination for Adults with Diabetes Mellitus: Recommendations of the Advisory Committee on Immunization Practices (ACIP).* MMWR 2011; 60 (No. RR-50):1709-1711. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a4.htm; the recommendation is to vaccinate as soon as possible after a diagnosis of diabetes is made, and to vaccinate all previously unvaccinated adults aged ≥60 years with diabetes at the discretion of the treating clinician after assessing their risk and the likelihood of an adequate immune response to vaccination.

[23] Centers for Disease Control and Prevention. (2005). *Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America*. MMWR 2005; 54 (No. RR-12):1-81. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm, including all quoted below:

"Case management for homeless persons with TB should be structured to encourage adherence to treatment regimens by making TB treatment a major priority for the patient. It should include provision of housing, at least on a temporary basis; an increasing number of models have demonstrated the importance of a housing incentive in successful treatment of TB in homeless persons. Case management should also include establishing linkages with providers of alcohol and substance treatment services, mental health services, and social services."

"Targeted education of populations at high risk might be particularly effective in neutralizing the stigma associated with TB among foreign-born populations on the basis of cultural beliefs in their country of origin. Programs for patient education should always be designed with input from the targeted community."

"…education campaigns for foreign-born persons at high risk…should communicate the importance of TB as a personal and public health threat, the symptoms to look for, how to access diagnostic and targeted testing services in the community, and the concept of LTBI. The purpose of this education is to destigmatize the infection, acquaint the population with available medical and public health services, and explain the approaches used to treat, prevent, and control TB."

"Culturally appropriate case management should be instituted, including readily available professional translation and interpretation services, for all foreign-born persons. If possible, outreach workers should be from the patient's own cultural background."

[24] Centers for Disease Control and Prevention. (2105). *Epidemiology and Prevention of Vaccine-Preventable Diseases.* See Chapter 3: Immunization Strategies for Healthcare Practices and Providers. Retrieved from http://www.cdc.gov/vaccines/pubs/pinkbook/strat.html; and Centers for Disease Control and Prevention. (1997). *Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP).* MMWR 1997;46 (No. RR-08):1-24. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm.

[25] Casey, M.M., Klingner, J., Prasad, S., Gregg, W., & Moscovice, I. (2011). *Evidence-Based Pneumonia Quality Improvement Programs and Strategies for Critical Access Hospitals.* Retrieved from http://www.flexmonitoring.org/wp-content/uploads/2013/07/PolicyBrief22_QI-Pneumonia.pdf.

[26] Addresses Healthy People 2020 emerging health issue of "increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities." https://www.healthypeople.gov/2020/topics-objectives/topic/educational-and-community-based-programs.

[27] Office of Disease Prevention and Health Promotion, HealthyPeople.gov. (Undated). *Preparedness*. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/preparedness.

[28] Auf der Heide, E., & Scanlon, J. (2007). The role of the health sector in planning and response. In: Waugh, W.L., & Tierney, K. (2007): *Emergency Management Principles and Practice for Local Government*, 2nd ed., ICMA Press, Washington, DC. Retrieved from http://www.atsdr.cdc.gov/Auf_der_Heide_2007_Role_of_the_Health_Sector_in_Planning_&_Response.pdf .

[29] Area Agency on Aging 1B. (2013). *Evidence-Based Disease Prevention Programs*. Retrieved from http://www.aaa1b.org/wp-content/uploads/2012/05/List-of-Evidence-Based-Programs.pdf.

[30] Chang, J.T., Morton, S.C., Rubenstein, L.Z., Mojica, W.A., Maglione, M., Suttorp, M.J., Roth, E.A., & Shekelle, P.G. (2004). *Interventions for the prevention of falls in older adults: systematic review and meta-analysis of randomised clinical trials.* Retrieved from https://ubmm.med.buffalo.edu/uploads/DH22/Fall%20Prevention_Meta%20Analysis.pdf.

[31] Mann, W. C., Ottenbacher, K. J., Fraas, L., Tomita, M., & Granger, C. V. (1999). Effectiveness of assistive technology and environmental interventions in maintaining independence and reducing home care costs for the frail elderly: A randomized controlled trial. *Archives of Family Medicine*, 8(3): 210.