2017–2019 IMPLEMENTATION STRATEGY REPORT

Stanford HEALTH CARE
STANFORD MEDICINE

ValleyCare

2017–2019 IMPLEMENTATION STRATEGY REPORT

General Information

Contact Person:	**Denise Bouillerce** **Director, Marketing/Public Relations**
Date Written Plan Was Required to be Adopted by Authorized Governing Body:	January 15, 2017
Date Written Plan Was Adopted by Authorized Governing Body:	September 16, 2016
Authorized Governing Body that Adopted the Written Plan:	Finance Committee Stanford Health Care – ValleyCare Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	The Hospital Committee for the Livermore-Pleasanton Areas EIN 94-1429628
Address of Hospital Organization:	1111 E. Stanley Blvd. Livermore, CA 94550

TABLE OF CONTENTS

I. About ValleyCare 3

II. ValleyCare's Service Area 3

III. Purpose of Implementation Strategy 4

IV. List of Community Health Needs Identified in the 2016 CHNA Report 4

V. Who Was Involved in Strategy Development 6

VI. Health Needs ValleyCare Plans to Address 6

- A. Process & Criteria Used 6
- B. Health Needs ValleyCare Plans to Address 7

VII. Implementation Strategies 9

- A. Health Care Access & Delivery 9
- B. Behavioral Health 11
- C. Obesity, Diabetes, Healthy Eating, Active Living 13

VIII. Evaluation Plans 15

IX. Health Needs ValleyCare Does Not Plan to Address 15

Appendix: Implementation Strategy Report IRS Checklist 17

Endnotes 18

I. About ValleyCare

Stanford Health Care – ValleyCare has been dedicated to providing high quality, not-for-profit health care to the Tri-Valley and surrounding communities since 1961. Through highly skilled physicians, nurses, and staff, and state-of-the art technology, ValleyCare provides a wide range of health care services at its Livermore, Pleasanton, and Dublin medical facilities. ValleyCare has a total of 242 beds and a medical staff of approximately 500, offering an array of inpatient and outpatient services to the community. On May 18, 2015, ValleyCare affiliated with Stanford Health Care, and Stanford Health Care became the sole corporate member of ValleyCare. ValleyCare's mission is to care, to educate, and to discover.

II. ValleyCare's Service Area

Figure 1. ValleyCare Service Area Map

The Tri-Valley region is based around the four suburban cities of Livermore, Pleasanton, Dublin, and San Ramon in the three valleys from which it takes its name: Amador Valley, Livermore Valley, and San Ramon Valley. Livermore, Pleasanton, and Dublin are in Alameda County, while San Ramon is in Contra Costa County. With facilities in Pleasanton, Livermore, and Dublin,

ValleyCare's primary service area is the Tri-Valley, and the area accounts for the majority of ValleyCare's inpatient discharges.

The population of the ValleyCare service area is 285,331. About two thirds (64%) of people in the service area are White, and about one quarter (26%) are Asian. Black residents make up less than 3% of the population, and 13% of residents are of Hispanic/Latino ethnicity (of any race). One in ten residents has limited English proficiency, and 5% live in linguistically isolated households. Children under 18 make up about a quarter (26%) of the population.

III. Purpose of Implementation Strategy

This Implementation Strategy Report (IS Report) describes ValleyCare's planned response to the needs identified through the 2016 Community Health Needs Assessment (CHNA) process. It fulfills Section 1.501(r)–3 of the IRS regulations governing not-for-profit 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) ValleyCare intends to take include the anticipated impact of the strategies, the resources ValleyCare plans to commit to address the health needs, and any planned collaboration between ValleyCare and other facilities or organizations in addressing the health needs.

For information about ValleyCare's 2016 CHNA process and for a copy of the 2016 CHNA report, please visit www.valleycare.com/about-community-benefits.aspx.

IV. List of Community Health Needs Identified in the 2016 CHNA Report

The 2016 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. ValleyCare's consultants used this primary qualitative input to determine the community's priorities. In addition, ValleyCare's consultants analyzed quantitative (statistical) data 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[i] or, if such benchmarks were not available, statewide averages and rates.

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[i] 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.

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). The 2016 CHNA process identified a total of 14 health needs.

In March 2016, Stanford Health Care – ValleyCare convened a group of community and hospital representatives to review results of the CHNA data collection and data synthesis and to prioritize the health needs in fulfillment of IRS regulations. The ValleyCare group prioritized the health needs list by applying criteria to the list of 14 health needs. For details on the criteria used, please see the 2016 CHNA report at www.valleycare.com/about-community-benefits.aspx.

Table 1 lists the health needs identified for the Stanford Health Care – ValleyCare service area through the 2016 CHNA process. The table is ordered by priority, with 1 being the highest priority. The health need selection process is described in Section VI of this report.

Table 1. Health Needs List in Priority Order

ValleyCare 2016 CHNA Health Needs
1. Health Care access & delivery
2. Mental health
3. Obesity, diabetes, healthy eating, active living
4. Cardiovascular disease & stroke
5. Cancer
6. Substance abuse
7. Oral health
8. Maternal & child health
9. Communicable diseases
10. Economic security
11. Violence & injury prevention
12. Asthma
13. Unintentional injuries
14. Climate & health

V. Who Was Involved in Strategy Development

Denise Bouillerce (Director, Marketing/Public Relations) and Shelby Salonga (Manager, Marketing/Public Relations) led the Stanford Health Care – ValleyCare implementation strategy development as the community benefit team. The Community Benefit Advisory Committee (CBAC) (see list of members in box below) recommended 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 CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VI. Health Needs ValleyCare Plans to Address

A. Process & Criteria Used

The community benefit team provided a summary of the 2016 CHNA health needs to the CBAC prior to an in-person meeting on May 12, 2016 to select health needs for the hospital to address in FY2017–FY2019. During the meeting, the consultants explained the selection criteria and facilitated a discussion about the identified health needs. CBAC members reviewed the list of needs and discussed each identified health need, keeping in mind the selection criteria. The CBAC came to consensus on its recommendations for selection and provided justifications for the needs it did not recommend for selection.

CBAC Members:

- **Scott Gregerson**, President
- **Gina Teeples**, Chief Nursing Officer
- **Andrea Herbert**, Executive Director, Ambulatory Care Services and Strategic Development

The consultants outlined the following criteria to be used to select the health needs:

- **Disproportionalities exist:** Disproportionalities in the health need exist in the community (i.e., there are disparities or inequities by ethnic population, income level, area of residence, gender, sexual orientation, etc.).
- **ValleyCare's role:** ValleyCare has the necessary resources and/or expertise to make an impact on the health need in the community.
- **Possibilities for leverage:** Local partnership and/or collaboration opportunities exist for ValleyCare in addressing the health need.

B. Health Needs ValleyCare Plans to Address

The CBAC recommended three health needs for the hospital to address for the next three fiscal years (2017-2019). ValleyCare has unique resources and capacity to dedicate to the chosen health needs, and also, the community had designated those three as top priorities. The health needs summarized below cite statistical data from the ValleyCare service area (the VCSA) where available. When no VCSA data were available, the summaries below cite data from the region that includes the Tri-Valley and Central Contra Costa County (TV/CCC). If data from this region were not available, Alameda County and/or Contra Costa County data are presented.[ii] Health needs are listed in priority order.

Health Care Access & Delivery

In Alameda County, the proportion of residents that reported a delay or difficulty in obtaining care was well above the HP2020 objective. In addition, Alameda County does not meet the HP2020 objective for people with a usual source of care. Stark ethnic disparities exist in the uninsured population of the TV/CCC. The VCSA falls short of the state benchmark for the rate of Federally Qualified Health Centers. The community shared concerns about many aspects of health care access and delivery, including difficulties with navigating the complex health system, difficulties obtaining timely appointments with professionals (due to a perceived lack of clinical providers—especially those that accept Medi-Cal), the need for cultural competence of all health system staff, and difficulties with affording and accessing public transportation. While the CHNA identified oral health as a separate health need, the data suggest that oral health is a need in the community due to issues of access. This Health Care Access & Delivery need, which includes access to primary care and specialty care, specifically includes oral health.

Behavioral Health

Although the rate of death due to intentional self-harm (suicide) in the VCSA was lower than the state average, the suicide rate in TV/CCC for Whites was exponentially higher than the rate for Native Hawaiians/Pacific Islanders. However, White adults are also much less likely to report a need for mental health care as compared to other racial and ethnic groups. Severe mental illness ED visits are higher in Alameda County than in the state. The rate of binge drinking in the VCSA is higher than in Contra Costa County and the state. Also, VCSA residents' total household expenditures towards alcohol are slightly higher than the state average. The age-adjusted rate of substance abuse-related Emergency Department visits is higher in Alameda County than in the state overall, with stark ethnic disparities apparent (for Blacks, Native Americans/Alaskan Natives, and Whites). Providers who participated in the CHNA are seeing an increase in drug use

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[ii] Detailed health profiles of top priority health needs, which include statistical data, are included in the CHNA report found at www.valleycare.com/about-community-benefits.aspx.

(especially marijuana and opiates). The community expressed concern about the lack of insurance benefits for mental health issues, especially for things like stress and depression. CHNA participants also discussed the difficulty in accessing mental health specialty care, cultural and language barriers, stigma, and the lack of education about mental health and mental health resources. Regarding specific populations, the community is concerned about those who have experienced trauma, as well as youth, specifically LGBTQ youth. In addition, the community perceives a connection between domestic violence and drug/alcohol abuse and community members expressed concerns about the lack of effective local substance abuse treatment services and facilities.

Note: The CBAC and community benefit team acknowledged that mental health and substance abuse/tobacco use are conditions that often co-occur. “Behavioral health” is an umbrella term covering the full spectrum of mental health and substance use issues, including alcohol, tobacco, and other drugs.[iii] By combining these two needs into one, the hospital can be more flexible in its approach to addressing either of these conditions separately, or addressing them concurrently. In addition, the team recognized that behavioral health is a driver of many other health issues and can make addressing physical health more difficult.

Obesity, Diabetes, Healthy Eating, Active Living

VCSA residents experience similarly high proportions of overweight compared to the state. In Alameda and Contra Costa Counties combined, half of both Whites and Blacks are overweight or obese, which is higher than the overall county proportions. A higher percentage of youth in the VCSA have low fruit/vegetable consumption compared to Alameda County and the state average. White youth in Alameda County are much more likely to have low fruit/vegetable consumption compared to Latino and Black youth. In the VCSA, a higher proportion of residents live in food deserts compared to the state average. There are fewer grocery stores and more fast food restaurants per capita in the VCSA compared to the state. In the VCSA, a higher percentage of the population has a commute over 60 minutes compared to the state. The amount of commute time can negatively impact other health-related activities (e.g., being physically active, sleeping, and preparing healthy meals). The community expressed concern about diabetes and diabetes management, access to open spaces/safe places to exercise, the expense of buying healthy food, and the need for more education about food resources. The community is most concerned about how the low-income population is impacted by this need.

[iii] See the description of behavioral health integration from the Substance Abuse and Mental Health Services Administration, which is the U.S. Department of Health and Human Services’ agency that “leads public health efforts to advance the behavioral health of the nation,” at www.integration.samhsa.gov/integrated-care-models/CIHS_quickStart_decisiontree_with_links_as.pdf.

VII. Implementation Strategies

ValleyCare plans to invest its community benefit efforts, including grants, sponsorships, in-kind support, and collaboration/partnership activities, in work that benefits the larger community, including health research, health education and training, serving vulnerable populations, charity care, and unreimbursed Medi-Cal and Medicare. These activities provide essential services for those in need in the community. This section describes ValleyCare's plans for its community benefit activities during fiscal years 2017–2019.

A. Health Care Access & Delivery

Long-Term Goal: Increase number of Tri-Valley area residents who have access to appropriate health care services.

Intermediate Goal A.1: Improve access to quality primary and specialty care and preventive health care services for at-risk community members.

Goal A.1 Strategies:

Allocate resources to support:

- Participation in government-sponsored programs for low-income individuals (i.e., Medi-Cal Managed Care).
- Provision of Charity Care to ensure low-income individuals obtain needed medical services.

Provide grants, sponsorships, or in-kind support to community health centers, clinics, or Federally Qualified Health Centers (FQHCs) (e.g., Axis Community Health) for efforts such as:

- Providing information and opportunities for students to learn more about health care professions (e.g., the High School ROP program, the School Outreach/Medical Explorers Program, surgery simulation program for Advanced Placement high school students).[1,2]
- Providing support for those who are enrolled in an educational program by providing the setting in which specialized health care workers are trained (e.g., Dietetics Internship Program, Preceptorship program for registered nurses, nursing graduate students' mentorship program, surgical technology students' training, physical and sports medicine college student internships).[2]
- Chronic disease self-management interventions in community gathering places, including specific programs such as 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.[3]
- The ValleyCare Health Library and Resource Center, accessible to all community members free of charge.[4]

- Building the capacity of local community-based clinics to provide primary and preventive health care services by providing funding and other resources.[2]
- Supporting trained care coordinators to facilitate health care access for underserved residents.[5]
- Providing medical supplies for first aid to local community events, and providing treatment for athletic injuries at youth sporting events.
- Providing free TB screenings at ValleyCare Urgent Care to incoming residents of local homeless shelters (e.g., Tri-Valley Haven and Shepherd's Gate), including imaging services if needed to assist in screening for disease.[6]
- Improving access to oral health care for low-income residents, e.g., by expanding the oral health safety net.[7]
- Supporting wellness strategies such as health fairs.[8]
- Supporting trained community health workers (e.g., educators) to provide one-on-one or group health education and social support for various health practices, including oral health, chronic disease self-management, and behavior change;[9] for example:
  - Prenatal breastfeeding education in small groups for expectant mothers.[10]
  - Asthma self-management education, including the role of medications, appropriate inhaler technique, identification of triggers, how to handle signs of worsening asthma, and when to seek care.[11]
  - Educational events open to the public regarding breast cancer.[12]
  - Cancer survivorship education and activities, including psychosocial support.[13]
  - Oral health education aimed at improving knowledge and changing oral health practices.[14]
  - Stroke awareness and prevention education.[15]
  - CPR classes provided in the community.[16]

Goal A.1 Anticipated Impact:

- Increased access to health care and health care services.
- Increased health care workforce pipeline.

B. Behavioral Health

Long-Term Goal: Improve behavioral health among residents in the Tri-Valley area.

Intermediate Goal B.1: Improve mental health and well-being among residents.

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:

- Cognitive behavioral therapy (CBT), a therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behavior through brief, direct, and time-limited structured counseling.[17] Can be effective for, e.g., reducing psychological harm from exposure to traumatic events,[18,19] post-partum depression.[20]
- Programs for educating community members in mindfulness-based stress reduction (MBSR) techniques to reduce depression and anxiety, and for stress management and pain management.[21]
- Programs for introducing mindfulness-based interventions (MBIs) in schools (for teachers and students) to address stress, coping, and resilience.[22]

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

- Partnering with community behavioral health services organizations, task forces, or similar collaborations on efforts to address behavioral health in the community.

Goal B.1 Anticipated Impact:

- Increased knowledge among community members of methods of coping with stress and depression.

Intermediate Goal B.2: Improve residents' access to coordinated mental health care.

Goal B.2 Strategies:

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

- Supporting coordination of behavioral health care and physical health care, such as co-location of services (e.g., Axis Community Health).[23,24] 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.[25]

  - 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.[26]
  - Staff-assisted depression care supports to ensure increased screening, accurate diagnosis, effective treatment, and follow-up.[27]
- Supporting providers or trained community members to screen for mental health issues (e.g., suicidal ideation, depression, and/or PTSD) among incoming ED patients and, where indicated, to make referrals to treatment.[28]

Goal B.2 Anticipated Impact:

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

Intermediate Goal B.3: Reduce drug and alcohol use among residents.

Goal B.3 Strategies:

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

- Screening and behavioral counseling interventions in primary care for alcohol misuse.[29]
- Use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) or similar (e.g., Project ASSERT) practices to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT-type practices take place in community health settings, such as clinics or emergency rooms, conducted by providers (SBIRT[30]) or trained community members (Project ASSERT[31]).
- Reduction of youth substance use and improvement in youth decision-making through programs such as “Every 15 Minutes”[32] or “Keepin’ it REAL.”[33]

Goal B.3 Anticipated Impact:

- Increased early screening and prevention.
- Increased knowledge among residents of the effects of illicit drug use and alcohol and prescription medication misuse.
- Increased knowledge of coping with stress and depression.
- Improved access to behavioral health services among community members.

C. Obesity, Diabetes, Healthy Eating, Active Living

Long-Term Goal: Increase healthy behaviors among children, youth, and adults in the Tri-Valley area to manage, reduce, or prevent obesity and diabetes.

Intermediate Goal C.1: Increase healthy eating and active living among children, youth, and adults in the Tri-Valley area.

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:

- Assisting schools in implementing guidelines for promoting healthy eating and physical activity, including but not limited to providing a quality school meal program and healthy eating choices outside of the meal program; employing qualified persons to provide physical education, health education, and nutrition services; and partnering with families to address healthy eating and physical activity.[34]
- Behavioral interventions aimed at reducing recreational, sedentary screen time among children and adolescents, and may also include interventions focused on increasing physical activity and/or improving diet.[35]
- Strategies to increase fruit and vegetable consumption, including but not limited to starting or expanding farmers' markets; support for including fruits and vegetables in emergency food programs such as food banks, food pantries, homeless shelters, emergency kitchens, etc.; ensuring access to fruits and vegetables in workplace cafeterias and other food service venues; improving access to retail stores that sell high-quality fruits and vegetables or increasing the availability of high-quality fruits and vegetables at retail stores in underserved communities; offering nutrition education on how to use/prepare and store fruits and vegetables.[36]
- In-kind support of community health workers (e.g., educators) for health education, and as outreach, enrollment, and information agents to increase healthy behaviors.[37]
- Exercise programs that help older adults increase strength, balance, and mobility.[3]
- Programs of education and support to assist older adults in self-management of their nutritional health.[3]
- Programs of education and support to teach new mothers methods of gaining energy, living a healthy lifestyle, and becoming motivated to take care of new families.[38]

Participate in collaboration and partnerships to promote healthy eating and/or active living such as:

- Tri-Valley Health Initiative, including health fairs for screening and education.
- All In to End Hunger 2020.

Goal C.1 Anticipated Impact:

- Increased knowledge about healthy behaviors.
- Increased access to physical activity.
- Increased access to healthy foods.
- 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 among adults in the Tri-Valley area.

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:

- Diabetes self-management interventions in community gathering places,[39,40] including diabetes management education generally.[3]

Goal C.2 Anticipated Impact:

- Increased knowledge about diabetes and diabetes management.
- Improved diabetes self-management.

VIII. Evaluation Plans

ValleyCare 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 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, number of people reached/served, number and role of volunteers, and volunteer hours. In addition, ValleyCare will require grantees to propose, track, and report outcomes, including behavior and health outcomes as appropriate. For example, outcome measures for a strategy that addresses obesity/overweight by increasing access to physical activity and healthy eating options might include number of students walking or biking to school, frequency of access to fresh locally grown fruits and vegetables at schools, or number of weekly physical activity minutes.

IX. Health Needs ValleyCare Does Not Plan to Address

The CBAC was careful to recommend a set of health needs to address that could make an impact in the community. The remaining health needs did not meet the criteria to the same extent as the chosen needs did; therefore, ValleyCare does not plan to address them at this time.

- **Asthma:** Many other community-based organizations address this need (e.g., Asthma Coalition, Asthma Start). ValleyCare is better positioned to address education about this need via health care access and delivery strategies. Additionally, asthma was not a high priority of the community (i.e., the prioritization score was lower) compared to other needs.
- **Cancer:** ValleyCare is better positioned to address drivers of this need via strategies related to obesity, diabetes, healthy eating, and active living, and education about this need via health care access and delivery strategies.
- **Cardiovascular Disease & Stroke**: ValleyCare is better positioned to address drivers of this need via strategies related to education about obesity, diabetes, healthy eating, active living, and health care access and delivery.
- **Climate & Health:** This topic is outside of ValleyCare's core competencies (i.e., ValleyCare has little expertise in this area) and the facility feels it cannot make a significant impact on this need through community benefit investment.
- **Communicable Diseases:** This need is being addressed by other community-based organizations and county public health departments. By increasing access to health care as a strategy related to health care access and delivery, certain key activities related to communicable diseases, such as screenings and vaccinations, may be addressed indirectly.
- **Economic Security:** ValleyCare lacks sufficient expertise to address this need. Many other local community-based organizations support vulnerable populations who lack economic security. Also, ValleyCare serves the low-income community through Charity Care and other

health care access and delivery strategies. By increasing nutritious food access as a strategy related to obesity, diabetes, healthy eating, and active living, one of the key indicators of economic insecurity in the Tri-Valley area, food insecurity, may be addressed indirectly.

- **Maternal & Child Health:** ValleyCare is better positioned to address this need through health care access and delivery strategies.
- **Violence & Injury Prevention:** While ValleyCare lacks expertise to address this health need, behavioral health issues such as substance abuse, stress, and anxiety have been shown to be drivers of violence and intentional injury. ValleyCare believes that strategies intended to address the community's behavioral health need have the potential to decrease violence and intentional injury in the community as well.
- **Unintentional Injuries**: While ValleyCare lacks expertise to address this health need, behavioral health issues such as substance abuse have been shown to be drivers of unintentional injury (e.g., motor vehicle accidents due to drunk driving). ValleyCare believes that strategies intended to address the community's behavioral health need have the potential to decrease certain types of unintentional injuries in the community as well.

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)	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)	September 16, 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

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[1] 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.

[2] Addresses HP2020 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.

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

[4] 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).

[5] Natale-Pereira, A., Enard, K. R., Nevarez, L. and Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer*, 117: 3541–3550. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/cncr.26264/full; and Yates, P. (2004). Cancer Care Coordinators: Realizing the Potential for Improving the Patient Journey. *Cancer Forum*, 28(3):128-132. Retrieved from http://eprints.qut.edu.au/1739/1/1739.pdf; see also Brown, R. S., Peikes, D., Peterson, G., Schore, J., & Razafindrakoto, C. M. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*, 31(6), 1156-1166. Retrieved from http://content.healthaffairs.org/content/31/6/1156.full.html.

[6] 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; also addresses HP2020 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.

[7] Chazin, S. (2016). *Guiding Innovations to Improve the Oral Health of Adult Medicaid Beneficiaries*. Center for Health Care Strategies, Inc., January 2016. Retrieved from www.chcs.org/media/Adult-Dental-Innovations_final2.pdf.

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