

# 2023 – 2025 Community Health Needs Assessment Implementation Strategy



**Stanford**  
MEDICINE

Health Care  
*Tri-Valley*



**Stanford**  
MEDICINE

Health Care  
*Tri-Valley*

# Stanford Health Care Tri-Valley Fiscal Years 2023–2025 Community Health Needs Assessment Implementation Strategy

## GENERAL INFORMATION

Contact Person:	Denise Bouillercce Senior Director, Government & Community Relations, PR/Marketing
Years the Plan Refers to:	Fiscal Years 2023–2025
Date Written Plan Was Adopted by Authorized Governing Body:	November 17, 2022
Authorized Governing Body that Adopted the Written Plan:	Finance Committee Stanford Health Care Tri-Valley <sup>a</sup> Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	Stanford Health Care Tri-Valley EIN 94-1429628
Address of Hospital Organization:	1111 E. Stanley Blvd. Livermore, CA 94550

<sup>a</sup> Stanford Health Care – ValleyCare changed its name to Stanford Health Care Tri-Valley on July 26, 2022. See press release of same date: <https://stanfordhealthcare.org/newsroom/news/press-releases/2022/valleycare-changes-name-to-tri-valley.html>

## TABLE OF CONTENTS

GENERAL INFORMATION	1
TABLE OF CONTENTS	2
I. ABOUT STANFORD HEALTH CARE TRI-VALLEY	3
II. STANFORD HEALTH CARE TRI-VALLEY’S SERVICE AREA	3
III. PURPOSE OF IMPLEMENTATION STRATEGY	4
IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA	5
V. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) DEVELOPMENT	6
VI. HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS	7
A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS	7
B. DESCRIPTION OF HEALTH NEEDS STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS	8
Behavioral Health	8
Economic Stability and Housing	9
Health Care Access and Delivery	11
Healthy Lifestyles	13
VII. STANFORD HEALTH CARE TRI-VALLEY’S IMPLEMENTATION STRATEGY	14
A. BEHAVIORAL HEALTH	15
B. ECONOMIC STABILITY AND HOUSING	16
C. HEALTH CARE ACCESS AND DELIVERY	18
D. HEALTHY LIFESTYLES	20
VIII. EVALUATION PLANS	21
IX. HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY DOES NOT PLAN TO ADDRESS	21
APPENDIX A: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST	23
APPENDIX B: ENDNOTES	24

## I. ABOUT STANFORD HEALTH CARE TRI-VALLEY

On July 26, 2022, Stanford Health Care – ValleyCare changed its name to Stanford Health Care Tri-Valley.<sup>b</sup> Stanford Health Care Tri-Valley has provided high-quality, nonprofit health care to the Tri-Valley and surrounding communities since 1961. Through state-of-the-art technology and highly skilled physicians, nurses, and staff, Stanford Health Care Tri-Valley provides a wide range of health care services at its Livermore, Pleasanton, and Dublin medical facilities. Stanford Health Care Tri-Valley has a total of 242 beds and a medical staff of approximately 500, offering an array of inpatient and outpatient services to the community.

## II. STANFORD HEALTH CARE TRI-VALLEY'S SERVICE AREA

Stanford Health Care Tri-Valley's primary service area is the Tri-Valley, located in California's East Bay Area. The Tri-Valley encompasses the suburban cities of Livermore, Pleasanton, Dublin, Danville, 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, and Danville and San Ramon are in Contra Costa County. Stanford Health Care Tri-Valley operates facilities in Pleasanton, Livermore, and Dublin. The Tri-Valley accounts for a majority of Stanford Health Care Tri-Valley's inpatient discharges.

The U.S. Census estimates a population of about 379,000 in the Tri-Valley. The area is highly diverse: The two largest ethnic subpopulations are white and Asian (51% and 28%, respectively). The non-white population accounts for 49% of the population in the Tri-Valley area.<sup>c</sup>

Housing costs are high. In the Tri-Valley, the median rent is \$2,374. The 2021 median home price was about \$1,050,000 in Alameda County and \$800,000 in Contra Costa County.<sup>d</sup>

Two key social determinants, income and education, have a significant impact on health outcomes. The median household income in the Tri-Valley is \$154,165, close to double that of California (\$82,053).<sup>e</sup> Additionally, median incomes in the major cities in the Tri-Valley differ at the high and low ends from California. On average, 69% of people in Tri-Valley cities live in households with incomes of \$100,000 or more, compared with only 41% in California overall. Only about 14% of the population in Tri-Valley cities have household incomes below \$50,000, compared to more than double that

---

<sup>b</sup> See press release: <https://stanfordhealthcare.org/newsroom/news/press-releases/2022/valleycare-changes-name-to-tri-valley.html>

<sup>c</sup> Data in this paragraph from ESRI Demographics, based on U.S. Census Bureau TIGER/Line geodatabases, using 2020 U.S. Census data.

<sup>d</sup> Redfin. (2021.) *Alameda County Housing Market*. Retrieved from <https://www.redfin.com/county/303/CA/Alameda-County/housing-market>. *Contra Costa County Housing Market*. Retrieved from <https://www.redfin.com/county/309/CA/Contra-Costa-County/housing-market>.

<sup>e</sup> U.S. Census Bureau, *American Community Survey, 5-Year Estimates, 2015–2019*.

proportion in California (32%). By comparison, the 2021 Self-Sufficiency Standard<sup>f</sup> for a two-adult family with two children was about \$128,017 in Alameda County and about \$132,360 in Contra Costa County.<sup>g</sup>

Even though over two-thirds of households in the Tri-Valley earn more than \$100,000 per year, more than 4% of Tri-Valley residents live below the Federal Poverty Level. Similarly, over 4% of adults in the Tri-Valley do not have a high school diploma. Just over 2% of people in the Tri-Valley are uninsured.<sup>h</sup>

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the Tri-Valley's population overall is healthier than the national average.<sup>i</sup> Although the Tri-Valley is quite diverse and has substantial resources, there is significant inequality in its population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality<sup>j</sup>, is higher in certain ZIP Codes compared to others. Certain areas also have poorer access to walkable neighborhoods (e.g., ZIP Code 94551 in Livermore) or jobs (e.g., ZIP Code 94582 in San Ramon). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

### **III. PURPOSE OF IMPLEMENTATION STRATEGY**

This Implementation Strategy Report (IS Report) describes Stanford Health Care Tri-Valley's planned response to the needs identified through the 2022 Community Health Needs Assessment (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 and will not address. Per these requirements, the following descriptions of the actions (strategies) Stanford Health Care Tri-Valley intends to take include the

---

<sup>f</sup> The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.

<sup>g</sup> Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool*. Retrieved from <http://www.selfsufficiencystandard.org/node/44>. "Family" is considered as two adults, one infant, and one school-age child.

<sup>h</sup> Data in this paragraph from U.S. Census Bureau, *American Community Survey*, 5-Year Estimates, 2015–2019.

<sup>i</sup> The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while the Tri-Valley is scored at -1.4. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041-1062. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/>.

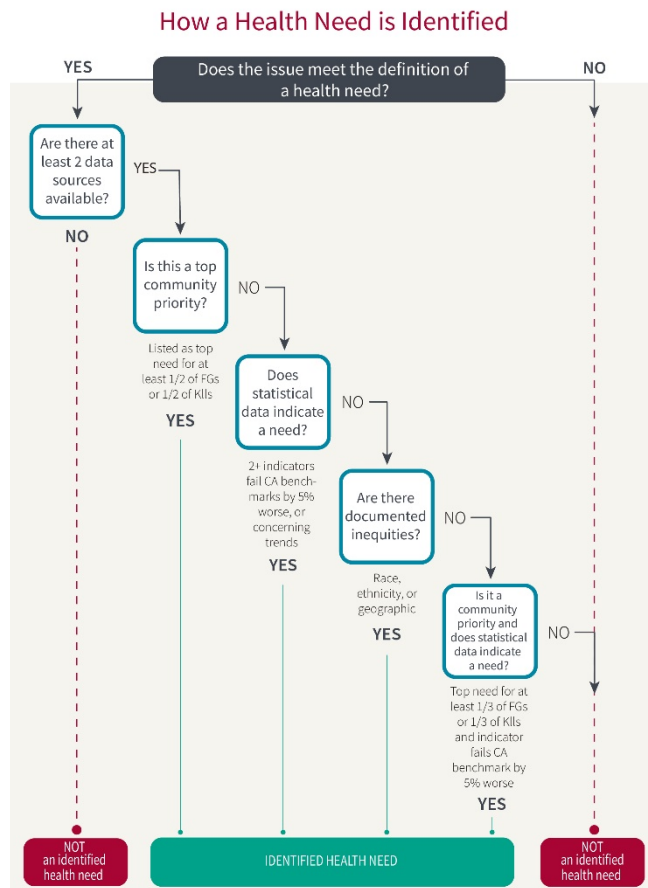
<sup>j</sup> The Gini index "measures the extent to which the distribution of income... among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from <https://stats.oecd.org/glossary/detail.asp?ID=4842>.

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 Tri-Valley’s 2022 CHNA process and for a copy of the 2022 CHNA report, please visit <https://stanfordhealthcare.org/tri-valley/about-us/community-benefits.html>.

#### IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community’s priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide averages and rates.



### DEFINITIONS

**Health condition:** A disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

**Health driver:** A behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health. May be a social determinant of health.

**Health need:** A poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

**Health outcome:** A snapshot of disease in a community that can be described in terms of both morbidity (quality of life) and mortality.

**Health indicator:** A characteristic of an individual, a population, or an environment that can be measured (directly or indirectly) and used to describe one or more aspects of the health of an individual or population.

To be considered a health need for the purposes of the 2022 CHNA, the need had to meet the definition of a health need (see Definitions box), be present in at least two data sources, and meet at least one of the following criteria: (1) be prioritized by a majority of key informants or focus groups, (2) have at least two direct indicators that fail the statewide benchmark by 5% or more, (3) have at least

four indicators that show ethnic disparities of 5% or more compared to the statewide benchmark, or (4) have a combination of at least one-third community prioritization and at least one direct indicator failing the benchmark by 5% or more. A total of nine health needs were identified in the 2022 CHNA.

Stanford Health Care Tri-Valley’s Community Benefit Advisory Group (CBAG) met virtually via Zoom on March 2, 2022, to review the health needs identified during the CHNA and to participate in the prioritization process. The CBAG used these criteria to prioritize the list of health needs:

- **Community priority.** The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process.
- **Clear disparities or inequities.** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Lacking sufficient community assets and/or resources.** The IRS requires that hospitals take into consideration whether existing assets/resources are available to address the issue.
- **Multiplier effect.** A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

Based on those criteria, the CBAG members reached consensus in ranking the nine community health needs as follows.

#### 2022 COMMUNITY HEALTH NEEDS LIST

1. **Housing and Homelessness**
2. **Behavioral Health**
3. **Economic Stability**
4. **Healthy Eating/Active Living, Diabetes and Obesity**
5. **Health Care Access and Delivery**
6. **Community Safety**
7. **Heart Disease and Stroke**
8. **Cancer**
9. **Climate and Natural Environment**

### COVID-19

The CHNA incorporated COVID-19 data in two ways: (1) Statistical data detailing the disease and associated health conditions and (2) qualitative data provided by community experts and residents. As a novel virus, statistical data were limited when the CHNA was conducted; however, community experts and residents offered ample qualitative data on the economic and social impacts of COVID-19 on local vulnerable communities. Stanford Health Care Tri-Valley will continue to monitor the trends and health impacts while addressing the health care needs of COVID-19.

## V. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) DEVELOPMENT

Stanford Health Care Tri-Valley gathered input from internal and external experts and other stakeholders, the latter through in-depth interviews with community partners. The hospital’s

Community Advisory Relations Board subcommittee, “Community Health Needs,” also provided input into the process, considering both the current state of assets in the service area and best practices to address the needs. The Stanford Health Care Tri-Valley Executive Team then selected the health needs to address. The executive team prioritized community voice and carefully considered the kinds of meaningful impact that Stanford Health Care Tri-Valley could make. It was especially important to the team to select needs that, when addressed, could reduce gaps in health equity among Tri-Valley residents.

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 THAT STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS**

### **A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS**

In the first quarter of 2022, the Stanford Health Care Tri-Valley Executive Team met to review the information collected for the 2022 CHNA. The Executive Team, by consensus, selected four health needs Stanford Health Care Tri-Valley would address, which would form the basis for Stanford Health Care Tri-Valley’s FY2023–2025 community benefit plan and implementation strategies. The team selected the needs that were of highest priority to the community and that are some of the biggest contributors to health inequities among community members.

### **2023–2025 SELECTED COMMUNITY HEALTH NEEDS**

- 1. Behavioral Health**
- 2. Economic Stability and Housing**
- 3. Health Care Access and Delivery**
- 4. Healthy Lifestyles<sup>k</sup>**

---

<sup>k</sup> In the CHNA, there were two separate needs called “Economic Stability” and “Housing and Homelessness.” Stanford Health Care Tri-Valley plans to address both and has merged these two needs into one, called “Economic Stability and Housing.” Additionally, the need originally termed “Healthy Eating/Active Living, Diabetes and Obesity” has been renamed to the more succinct “Healthy Lifestyles.”

## **B. DESCRIPTION OF HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS**

### **Behavioral Health**

Behavioral health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need, being prioritized by nearly all key informants and two out of five focus groups.

According to key informants, mental health, which was already bad in this service area, is now at a critical level after the fear, anxiety, stress, job loss, isolation, and lack of trust that resulted from the COVID-19 pandemic. Focus group participants stated that the COVID-19 pandemic negatively impacted mental health due to fear of being out in public, using public transportation, and a stigma about mask-wearing. Key informants stated that mental health does not discriminate based on age, race, or socio-economic status. Especially after the trauma of the pandemic, mental health is a crisis across all populations. Informants did, however, note disparities based on geography, explaining that many mental health providers are centralized in Oakland and San Francisco and not in the Tri-Valley area. Participants corroborated this, explaining there often is a long waiting list to see a mental health provider, specifically citing a shortage of Spanish-speaking therapists.

Focus group participants reported that children faced significant stress and anxiety because of the pandemic. According to key informants, school systems do not adequately support students of color and need to make schools more welcoming, inclusive, and safe places for children. Key informants stated that the pandemic had a major impact on the mental health of youth, citing an increase in suicide attempts, suspensions, and behavioral issues. Youth mental health statistics bear out this concern: cyberbullying is experienced by greater percentages of Pacific Islander youth in both counties, and by Native American youth in Contra Costa County, than by all youth statewide. Pacific Islander youth in Alameda County also experience depression-related feelings in higher proportions than California youth overall. School-based bullying and harassment are greater for multi-ethnic youth and youth of “Other” ancestries<sup>1</sup> in Contra Costa County than all California youth. Finally, in Alameda County, the proportion of teens contemplating suicide is higher than teens statewide for Native American, Pacific Islander, multi-ethnic, and Other youth, while in Contra Costa County, it is higher than the state for Asian, Pacific Islander, and multi-ethnic youth. Experts note that “racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care

---

<sup>1</sup> “Other” is a U.S. Census category for ethnicities not specifically called out in data sets.

when treated.”<sup>m</sup> An expert on the historical context of such disparities suggests that “racism and discrimination,” as well as “fear and mistrust of treatment,” pose barriers to BIPOC community members seeking help for behavioral health issues.<sup>n</sup>

Regarding substance use, binge drinking is higher in Dublin, Livermore, and Pleasanton than it is statewide. The impaired driving mortality rate is higher in the Tri-Valley/Central Contra Costa County area than in California. In addition, the rate of visits to emergency departments for substance use has been trending up in Alameda County overall. Related to these statistics, focus group participants indicated that drug and alcohol users make public spaces less safe for the community. Key informants mentioned a particular need to address substance use within the unhoused community.

### **Economic Stability and Housing**

More than two-thirds of key informants and one focus group rated economic stability, including education, income, and employment, as a high community priority. Half of all key informants and three of five focus groups identified housing and homelessness as a top community priority.

Housing costs and other costs of living in the Tri-Valley are extremely high; the median home rental cost is more than 40% higher than the median state home rental cost. The qualitative data reflect this: key informants asserted that the Tri-Valley area is an expensive place to live, and that many families struggle to support themselves on an income that is inadequate compared to the cost of living. They said the COVID-19 pandemic made the existing problem worse, with many families losing jobs and needing to make difficult decisions about how to divide their resources to pay for basic needs like housing, childcare, and food. Key informants noted that a lack of affordable housing in the Tri-Valley, made worse by the COVID-19 pandemic, has led to an increase in overcrowded homes. These housing struggles may cause anxiety, leading to mental/behavioral health difficulties and interpersonal issues, and sometimes escalating to domestic violence. Focus group participants also reported that the COVID-19 pandemic exacerbated the existing housing crisis. They also said that laws and resources that supported renters during the pandemic have been critically important.

---

<sup>m</sup> McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, 27(2), 393–403. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/>

<sup>n</sup> Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today*, American Counseling Association. Retrieved from <https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/>

Key informants mentioned gentrification leaving families unable to afford living in their changing communities, yet simultaneously not having the means to move away. Focus group participants said that residents are moving from the Tri-Valley because of housing prices. Participants acknowledged a significant need to develop more affordable housing.

Focus group participants indicated a lack of employment opportunities in the Tri-Valley area that pay enough to afford the expensive rents in the area. Key informants pointed to significant disparities in income in Pleasanton, Dublin, and Livermore, with many residents having significant means and others having little. They stated that many families are struggling to stay in the area for jobs and school, despite the steep cost of living. Our 2019 CHNA report described racial and ethnic disparities in income, with a larger proportion of the Black population in the Tri-Valley/Central Contra Costa area experiencing poverty than California's population overall.

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of both counties' Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English-language arts standards compared to California 11th graders overall. Also, a smaller percentage of both counties' Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards versus California's 11th graders. Related to these statistics, much smaller proportions of Alameda County's Black and Pacific Islander high school graduates and Contra Costa County's Black and Latinx high school graduates completed college-preparatory courses compared to high school graduates statewide. The high school drop-out rate is particularly high among Alameda County's Latinx youth compared to all California youth. Building on these figures, in our 2019 CHNA report, we found a higher proportion of the Tri-Valley/Central Contra Costa County area's Latinxs, Pacific Islanders, and residents of Other ethnicities over ages 24 without a high school diploma compared to all Californian adults over age 24.

Qualitative data showed that COVID created more economic insecurity for those who lost work. Focus group participants said that small businesses struggled to survive the pandemic. This has had a ripple effect throughout the economy, leading to loss of income, unemployment, and subsequent housing instability. According to key informants, pandemic related job loss was a significant issue in the community that had broad effects including increased food insecurity, homelessness, and significant mental health issues. Key informants noted that parental job loss because of the COVID-19 pandemic had a trickle-down effect through families, citing students who withdrew from school due to stressors at home. Prior to the pandemic, a larger percentage of Dublin youth were not in school and not working than California youth overall.

In reference to school, key informants said the virtual learning environment left many students behind academically. Statistics from before the pandemic indicated that greater proportions of Black students in both counties experience low school connectedness than all California students. Greater proportions of Latinx and Other students in Contra Costa County had low levels of meaningful participation in school than students statewide. Key informants also stated that access to childcare is a major issue. Affordable care is limited for low-income parents, and fear of exposure to COVID-19 has kept many parents wary of utilizing childcare services. Additionally, participants cited the need for more childcare facilities that can support children who have experienced homelessness or other trauma.

Focus group participants specifically called out children, single parents, and people experiencing homelessness as populations experiencing significant food insecurity. Even before the pandemic, the proportion of Black children in Contra Costa County who went to school without having breakfast was higher than the proportion of all children statewide. According to key informants, food insecurity is on the rise in the Tri-Valley, especially among the Asian community in Pleasanton. The COVID-19 pandemic made an existing problem worse, with many families losing jobs and needing to make difficult decisions about how to divide their resources to pay for basic needs like housing, childcare, and food. Focus group participants reported that those experiencing homelessness are facing co-occurring issues and barriers to health, like mental and behavioral health issues. Participants said that community resources for homeless veterans are particularly insufficient or non-existent, and those needing help have to go out of the county to get it.

### **Health Care Access and Delivery**

Almost all focus groups and over half of key informants identified health care access and delivery, which affects various other community health needs, as a top health need. Focus group participants cited a lack of providers and difficulty getting an appointment as issues contributing to access to care and mentioned specific communities facing inequities in accessing care: Latinx, undocumented people, veterans, older adults, and unhoused populations. Participants specifically stated that older adults and the uninsured face a disproportionate burden when it comes to income and paying for health care. Key informants pointed to an income gap impacting the ability of many to access care, specifically, those making too much to qualify for Medi-Cal yet not enough to afford private insurance. Informants also highlighted inequities in access to care in low-income, underserved, Black, and LGBTQ+ populations and called for diverse and culturally competent providers. Key informants additionally mentioned a rapidly increasing Asian population in the Tri-Valley area. Access issues have arisen due to the multitude of languages spoken and a lack of providers and interpreters who speak these languages. Inequities in health care access and

delivery, such as those described by key informants and focus group participants, have been shown to be major contributors to inequities in health outcomes.<sup>9</sup>

Focus group participants linked transportation with health, stating that traffic, road work, and a lack of affordable public transportation options makes accessing health care difficult. Key informants noted that many specialty services are in Oakland or San Francisco, which is a barrier to access for many without adequate transportation. As a result of the COVID-19 pandemic, informants noted that patients gained expanded options to see providers out of their area via telehealth. Key informants also mentioned seeing increased collaboration among community entities to figure out solutions to provide care faster. However, informants also acknowledged disparities when it comes to telehealth, specifically among older adults who have difficulty utilizing new technologies and low-income residents who might not have reliable access to a computer or the internet. Key informants also called out issues in delayed dental care, specifically for children and unhoused populations, due to the pandemic. Additionally, informants noted a workforce shortage across all types of care.

The COVID-19 pandemic exacerbated existing racial and health inequities, with people of color accounting for a disproportionate share of COVID-19 cases, hospitalizations, and deaths. Focus group participants agreed that the pandemic disproportionately impacted communities of color. Key informants mentioned that some communities are not accessing the vaccine because of their legal status. Informants pointed out the importance of considering the social determinants of health, and the need for providers to look at factors like housing, job stability, and food security, rather than a simple medical approach, to address structural racism's impact on health.

Multiple key informants pointed to a disparity in infant mortality in the Black community. They cited factors like a lack of culturally competent care, having to choose between significant others and doulas in the delivery room due to the pandemic, shortcomings in post-natal care, and racial tension and anxiety due to the pandemic. Statistics corroborate these observations: Infant mortality is higher among Alameda County's Black, Latinx, and multi-ethnic populations than in California overall. Low birth weight was a concern for the Alameda County Pacific Islander and multi-ethnic populations, as well as the Contra Costa County Asian population. Pre-term births are happening at higher rates for multi-ethnic babies in Contra Costa County than for all babies statewide. Teen births are higher for Contra Costa County Latinas than for young women across the state. Finally, breastfeeding rates are

---

<sup>9</sup> Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. *The Lancet*, 389(10077), 1431-1441. See also Yearby, R. (2018). Racial disparities in health status and access to healthcare: the continuation of inequality in the United States due to structural racism. *American Journal of Economics and Sociology*, 77(3-4), 1113-1152. Retrieved from [https://inside.nku.edu/content/dam/viceprovost/docs/CommonExperience/Racial%20Disparities%20in%20Health%20Status%20\(1\).pd.pdf](https://inside.nku.edu/content/dam/viceprovost/docs/CommonExperience/Racial%20Disparities%20in%20Health%20Status%20(1).pd.pdf)

especially low among Pacific Islander mothers in both counties compared to mothers statewide.

### **Healthy Lifestyles**

Two out of five focus groups and one key informant identified elements of healthy lifestyles as top health needs. According to key informants, a significant increase in screen time during the pandemic has led to an increase in childhood obesity. Larger proportions of children in Alameda and Contra Costa counties do not meet fitness standards compared to children statewide.

The rate of adults with diabetes is trending up in Alameda County. Moreover, the proportion of the adult population in Livermore with obesity is higher than in Alameda County overall. Perhaps related to this, a smaller proportion of Livermore adults walk regularly than all adults in Alameda County. Both key informants and focus group participants discussed the need for more safe parks and outdoor spaces in the community to exercise and recreate. Focus group participants indicated that existing outdoor parks and spaces have been taken over by groups that make the spaces feel unsafe (because of drug and alcohol use). In addition, focus group participants cited climate and environment issues (high temperatures and reduced air quality) as barriers to outdoor exercise opportunities.

In the Tri-Valley, a far larger percentage of workers drive alone, with long commutes, compared to all Californians. Related to this, focus group participants stated that long commutes to work negatively impact their well-being. Also, in both Dublin and Livermore, the proportions of employed people who walk to work are substantially smaller than the statewide average.

Tri-Valley residents have lower access to grocery stores than their counterparts statewide. Similarly, data show that among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in the Tri-Valley than the state average. Key informants stated the need for medical providers to do a better job of linking nutrition with overall health for patients and connecting them with community resources that could help support healthier dietary patterns.

Our 2019 CHNA report identified disparities in diabetes and obesity, with Tri-Valley/Central Contra Costa County Black adult and Latinx youth populations experiencing obesity at higher rates than the state. We also reported lower rates of diabetes management among Black people in the Tri-Valley/Central Contra Costa County area than the state. Some focus group participants in the 2022 CHNA said that “lifestyle diseases” like obesity and diabetes were prevalent in the community and that this was a result of inequities in neighborhoods’ built environment. Similarly, experts writing on behalf of the American Diabetes Association

describe placing “socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations.”<sup>p</sup>

## **VII. STANFORD HEALTH CARE TRI-VALLEY’S IMPLEMENTATION STRATEGY**

Stanford Health Care Tri-Valley’s annual community benefit investment focuses on improving the health of the community’s most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, the priority of community health investments from FY2023–FY2025 will address access to and delivery of care, access to behavioral health care, and healthy lifestyles, and economic stability through community and hospital-based programs and partnerships although other areas may also receive support. Additionally, Stanford Health Care Tri-Valley will collaborate with the Health Equity Council to find ways to mitigate and overcome inequities in the community, to improve health equity community-wide.

This plan represents a continuation of a multi-year strategic investment in community health. Stanford Health Care Tri-Valley believes that funding of, and relationships with, proven community partners yield 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.

---

<sup>p</sup> Ogunwole, S. M. & Golden, S. H. (2021). Social determinants of health and structural inequities—root causes of diabetes disparities. *Diabetes Care*, Jan. 2021, 44 (1): 11-13. Retrieved from <https://care.diabetesjournals.org/content/44/1/11>.

## A. BEHAVIORAL HEALTH

### Key CHNA Findings:

- Mental health in the Tri-Valley is considered by key informants to be at a critical level since the COVID-19 pandemic began and is perceived as especially bad for youth.
- Experts say there is limited access to mental/behavioral health care in the Tri-Valley compared to other parts of Alameda County.
- Substance use and alcohol are issues for Tri-Valley community members; binge drinking is higher in Dublin and Pleasanton than it is statewide.

Goal	Behavioral Health Strategies	Anticipated Impact
A.1 Improve Tri-Valley community members' access to mental/behavioral health care services	<ul style="list-style-type: none"> <li>i. Support efforts to coordinate delivery of behavioral health care and physical health care in the Tri-Valley<sup>1, 2, 3, 4, 5</sup></li> <li>ii. Support efforts to increase access to behavioral/mental health care across all Tri-Valley populations<sup>6, 7, 8, 9, 10</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Improved access to mental/behavioral health programs and services</li> <li>b. Increased proportion of community members served with effective mental/behavioral health services</li> <li>c. Improved coordination of physical and mental/behavioral health services</li> <li>d. Improved mental/behavioral health well-being among those served</li> </ul>
A.2 Improve mental health and well-being among Tri-Valley community members	<ul style="list-style-type: none"> <li>i. Participate in collaborations and partnerships on efforts to address behavioral health for Tri-Valley community members</li> </ul>	<ul style="list-style-type: none"> <li>a. Improved mental/behavioral health among Tri-Valley community members</li> </ul>

## B. ECONOMIC STABILITY AND HOUSING

### **Key CHNA Findings:**

- The cost of living in the Tri-Valley is extremely high and affordable housing is lacking.
- The COVID-19 pandemic exacerbated existing problems, with many losing jobs and needing to stretch resources further.
- Key informants said food insecurity and homelessness have been on the rise in the Tri-Valley due to the pandemic.
- Educational inequities, such as the completion of college prep courses, were likely made worse by lengthy periods of virtual schooling; this can affect future opportunities of Tri-Valley community members.

Goal	Economic Stability and Housing Strategies	Anticipated Impact
B.1 Reduce food insecurity and increase healthy food access for vulnerable community members	i. Support expanded access to food security and food access programs and/or support new programs to increase access to nutrient-dense foods for vulnerable Tri-Valley community members <sup>11, 12, 13</sup>	<ul style="list-style-type: none"> <li>a. Improved access to healthy food for low-income individuals across the Tri-Valley area</li> <li>b. Improved associated health outcomes</li> <li>c. Increased proportion of low-income individuals in the Tri-Valley who eat three meals per day</li> <li>d. Reduced proportion of individuals in the Tri-Valley experiencing poor health outcomes that are a result of food insecurity</li> <li>e. Reduced proportion of individuals who are food insecure</li> <li>f. Reduced proportion of individuals in Alameda and Contra Costa Counties experiencing poor health outcomes as a result of food insecurity.</li> <li>g. Reduced diabetes/obesity rates</li> </ul>

Goal	Economic Stability and Housing Strategies	Anticipated Impact
B.2 Reduce barriers to employment/careers that provide community members with a living wage	i. Support efforts to increase workforce-related educational attainment and/or job training <sup>14, 15, 16, 17, 18</sup>	<ul style="list-style-type: none"> <li>a. Reduced unemployment rates</li> <li>b. Reduced poverty rates in the Tri-Valley area</li> <li>c. Reduced California Self-Sufficiency Standard disparity</li> <li>d. Reduction of pay disparities</li> </ul>
B.3 Reduce housing instability among vulnerable community members to support improved health	<ul style="list-style-type: none"> <li>i. Support programs that expand affordable housing opportunities<sup>19, 20</sup></li> <li>ii. Support local homelessness prevention and intervention organizations and collaboratives<sup>21, 22, 23, 24, 25</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Improved access to stable housing for low-income individuals</li> <li>b. Increased access to social services to prevent homelessness</li> <li>c. Higher rate of community members retaining independence</li> <li>d. Reduced proportion of individuals who are housing insecure</li> </ul>

## C. HEALTH CARE ACCESS AND DELIVERY

### Key CHNA Findings:

- Smaller proportions of adults in Tri-Valley cities had routine annual check-ups compared to all Californian adults.
- Smaller proportions of Tri-Valley cities’ adults with high blood pressure were taking medication to manage their condition compared to their peers statewide.
- CHNA participants said there was a shortage of health care providers in the Tri-Valley.
- Key informants pointed to an income gap impacting the ability of many to access care.
- Key informants also highlighted inequities in access to care among low-income, Black, and LGBTQ+ populations and called for diverse and culturally competent providers.

Goal	Health Care Access and Delivery Strategies	Anticipated Impact
C.1 Improve access to affordable, high-quality health care services for vulnerable community members	i. Allocate resources to support: <ul style="list-style-type: none"> <li>a. Participation in government-sponsored programs for low-income individuals (i.e., Medi-Cal Managed Care)</li> <li>b. Provision of Charity Care to ensure low-income individuals obtain needed medical services</li> <li>c. Increased health insurance coverage<sup>26</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Reduced health care cost barriers for vulnerable populations</li> <li>b. Improved affordability of health care services</li> <li>c. Improved health insurance rates</li> <li>d. Reduced avoidable emergency department and hospital utilization</li> <li>e. Improved access to medical home</li> </ul>
	ii. Support wellness strategies (e.g., health fairs, education, screening) that improve equitable health outcomes <sup>27, 28</sup>	<ul style="list-style-type: none"> <li>a. Increased awareness of preventive care</li> <li>b. Increased use of medical home, including preventive care services</li> <li>c. Reduced avoidable emergency department and hospital utilization</li> <li>d. Improved health outcomes, particularly related to health disparities</li> </ul>

Goal	Health Care Access and Delivery Strategies	Anticipated Impact
	<ul style="list-style-type: none"> <li>iii. Support equitable access and delivery efforts such as:               <ul style="list-style-type: none"> <li>a. Street medicine<sup>29, 30</sup></li> <li>b. Care coordination interventions<sup>31, 32, 33, 34, 35</sup></li> <li>c. Advocacy for telehealth reimbursement</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>a. Reduced avoidable emergency department and hospital utilization</li> <li>b. Improved access to medical home</li> <li>c. Increased use of preventive care services</li> <li>d. Improved health outcomes, particularly related to health disparities</li> <li>e. Improved housing and economic security by addressing physical health conditions that contribute to housing instability</li> <li>f. Improved equitable access to telehealth</li> </ul>

## D. HEALTHY LIFESTYLES

### Key CHNA Findings:

- The Tri-Valley built environment is not optimal for healthy lifestyles:
  - A larger percentage of Tri-Valley community members have low access to grocery stores than their statewide peers.
  - There are half as many supercenters and club stores in the Tri-Valley per 1,000 people than there are statewide.
  - The walkability index in the Tri-Valley is worse than the California average.
- A smaller proportion of youth in some Tri-Valley cities are healthy (not overweight/obese, engaging in regular physical activity) compared to their counterparts across the state.
- There are ethnic disparities in heart disease deaths and child fitness statistics in the Tri-Valley, with BIPOC community members doing worse than non-BIPOC community members.

Goal	Healthy Lifestyles Strategies	Anticipated Impact
D.1 Increase healthy eating and active living among children, youth, and adults in the Tri-Valley area	i. Support efforts such as: <ul style="list-style-type: none"> <li>a. Supporting schools in promoting healthy eating and physical activity<sup>36,37,38</sup></li> <li>b. In-kind support of community health workers for health education, and as outreach, enrollment, and information agents to increase healthy behaviors<sup>39,40</sup></li> <li>c. Programs of education and support for healthy lifestyles across various populations (e.g., older adults, new mothers)<sup>41, 42, 43, 44</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Increased knowledge about healthy behaviors</li> <li>b. Increased access to physical activity</li> <li>c. Increased access to healthy foods</li> <li>d. Increased physical activity</li> <li>e. Increased consumption of healthy foods</li> <li>f. Reduced consumption of unhealthy foods</li> <li>g. More policies/practices that support increased physical activity and improved access to healthy foods</li> </ul>
	ii. Participate in collaborations and partnerships to promote healthy eating and/or active living, such as health fairs for screening and education <sup>27, 28</sup>	<ul style="list-style-type: none"> <li>a. Increased knowledge about healthy behaviors</li> <li>b. Increased physical activity</li> <li>c. Increased consumption of healthy foods</li> <li>d. Reduced consumption of unhealthy foods</li> </ul>

## VIII. EVALUATION PLANS

As part of Stanford Health Care Tri-Valley's ongoing community health improvement efforts, Stanford Health Care Tri-Valley partners with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through its triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or provide information that justifies the need for and effectiveness of the proposed program strategies.

Stanford Health Care Tri-Valley 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, Stanford Health Care Tri-Valley will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

## IX. HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY DOES NOT PLAN TO ADDRESS

As described in Section VI(A) of this report, the Executive Team was careful to select 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; therefore, Stanford Health Care Tri-Valley does not plan to address them at this time.

**Cancer:** Stanford Health Care Tri-Valley is better positioned to address drivers of this need via strategies related to healthy lifestyles, and education about this need via health care access and delivery strategies. Additionally, cancer was of lower priority to the community than the needs selected to be addressed by Stanford Health Care Tri-Valley.

**Climate and Natural Environment:** This topic is outside of Stanford Health Care Tri-Valley's core competencies (i.e., Stanford Health Care Tri-Valley has little expertise in this area), and the hospital feels it cannot make a significant impact on this need through community benefit investment. Also, this need was of lower priority to the community than the needs that Stanford Health Care Tri-Valley selected.

**Community Safety:** This need was of lower priority to the community than the needs selected to be addressed by Stanford Health Care Tri-Valley. Although Stanford Health Care Tri-Valley lacks the expertise to address this health need, behavioral health issues such as substance use, stress, and anxiety have been shown to be drivers of bullying and violence. Thus, Stanford Health Care Tri-Valley

believes that strategies intended to address the community's behavioral health need have the potential to address community safety as well.

**Heart Disease and Stroke:** This need was of lower priority to the community than the needs selected to be addressed by Stanford Health Care Tri-Valley. Moreover, Stanford Health Care Tri-Valley is better positioned to address drivers of this need via strategies related to education about healthy lifestyles and health care access and delivery.

## APPENDIX A: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST

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

Federal Requirements Checklist	Regulation Subsection Number	Report Section
The Implementation Strategy is a written plan which includes:		
(1) Description of <b>how the hospital facility plans to address</b> 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
(2) Description of why a hospital facility is <b>not addressing</b> a significant health need identified in the CHNA. <i>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.</i>	(c)(3)	IX
(3) For those hospital facilities that adopted a joint CHNA report, a <b>joint implementation strategy</b> 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
(4) An authorized body <b>adopts the implementation strategy</b> on or before January 15 <sup>th</sup> , 2023, which is the 15 <sup>th</sup> 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)	General Information
<b>Exceptions:</b> Our hospital does not qualify for any exception described in Section (D) for acquired, new, transferred, and terminated facilities.	(d)	N/A

## APPENDIX B: ENDNOTES

- <sup>1</sup> Chuang, E., Pourat, N., Haley, L. A., O'Masta, B., Albertson, E., & Lu, C. (2020). Integrating health and human services in California's Whole Person Care Medicaid 1115 waiver demonstration: An overview of a California demonstration program focused on improving the integrated delivery of health, behavioral health, and social services for certain Medicaid beneficiaries. *Health Affairs*, 39(4), 639-648. Retrieved from <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01617>
- <sup>2</sup> Olson, J. R., Benjamin, P. H., Azman, A. A., Kellogg, M. A., Pullmann, M. D., Suter, J. C., & Bruns, E. J. (2021). Systematic review and meta-analysis: Effectiveness of wraparound care coordination for children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 60(11), 1353-1366. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0890856721001556>
- <sup>3</sup> Satcher, D., & Rachel, S. A. (2017). Promoting mental health equity: the role of integrated care. *Journal of clinical psychology in medical settings*, 24(3), 182-186.
- <sup>4</sup> 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. *Health Home Information Resources Center*. Retrieved from [https://www.chcs.org/media/HH\\_IRC\\_Collaborative\\_Care\\_Model\\_052113\\_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf) See also: Wong, W., Anderson, K. M., Dankwa-Mullan, I., Simon, M. A., & Vega, W. A. (2012). The patient-centered medical home: a path toward health equity?. *NAM Perspectives*. Retrieved from <https://nam.edu/wp-content/uploads/2015/06/PatientCenteredMedicalHome.pdf>
- <sup>5</sup> Ginsburg, S. (2008). Colocating health services: a way to improve coordination of children's health care? *The Commonwealth Fund*, July 2008. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2008/jul/colocating-health-services-way-improve-coordination-childrens>
- <sup>6</sup> Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health*, 88(11): 1610-1615. Retrieved from <https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610>
- <sup>7</sup> Weaver, A., & Lapidus, A. (2018). Mental health interventions with community health workers in the United States: a systematic review. *Journal of Health Care for the Poor and Underserved*, 29(1), 159-180. Retrieved from [https://web.archive.org/web/20190429000716id\\_/https://muse.jhu.edu/article/686958/pdf](https://web.archive.org/web/20190429000716id_/https://muse.jhu.edu/article/686958/pdf)
- <sup>8</sup> Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing community health workers to address mental health disparities for underserved populations: a systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(2), 195-211. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803443/>
- <sup>9</sup> Kaslow, N.J., Friis-Healy, E.A., Cattie, J.E., Cook, S.C., Crowell, A.L., Cullum, K.A., Del Rio, C., Marshall-Lee, E.D., LoPilato, A.M., VanderBroek-Stice, L. and Ward, M.C. (2020). Flattening the emotional distress curve: A behavioral health pandemic response strategy for COVID-19. *American Psychologist*, 75(7), 875.
- <sup>10</sup> 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>

- 
- <sup>11</sup> Palar, K., Napoles, T., Hufstедler, L.L., Seligman, H., Hecht, F.M., Madsen, K., Ryle, M., Pitchford, S., Frongillo, E.A., & Weiser, S.D. (2017). Comprehensive and medically appropriate food support is associated with improved HIV and diabetes health. *Journal of Urban Health*, 94(1): 87-99. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5359179/>. See also: Berkowitz, S.A., Delahanty, L.M., Terranova, J., Steiner, B., Ruazol, M.P., Singh, R., Shahid, N.N., & Wexler, D.J. (2019). Medically tailored meal delivery for diabetes patients with food insecurity: a randomized cross-over trial. *Journal of general internal medicine*, 34(3): 396-404.
- <sup>12</sup> The Community Guide. (2019). *Obesity: Multicomponent Interventions to Increase Availability of Healthier Foods and Beverages in Schools*. Retrieved from <https://www.thecommunityguide.org/findings/obesity-multicomponent-interventions-increase-availability-healthier-foods-and-beverages>
- <sup>13</sup> Centers for Disease Control and Prevention. (2011). *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Atlanta: U.S. Department of Health and Human Services. Retrieved from [www.cdc.gov/obesity/downloads/FandV\\_2011\\_WEB\\_TAG508.pdf](http://www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf)
- <sup>14</sup> Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689-695.
- <sup>15</sup> Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836-851.
- <sup>16</sup> See, for example, Sieck, L., Chatterjee, T., & Birch, A. (2022). Priming the pipeline: inspiring diverse young scholars in the radiologic sciences begins during early childhood education. *Journal of the American College of Radiology*, 19(2), 384-388. Retrieved from [https://www.jacr.org/article/S1546-1440\(21\)00852-8/fulltext](https://www.jacr.org/article/S1546-1440(21)00852-8/fulltext)
- <sup>17</sup> Poremski, D., Rabouin, D., & Latimer, E. (2017). A randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(2), 217-224.
- <sup>18</sup> Bretherton, J., & Pleave, N. (2019). Is work an answer to homelessness?: Evaluating an employment programme for homeless adults. *European Journal of Homelessness*, 59-83. Retrieved from [https://eprints.whiterose.ac.uk/145311/1/13\\_1\\_A3\\_Bretherton\\_v02.pdf](https://eprints.whiterose.ac.uk/145311/1/13_1_A3_Bretherton_v02.pdf)
- <sup>19</sup> Hope, H. (2022). Accessory dwelling units promoted as a strategy to increase affordable housing stock at White House event. *Smart Growth America*. Retrieved from <https://smartgrowthamerica.org/white-house-adus-event/> See also: California Department of Housing and Community Development. (2021). *Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs)*. Retrieved from <https://www.hcd.ca.gov/policy-research/accessorydwellingunits.shtml>
- <sup>20</sup> Benton, A. L. (2014). *Creating a Shared Home: Promising Approaches for Using Shared Housing to Prevent and End Homelessness in Massachusetts*. Retrieved from <https://ash.harvard.edu/files/ash/files/3308562.pdf?m=1637364880>
- <sup>21</sup> Schapiro, R., Blankenship, K., Rosenberg, A., & Keene, D. (2022). The effects of rental assistance on housing stability, quality, autonomy, and affordability. *Housing Policy Debate*, 32(3), 456-472. Retrieved from [https://www.nlihc.org/sites/default/files/Effects\\_of\\_Rental\\_Assistance.pdf](https://www.nlihc.org/sites/default/files/Effects_of_Rental_Assistance.pdf) and see Pfeiffer, D. (2018). Rental housing assistance and health: Evidence from the survey of income and program participation. *Housing Policy Debate*, 28(4), 515-533. Retrieved from [http://www.nlihc.org/sites/default/files/Rental-Housing-Assistance-Health-Evidence\\_Survey-of-Income-Program-Participation.pdf](http://www.nlihc.org/sites/default/files/Rental-Housing-Assistance-Health-Evidence_Survey-of-Income-Program-Participation.pdf). See also Liu, L. (2022). *Early Effects of the COVID Emergency Rental Assistance Programs: A Case Study*. Available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=4095328](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4095328)
- <sup>22</sup> Holl, M., Van Den Dries, L., & Wolf, J. R. (2016). Interventions to prevent tenant evictions: a systematic review. *Health & Social Care in the Community*, 24(5), 532-546. Retrieved from <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/hsc.12257>. See also Cassidy, M. T., & Currie, J. (2022). The Actionable Insights, LLC • Stanford Health Care Tri-Valley FY 2023–2025 IS Report

---

effects of legal representation on tenant outcomes in housing court: Evidence from New York City's Universal Access Program (No. w29836). *National Bureau of Economic Research*. Retrieved from [https://www.nber.org/system/files/working\\_papers/w29836/w29836.pdf](https://www.nber.org/system/files/working_papers/w29836/w29836.pdf)

<sup>23</sup> Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal*, 27(4), 334.

<sup>24</sup> McHugo, G.J., Bebout, R.R., Harris, M., Cleghorn, S., Herring, G., Xie, H., Becker, D. and Drake, R.E. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, 30(4), 969-982. Retrieved from [https://www.researchgate.net/profile/Gregory-Mchugo/publication/7786047\\_A\\_Randomized\\_Controlled\\_Trial\\_of\\_Integrated\\_Versus\\_Parallel\\_Housing\\_Services\\_for\\_Homeless\\_Adults\\_With\\_Severe\\_Mental\\_Illness/links/004635190e3121c6e9000000/A-Randomized-Controlled-Trial-of-Integrated-Versus-Parallel-Housing-Services-for-Homeless-Adults-With-Severe-Mental-Illness.pdf](https://www.researchgate.net/profile/Gregory-Mchugo/publication/7786047_A_Randomized_Controlled_Trial_of_Integrated_Versus_Parallel_Housing_Services_for_Homeless_Adults_With_Severe_Mental_Illness/links/004635190e3121c6e9000000/A-Randomized-Controlled-Trial-of-Integrated-Versus-Parallel-Housing-Services-for-Homeless-Adults-With-Severe-Mental-Illness.pdf)

<sup>25</sup> Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A.H., Arya, N., & Hannigan, T. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PloS One*, 15(4), p.e0230896. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0230896>

<sup>26</sup> 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." U.S. Department of Health and Human Services. (2019). Strategic goal 1: Reform, strengthen, and modernize the nation's healthcare system. Retrieved from [http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj\\_a](http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj_a)

<sup>27</sup> Health fairs and similar community events must include follow-up: Williams, M. (2012). Follow-up resources are key to health fairs' success. *American Medical News*, [amednews.com](https://amednews.com/article/20120312/profession/303129958/5/). Retrieved from <https://amednews.com/article/20120312/profession/303129958/5/>

<sup>28</sup> Access to influenza vaccine increases uptake of vaccination: Alessandrini, V., Anselem, O., Girault, A., Mandelbrot, L., Luton, D., Launay, O., & Goffinet, F. (2019). Does the availability of influenza vaccine at prenatal care visits and of immediate vaccination improve vaccination coverage of pregnant women? *PloS one*, 14(8), e0220705. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0220705>

<sup>29</sup> Withers, J. (2011). Street medicine: an example of reality-based health care. *Journal of Health Care for the Poor and Underserved*, 22(1), 1-4. Retrieved from [http://www.clinicians.com/images/upload/01\\_HPU22.1ACU.pdf](http://www.clinicians.com/images/upload/01_HPU22.1ACU.pdf)

<sup>30</sup> Community Preventive Services Task Force. (2015). Interventions to improve access to primary care for people who are homeless: A systematic review. *The Community Guide*. Retrieved from [www.ncbi.nlm.nih.gov/pmc/articles/PMC4832090/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4832090/)

<sup>31</sup> 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. *Health Home Information Resources Center*. Retrieved from [https://www.chcs.org/media/HH\\_IRC\\_Collaborative\\_Care\\_Model\\_052113\\_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf)

<sup>32</sup> Richards, D. A., Hill, J. J., Gask, L., Lovell, K., Chew-Graham, C., Bower, P., Cape, J., Pilling, S., Araya, R., Kessler, D., Bland, J. M., Green, C., Gilbody, S., Lewis, G., Manning, C., Hughes-Morley, A., & Barkham, B. (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*, 2013(347):f4913.

<sup>33</sup> Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care*, 15(6). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628509/>

- 
- <sup>34</sup> Community Preventive Services Task Force. (2019). Mental health and mental illness: Collaborative care for the management of depressive disorders. *The Community Guide*. Retrieved from <https://www.thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders>
- <sup>35</sup> Health and Medicine Division of the National Academies of Sciences, Engineering, Medicine. (2011). *Report brief: Improving access to oral health care for vulnerable and underserved populations*. Retrieved from: <http://www.nationalacademies.org/hmd/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations/Report-Brief.aspx>
- <sup>36</sup> Centers for Disease Control and Prevention. (2011). *School Health Guidelines to Promote Healthy Eating and Physical Activity*. MMWR 2011; 60 (No. RR-5):1-76. Retrieved from [www.cdc.gov/mmwr/pdf/rr/rr6005.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6005.pdf)
- <sup>37</sup> The Community Guide. (2019). *Obesity: Meal or Fruit and Vegetable Snack Interventions to Increase Healthier Foods and Beverages Provided by Schools*. Retrieved from <https://www.thecommunityguide.org/findings/obesity-meal-fruit-vegetable-snack-interventions-increase-healthier-foods-beverages-schools>
- <sup>38</sup> The Community Guide. (2019). *Obesity: Multicomponent Interventions to Increase Availability of Healthier Foods and Beverages in Schools*. Retrieved from <https://www.thecommunityguide.org/findings/obesity-multicomponent-interventions-increase-availability-healthier-foods-and-beverages>
- <sup>39</sup> Community Preventive Services Task Force. (2017). Diabetes management: Interventions engaging community health workers. *The Community Guide*. Retrieved from [thecommunityguide.org/findings/diabetes-management-interventions-engaging-community-health-workers](https://www.thecommunityguide.org/findings/diabetes-management-interventions-engaging-community-health-workers)
- <sup>40</sup> Brownstein, J. N., Chowdhury, F. M., Norris, S. L., Horsley, T., Jack Jr, L., Zhang, X., & Satterfield, D. (2007). Effectiveness of community health workers in the care of people with hypertension. *American Journal of Preventive Medicine*, 32(5), 435-447. See also: Khetan, A. K., Purushothaman, R., Chami, T., Hejjaji, V., Mohan, S. K. M., Josephson, R. A., & Webel, A. R. (2017). The effectiveness of community health workers for CVD prevention in LMIC. *Global Heart*, 12(3), 233-243.
- <sup>41</sup> Centers for Disease Control and Prevention. (2011). *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Atlanta: U.S. Department of Health and Human Services. Retrieved from [www.cdc.gov/obesity/downloads/FandV\\_2011\\_WEB\\_TAG508.pdf](http://www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf)
- <sup>42</sup> Hartman, M. A., Hosper, K., & Stronks, K. (2011). Targeting physical activity and nutrition interventions towards mothers with young children: a review on components that contribute to attendance and effectiveness. *Public health nutrition*, 14(8), 1364-1381. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK91967/>
- <sup>43</sup> Cunningham-Sabo, L., Lohse, B., Smith, S., Browning, R., Strutz, E., Nigg, C., Balgopal, M., Kelly, K., & Ruder, E. (2016). Fuel for fun: a cluster-randomized controlled study of cooking skills, eating behaviors, and physical activity of 4th graders and their families. *BMC Public Health* 16(444). Retrieved from <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-016-3118-6>
- <sup>44</sup> Van der Bij, A. K., Laurant, M. G., & Wensing, M. (2002). Effectiveness of physical activity interventions for older adults: A review. *American Journal of Preventive Medicine*, 22(2), 120-133.



**Stanford**  
MEDICINE

Health Care  
*Tri-Valley*

# Stanford Health Care Tri-Valley Fiscal Years 2023–2025 Community Health Needs Assessment Implementation Strategy

## GENERAL INFORMATION

Contact Person:	Denise Bouillercce Senior Director, Government & Community Relations, PR/Marketing
Years the Plan Refers to:	Fiscal Years 2023–2025
Date Written Plan Was Adopted by Authorized Governing Body:	November 17, 2022
Authorized Governing Body that Adopted the Written Plan:	Finance Committee Stanford Health Care Tri-Valley <sup>a</sup> Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	Stanford Health Care Tri-Valley EIN 94-1429628
Address of Hospital Organization:	1111 E. Stanley Blvd. Livermore, CA 94550

<sup>a</sup> Stanford Health Care – ValleyCare changed its name to Stanford Health Care Tri-Valley on July 26, 2022. See press release of same date: <https://stanfordhealthcare.org/newsroom/news/press-releases/2022/valleycare-changes-name-to-tri-valley.html>

## **TABLE OF CONTENTS**

GENERAL INFORMATION	1
TABLE OF CONTENTS	2
I. ABOUT STANFORD HEALTH CARE TRI-VALLEY	3
II. STANFORD HEALTH CARE TRI-VALLEY’S SERVICE AREA	3
III. PURPOSE OF IMPLEMENTATION STRATEGY	4
IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA	5
V. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) DEVELOPMENT	6
VI. HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS	7
A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS	7
B. DESCRIPTION OF HEALTH NEEDS STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS	8
Behavioral Health	8
Economic Stability and Housing	9
Health Care Access and Delivery	11
Healthy Lifestyles	13
VII. STANFORD HEALTH CARE TRI-VALLEY’S IMPLEMENTATION STRATEGY	14
A. BEHAVIORAL HEALTH	15
B. ECONOMIC STABILITY AND HOUSING	16
C. HEALTH CARE ACCESS AND DELIVERY	18
D. HEALTHY LIFESTYLES	20
VIII. EVALUATION PLANS	21
IX. HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY DOES NOT PLAN TO ADDRESS	21
APPENDIX A: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST	23
APPENDIX B: ENDNOTES	24

## **I. ABOUT STANFORD HEALTH CARE TRI-VALLEY**

On July 26, 2022, Stanford Health Care – ValleyCare changed its name to Stanford Health Care Tri-Valley.<sup>b</sup> Stanford Health Care Tri-Valley has provided high-quality, nonprofit health care to the Tri-Valley and surrounding communities since 1961. Through state-of-the-art technology and highly skilled physicians, nurses, and staff, Stanford Health Care Tri-Valley provides a wide range of health care services at its Livermore, Pleasanton, and Dublin medical facilities. Stanford Health Care Tri-Valley has a total of 242 beds and a medical staff of approximately 500, offering an array of inpatient and outpatient services to the community.

## **II. STANFORD HEALTH CARE TRI-VALLEY’S SERVICE AREA**

Stanford Health Care Tri-Valley’s primary service area is the Tri-Valley, located in California’s East Bay Area. The Tri-Valley encompasses the suburban cities of Livermore, Pleasanton, Dublin, Danville, 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, and Danville and San Ramon are in Contra Costa County. Stanford Health Care Tri-Valley operates facilities in Pleasanton, Livermore, and Dublin. The Tri-Valley accounts for a majority of Stanford Health Care Tri-Valley’s inpatient discharges.

The U.S. Census estimates a population of about 379,000 in the Tri-Valley. The area is highly diverse: The two largest ethnic subpopulations are white and Asian (51% and 28%, respectively). The non-white population accounts for 49% of the population in the Tri-Valley area.<sup>c</sup>

Housing costs are high. In the Tri-Valley, the median rent is \$2,374. The 2021 median home price was about \$1,050,000 in Alameda County and \$800,000 in Contra Costa County.<sup>d</sup>

Two key social determinants, income and education, have a significant impact on health outcomes. The median household income in the Tri-Valley is \$154,165, close to double that of California (\$82,053).<sup>e</sup> Additionally, median incomes in the major cities in the Tri-Valley differ at the high and low ends from California. On average, 69% of people in Tri-Valley cities live in households with incomes of \$100,000 or more, compared with only 41% in California overall. Only about 14% of the population in Tri-Valley cities have household incomes below \$50,000, compared to more than double that

---

<sup>b</sup> See press release: <https://stanfordhealthcare.org/newsroom/news/press-releases/2022/valleycare-changes-name-to-tri-valley.html>

<sup>c</sup> Data in this paragraph from ESRI Demographics, based on U.S. Census Bureau TIGER/Line geodatabases, using 2020 U.S. Census data.

<sup>d</sup> Redfin. (2021.) *Alameda County Housing Market*. Retrieved from <https://www.redfin.com/county/303/CA/Alameda-County/housing-market>. *Contra Costa County Housing Market*. Retrieved from <https://www.redfin.com/county/309/CA/Contra-Costa-County/housing-market>.

<sup>e</sup> U.S. Census Bureau, *American Community Survey, 5-Year Estimates, 2015–2019*.

proportion in California (32%). By comparison, the 2021 Self-Sufficiency Standard<sup>f</sup> for a two-adult family with two children was about \$128,017 in Alameda County and about \$132,360 in Contra Costa County.<sup>g</sup>

Even though over two-thirds of households in the Tri-Valley earn more than \$100,000 per year, more than 4% of Tri-Valley residents live below the Federal Poverty Level. Similarly, over 4% of adults in the Tri-Valley do not have a high school diploma. Just over 2% of people in the Tri-Valley are uninsured.<sup>h</sup>

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the Tri-Valley's population overall is healthier than the national average.<sup>i</sup> Although the Tri-Valley is quite diverse and has substantial resources, there is significant inequality in its population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality<sup>j</sup>, is higher in certain ZIP Codes compared to others. Certain areas also have poorer access to walkable neighborhoods (e.g., ZIP Code 94551 in Livermore) or jobs (e.g., ZIP Code 94582 in San Ramon). In our assessment of the health needs in our community, we focus particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

### **III. PURPOSE OF IMPLEMENTATION STRATEGY**

This Implementation Strategy Report (IS Report) describes Stanford Health Care Tri-Valley's planned response to the needs identified through the 2022 Community Health Needs Assessment (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 and will not address. Per these requirements, the following descriptions of the actions (strategies) Stanford Health Care Tri-Valley intends to take include the

---

<sup>f</sup> The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.

<sup>g</sup> Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool*. Retrieved from <http://www.selfsufficiencystandard.org/node/44>. "Family" is considered as two adults, one infant, and one school-age child.

<sup>h</sup> Data in this paragraph from U.S. Census Bureau, *American Community Survey*, 5-Year Estimates, 2015–2019.

<sup>i</sup> The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while the Tri-Valley is scored at -1.4. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041-1062. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/>.

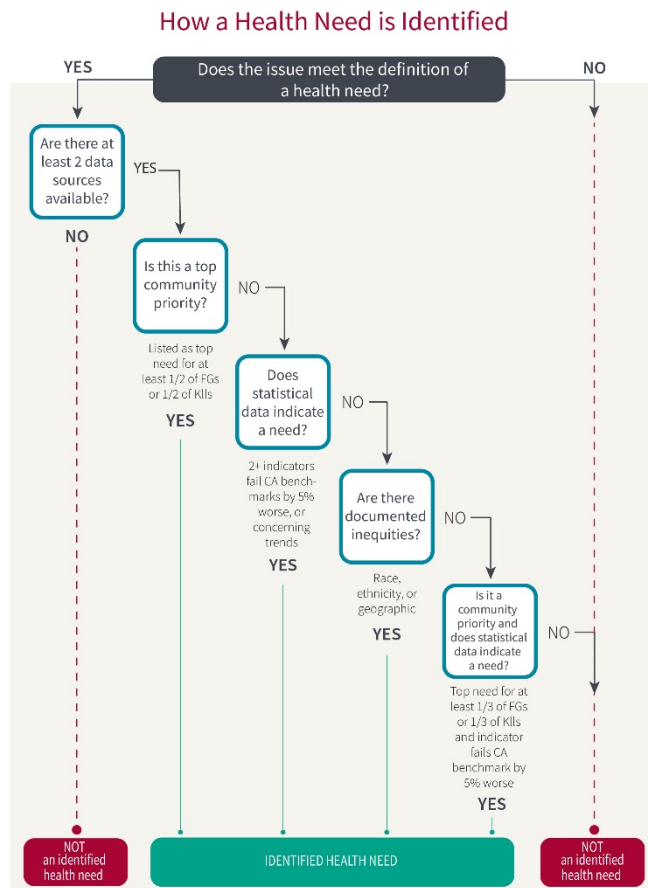
<sup>j</sup> The Gini index "measures the extent to which the distribution of income... among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from <https://stats.oecd.org/glossary/detail.asp?ID=4842>.

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 Tri-Valley’s 2022 CHNA process and for a copy of the 2022 CHNA report, please visit <https://stanfordhealthcare.org/tri-valley/about-us/community-benefits.html>.

#### IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community’s priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide averages and rates.



### DEFINITIONS

**Health condition:** A disease, impairment, or other state of physical or mental ill health that contributes to a poor health outcome.

**Health driver:** A behavioral, environmental, or clinical care factor, or a more upstream social or economic factor that impacts health. May be a social determinant of health.

**Health need:** A poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.

**Health outcome:** A snapshot of disease in a community that can be described in terms of both morbidity (quality of life) and mortality.

**Health indicator:** A characteristic of an individual, a population, or an environment that can be measured (directly or indirectly) and used to describe one or more aspects of the health of an individual or population.

To be considered a health need for the purposes of the 2022 CHNA, the need had to meet the definition of a health need (see Definitions box), be present in at least two data sources, and meet at least one of the following criteria: (1) be prioritized by a majority of key informants or focus groups, (2) have at least two direct indicators that fail the statewide benchmark by 5% or more, (3) have at least

four indicators that show ethnic disparities of 5% or more compared to the statewide benchmark, or (4) have a combination of at least one-third community prioritization and at least one direct indicator failing the benchmark by 5% or more. A total of nine health needs were identified in the 2022 CHNA.

Stanford Health Care Tri-Valley’s Community Benefit Advisory Group (CBAG) met virtually via Zoom on March 2, 2022, to review the health needs identified during the CHNA and to participate in the prioritization process. The CBAG used these criteria to prioritize the list of health needs:

- **Community priority.** The community prioritizes the issue over other issues about which it has expressed concern during the CHNA primary data collection process.
- **Clear disparities or inequities.** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **Lacking sufficient community assets and/or resources.** The IRS requires that hospitals take into consideration whether existing assets/resources are available to address the issue.
- **Multiplier effect.** A successful solution to the health need has the potential to solve multiple problems. For example, if rates of obesity go down, diabetes rates could also go down.

Based on those criteria, the CBAG members reached consensus in ranking the nine community health needs as follows.

#### 2022 COMMUNITY HEALTH NEEDS LIST

1. **Housing and Homelessness**
2. **Behavioral Health**
3. **Economic Stability**
4. **Healthy Eating/Active Living, Diabetes and Obesity**
5. **Health Care Access and Delivery**
6. **Community Safety**
7. **Heart Disease and Stroke**
8. **Cancer**
9. **Climate and Natural Environment**

### COVID-19

The CHNA incorporated COVID-19 data in two ways: (1) Statistical data detailing the disease and associated health conditions and (2) qualitative data provided by community experts and residents. As a novel virus, statistical data were limited when the CHNA was conducted; however, community experts and residents offered ample qualitative data on the economic and social impacts of COVID-19 on local vulnerable communities. Stanford Health Care Tri-Valley will continue to monitor the trends and health impacts while addressing the health care needs of COVID-19.

## V. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) DEVELOPMENT

Stanford Health Care Tri-Valley gathered input from internal and external experts and other stakeholders, the latter through in-depth interviews with community partners. The hospital’s

Community Advisory Relations Board subcommittee, “Community Health Needs,” also provided input into the process, considering both the current state of assets in the service area and best practices to address the needs. The Stanford Health Care Tri-Valley Executive Team then selected the health needs to address. The executive team prioritized community voice and carefully considered the kinds of meaningful impact that Stanford Health Care Tri-Valley could make. It was especially important to the team to select needs that, when addressed, could reduce gaps in health equity among Tri-Valley residents.

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 THAT STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS**

### **A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS**

In the first quarter of 2022, the Stanford Health Care Tri-Valley Executive Team met to review the information collected for the 2022 CHNA. The Executive Team, by consensus, selected four health needs Stanford Health Care Tri-Valley would address, which would form the basis for Stanford Health Care Tri-Valley’s FY2023–2025 community benefit plan and implementation strategies. The team selected the needs that were of highest priority to the community and that are some of the biggest contributors to health inequities among community members.

### **2023–2025 SELECTED COMMUNITY HEALTH NEEDS**

- 1. Behavioral Health**
- 2. Economic Stability and Housing**
- 3. Health Care Access and Delivery**
- 4. Healthy Lifestyles<sup>k</sup>**

---

<sup>k</sup> In the CHNA, there were two separate needs called “Economic Stability” and “Housing and Homelessness.” Stanford Health Care Tri-Valley plans to address both and has merged these two needs into one, called “Economic Stability and Housing.” Additionally, the need originally termed “Healthy Eating/Active Living, Diabetes and Obesity” has been renamed to the more succinct “Healthy Lifestyles.”

## **B. DESCRIPTION OF HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY PLANS TO ADDRESS**

### **Behavioral Health**

Behavioral health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need, being prioritized by nearly all key informants and two out of five focus groups.

According to key informants, mental health, which was already bad in this service area, is now at a critical level after the fear, anxiety, stress, job loss, isolation, and lack of trust that resulted from the COVID-19 pandemic. Focus group participants stated that the COVID-19 pandemic negatively impacted mental health due to fear of being out in public, using public transportation, and a stigma about mask-wearing. Key informants stated that mental health does not discriminate based on age, race, or socio-economic status. Especially after the trauma of the pandemic, mental health is a crisis across all populations. Informants did, however, note disparities based on geography, explaining that many mental health providers are centralized in Oakland and San Francisco and not in the Tri-Valley area. Participants corroborated this, explaining there often is a long waiting list to see a mental health provider, specifically citing a shortage of Spanish-speaking therapists.

Focus group participants reported that children faced significant stress and anxiety because of the pandemic. According to key informants, school systems do not adequately support students of color and need to make schools more welcoming, inclusive, and safe places for children. Key informants stated that the pandemic had a major impact on the mental health of youth, citing an increase in suicide attempts, suspensions, and behavioral issues. Youth mental health statistics bear out this concern: cyberbullying is experienced by greater percentages of Pacific Islander youth in both counties, and by Native American youth in Contra Costa County, than by all youth statewide. Pacific Islander youth in Alameda County also experience depression-related feelings in higher proportions than California youth overall. School-based bullying and harassment are greater for multi-ethnic youth and youth of “Other” ancestries<sup>1</sup> in Contra Costa County than all California youth. Finally, in Alameda County, the proportion of teens contemplating suicide is higher than teens statewide for Native American, Pacific Islander, multi-ethnic, and Other youth, while in Contra Costa County, it is higher than the state for Asian, Pacific Islander, and multi-ethnic youth. Experts note that “racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care

---

<sup>1</sup> “Other” is a U.S. Census category for ethnicities not specifically called out in data sets.

when treated.”<sup>m</sup> An expert on the historical context of such disparities suggests that “racism and discrimination,” as well as “fear and mistrust of treatment,” pose barriers to BIPOC community members seeking help for behavioral health issues.<sup>n</sup>

Regarding substance use, binge drinking is higher in Dublin, Livermore, and Pleasanton than it is statewide. The impaired driving mortality rate is higher in the Tri-Valley/Central Contra Costa County area than in California. In addition, the rate of visits to emergency departments for substance use has been trending up in Alameda County overall. Related to these statistics, focus group participants indicated that drug and alcohol users make public spaces less safe for the community. Key informants mentioned a particular need to address substance use within the unhoused community.

### **Economic Stability and Housing**

More than two-thirds of key informants and one focus group rated economic stability, including education, income, and employment, as a high community priority. Half of all key informants and three of five focus groups identified housing and homelessness as a top community priority.

Housing costs and other costs of living in the Tri-Valley are extremely high; the median home rental cost is more than 40% higher than the median state home rental cost. The qualitative data reflect this: key informants asserted that the Tri-Valley area is an expensive place to live, and that many families struggle to support themselves on an income that is inadequate compared to the cost of living. They said the COVID-19 pandemic made the existing problem worse, with many families losing jobs and needing to make difficult decisions about how to divide their resources to pay for basic needs like housing, childcare, and food. Key informants noted that a lack of affordable housing in the Tri-Valley, made worse by the COVID-19 pandemic, has led to an increase in overcrowded homes. These housing struggles may cause anxiety, leading to mental/behavioral health difficulties and interpersonal issues, and sometimes escalating to domestic violence. Focus group participants also reported that the COVID-19 pandemic exacerbated the existing housing crisis. They also said that laws and resources that supported renters during the pandemic have been critically important.

---

<sup>m</sup> McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, 27(2), 393–403. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/>

<sup>n</sup> Perzichilli, T. (2020). The historical roots of racial disparities in the mental health system. *Counseling Today*, American Counseling Association. Retrieved from <https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/>

Key informants mentioned gentrification leaving families unable to afford living in their changing communities, yet simultaneously not having the means to move away. Focus group participants said that residents are moving from the Tri-Valley because of housing prices. Participants acknowledged a significant need to develop more affordable housing.

Focus group participants indicated a lack of employment opportunities in the Tri-Valley area that pay enough to afford the expensive rents in the area. Key informants pointed to significant disparities in income in Pleasanton, Dublin, and Livermore, with many residents having significant means and others having little. They stated that many families are struggling to stay in the area for jobs and school, despite the steep cost of living. Our 2019 CHNA report described racial and ethnic disparities in income, with a larger proportion of the Black population in the Tri-Valley/Central Contra Costa area experiencing poverty than California's population overall.

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of both counties' Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English-language arts standards compared to California 11th graders overall. Also, a smaller percentage of both counties' Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards versus California's 11th graders. Related to these statistics, much smaller proportions of Alameda County's Black and Pacific Islander high school graduates and Contra Costa County's Black and Latinx high school graduates completed college-preparatory courses compared to high school graduates statewide. The high school drop-out rate is particularly high among Alameda County's Latinx youth compared to all California youth. Building on these figures, in our 2019 CHNA report, we found a higher proportion of the Tri-Valley/Central Contra Costa County area's Latinxs, Pacific Islanders, and residents of Other ethnicities over ages 24 without a high school diploma compared to all Californian adults over age 24.

Qualitative data showed that COVID created more economic insecurity for those who lost work. Focus group participants said that small businesses struggled to survive the pandemic. This has had a ripple effect throughout the economy, leading to loss of income, unemployment, and subsequent housing instability. According to key informants, pandemic related job loss was a significant issue in the community that had broad effects including increased food insecurity, homelessness, and significant mental health issues. Key informants noted that parental job loss because of the COVID-19 pandemic had a trickle-down effect through families, citing students who withdrew from school due to stressors at home. Prior to the pandemic, a larger percentage of Dublin youth were not in school and not working than California youth overall.

In reference to school, key informants said the virtual learning environment left many students behind academically. Statistics from before the pandemic indicated that greater proportions of Black students in both counties experience low school connectedness than all California students. Greater proportions of Latinx and Other students in Contra Costa County had low levels of meaningful participation in school than students statewide. Key informants also stated that access to childcare is a major issue. Affordable care is limited for low-income parents, and fear of exposure to COVID-19 has kept many parents wary of utilizing childcare services. Additionally, participants cited the need for more childcare facilities that can support children who have experienced homelessness or other trauma.

Focus group participants specifically called out children, single parents, and people experiencing homelessness as populations experiencing significant food insecurity. Even before the pandemic, the proportion of Black children in Contra Costa County who went to school without having breakfast was higher than the proportion of all children statewide. According to key informants, food insecurity is on the rise in the Tri-Valley, especially among the Asian community in Pleasanton. The COVID-19 pandemic made an existing problem worse, with many families losing jobs and needing to make difficult decisions about how to divide their resources to pay for basic needs like housing, childcare, and food. Focus group participants reported that those experiencing homelessness are facing co-occurring issues and barriers to health, like mental and behavioral health issues. Participants said that community resources for homeless veterans are particularly insufficient or non-existent, and those needing help have to go out of the county to get it.

### **Health Care Access and Delivery**

Almost all focus groups and over half of key informants identified health care access and delivery, which affects various other community health needs, as a top health need. Focus group participants cited a lack of providers and difficulty getting an appointment as issues contributing to access to care and mentioned specific communities facing inequities in accessing care: Latinx, undocumented people, veterans, older adults, and unhoused populations. Participants specifically stated that older adults and the uninsured face a disproportionate burden when it comes to income and paying for health care. Key informants pointed to an income gap impacting the ability of many to access care, specifically, those making too much to qualify for Medi-Cal yet not enough to afford private insurance. Informants also highlighted inequities in access to care in low-income, underserved, Black, and LGBTQ+ populations and called for diverse and culturally competent providers. Key informants additionally mentioned a rapidly increasing Asian population in the Tri-Valley area. Access issues have arisen due to the multitude of languages spoken and a lack of providers and interpreters who speak these languages. Inequities in health care access and

delivery, such as those described by key informants and focus group participants, have been shown to be major contributors to inequities in health outcomes.<sup>9</sup>

Focus group participants linked transportation with health, stating that traffic, road work, and a lack of affordable public transportation options makes accessing health care difficult. Key informants noted that many specialty services are in Oakland or San Francisco, which is a barrier to access for many without adequate transportation. As a result of the COVID-19 pandemic, informants noted that patients gained expanded options to see providers out of their area via telehealth. Key informants also mentioned seeing increased collaboration among community entities to figure out solutions to provide care faster. However, informants also acknowledged disparities when it comes to telehealth, specifically among older adults who have difficulty utilizing new technologies and low-income residents who might not have reliable access to a computer or the internet. Key informants also called out issues in delayed dental care, specifically for children and unhoused populations, due to the pandemic. Additionally, informants noted a workforce shortage across all types of care.

The COVID-19 pandemic exacerbated existing racial and health inequities, with people of color accounting for a disproportionate share of COVID-19 cases, hospitalizations, and deaths. Focus group participants agreed that the pandemic disproportionately impacted communities of color. Key informants mentioned that some communities are not accessing the vaccine because of their legal status. Informants pointed out the importance of considering the social determinants of health, and the need for providers to look at factors like housing, job stability, and food security, rather than a simple medical approach, to address structural racism's impact on health.

Multiple key informants pointed to a disparity in infant mortality in the Black community. They cited factors like a lack of culturally competent care, having to choose between significant others and doulas in the delivery room due to the pandemic, shortcomings in post-natal care, and racial tension and anxiety due to the pandemic. Statistics corroborate these observations: Infant mortality is higher among Alameda County's Black, Latinx, and multi-ethnic populations than in California overall. Low birth weight was a concern for the Alameda County Pacific Islander and multi-ethnic populations, as well as the Contra Costa County Asian population. Pre-term births are happening at higher rates for multi-ethnic babies in Contra Costa County than for all babies statewide. Teen births are higher for Contra Costa County Latinas than for young women across the state. Finally, breastfeeding rates are

---

<sup>9</sup> Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. *The Lancet*, 389(10077), 1431-1441. See also Yearby, R. (2018). Racial disparities in health status and access to healthcare: the continuation of inequality in the United States due to structural racism. *American Journal of Economics and Sociology*, 77(3-4), 1113-1152. Retrieved from [https://inside.nku.edu/content/dam/viceprovost/docs/CommonExperience/Racial%20Disparities%20in%20Health%20Status%20\(1\).pd.pdf](https://inside.nku.edu/content/dam/viceprovost/docs/CommonExperience/Racial%20Disparities%20in%20Health%20Status%20(1).pd.pdf)

especially low among Pacific Islander mothers in both counties compared to mothers statewide.

### **Healthy Lifestyles**

Two out of five focus groups and one key informant identified elements of healthy lifestyles as top health needs. According to key informants, a significant increase in screen time during the pandemic has led to an increase in childhood obesity. Larger proportions of children in Alameda and Contra Costa counties do not meet fitness standards compared to children statewide.

The rate of adults with diabetes is trending up in Alameda County. Moreover, the proportion of the adult population in Livermore with obesity is higher than in Alameda County overall. Perhaps related to this, a smaller proportion of Livermore adults walk regularly than all adults in Alameda County. Both key informants and focus group participants discussed the need for more safe parks and outdoor spaces in the community to exercise and recreate. Focus group participants indicated that existing outdoor parks and spaces have been taken over by groups that make the spaces feel unsafe (because of drug and alcohol use). In addition, focus group participants cited climate and environment issues (high temperatures and reduced air quality) as barriers to outdoor exercise opportunities.

In the Tri-Valley, a far larger percentage of workers drive alone, with long commutes, compared to all Californians. Related to this, focus group participants stated that long commutes to work negatively impact their well-being. Also, in both Dublin and Livermore, the proportions of employed people who walk to work are substantially smaller than the statewide average.

Tri-Valley residents have lower access to grocery stores than their counterparts statewide. Similarly, data show that among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in the Tri-Valley than the state average. Key informants stated the need for medical providers to do a better job of linking nutrition with overall health for patients and connecting them with community resources that could help support healthier dietary patterns.

Our 2019 CHNA report identified disparities in diabetes and obesity, with Tri-Valley/Central Contra Costa County Black adult and Latinx youth populations experiencing obesity at higher rates than the state. We also reported lower rates of diabetes management among Black people in the Tri-Valley/Central Contra Costa County area than the state. Some focus group participants in the 2022 CHNA said that “lifestyle diseases” like obesity and diabetes were prevalent in the community and that this was a result of inequities in neighborhoods’ built environment. Similarly, experts writing on behalf of the American Diabetes Association

describe placing “socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations.”<sup>p</sup>

## **VII. STANFORD HEALTH CARE TRI-VALLEY’S IMPLEMENTATION STRATEGY**

Stanford Health Care Tri-Valley’s annual community benefit investment focuses on improving the health of the community’s most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, the priority of community health investments from FY2023–FY2025 will address access to and delivery of care, access to behavioral health care, and healthy lifestyles, and economic stability through community and hospital-based programs and partnerships although other areas may also receive support. Additionally, Stanford Health Care Tri-Valley will collaborate with the Health Equity Council to find ways to mitigate and overcome inequities in the community, to improve health equity community-wide.

This plan represents a continuation of a multi-year strategic investment in community health. Stanford Health Care Tri-Valley believes that funding of, and relationships with, proven community partners yield 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.

---

<sup>p</sup> Ogunwole, S. M. & Golden, S. H. (2021). Social determinants of health and structural inequities—root causes of diabetes disparities. *Diabetes Care*, Jan. 2021, 44 (1): 11-13. Retrieved from <https://care.diabetesjournals.org/content/44/1/11>.

## A. BEHAVIORAL HEALTH

### Key CHNA Findings:

- Mental health in the Tri-Valley is considered by key informants to be at a critical level since the COVID-19 pandemic began and is perceived as especially bad for youth.
- Experts say there is limited access to mental/behavioral health care in the Tri-Valley compared to other parts of Alameda County.
- Substance use and alcohol are issues for Tri-Valley community members; binge drinking is higher in Dublin and Pleasanton than it is statewide.

Goal	Behavioral Health Strategies	Anticipated Impact
A.1 Improve Tri-Valley community members' access to mental/behavioral health care services	<ul style="list-style-type: none"> <li>i. Support efforts to coordinate delivery of behavioral health care and physical health care in the Tri-Valley<sup>1, 2, 3, 4, 5</sup></li> <li>ii. Support efforts to increase access to behavioral/mental health care across all Tri-Valley populations<sup>6, 7, 8, 9, 10</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Improved access to mental/behavioral health programs and services</li> <li>b. Increased proportion of community members served with effective mental/behavioral health services</li> <li>c. Improved coordination of physical and mental/behavioral health services</li> <li>d. Improved mental/behavioral health well-being among those served</li> </ul>
A.2 Improve mental health and well-being among Tri-Valley community members	<ul style="list-style-type: none"> <li>i. Participate in collaborations and partnerships on efforts to address behavioral health for Tri-Valley community members</li> </ul>	<ul style="list-style-type: none"> <li>a. Improved mental/behavioral health among Tri-Valley community members</li> </ul>

## B. ECONOMIC STABILITY AND HOUSING

### **Key CHNA Findings:**

- The cost of living in the Tri-Valley is extremely high and affordable housing is lacking.
- The COVID-19 pandemic exacerbated existing problems, with many losing jobs and needing to stretch resources further.
- Key informants said food insecurity and homelessness have been on the rise in the Tri-Valley due to the pandemic.
- Educational inequities, such as the completion of college prep courses, were likely made worse by lengthy periods of virtual schooling; this can affect future opportunities of Tri-Valley community members.

Goal	Economic Stability and Housing Strategies	Anticipated Impact
B.1 Reduce food insecurity and increase healthy food access for vulnerable community members	i. Support expanded access to food security and food access programs and/or support new programs to increase access to nutrient-dense foods for vulnerable Tri-Valley community members <sup>11, 12, 13</sup>	<ul style="list-style-type: none"> <li>a. Improved access to healthy food for low-income individuals across the Tri-Valley area</li> <li>b. Improved associated health outcomes</li> <li>c. Increased proportion of low-income individuals in the Tri-Valley who eat three meals per day</li> <li>d. Reduced proportion of individuals in the Tri-Valley experiencing poor health outcomes that are a result of food insecurity</li> <li>e. Reduced proportion of individuals who are food insecure</li> <li>f. Reduced proportion of individuals in Alameda and Contra Costa Counties experiencing poor health outcomes as a result of food insecurity.</li> <li>g. Reduced diabetes/obesity rates</li> </ul>

Goal	Economic Stability and Housing Strategies	Anticipated Impact
B.2 Reduce barriers to employment/careers that provide community members with a living wage	i. Support efforts to increase workforce-related educational attainment and/or job training <sup>14, 15, 16, 17, 18</sup>	<ul style="list-style-type: none"> <li>a. Reduced unemployment rates</li> <li>b. Reduced poverty rates in the Tri-Valley area</li> <li>c. Reduced California Self-Sufficiency Standard disparity</li> <li>d. Reduction of pay disparities</li> </ul>
B.3 Reduce housing instability among vulnerable community members to support improved health	<ul style="list-style-type: none"> <li>i. Support programs that expand affordable housing opportunities<sup>19, 20</sup></li> <li>ii. Support local homelessness prevention and intervention organizations and collaboratives<sup>21, 22, 23, 24, 25</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Improved access to stable housing for low-income individuals</li> <li>b. Increased access to social services to prevent homelessness</li> <li>c. Higher rate of community members retaining independence</li> <li>d. Reduced proportion of individuals who are housing insecure</li> </ul>

## C. HEALTH CARE ACCESS AND DELIVERY

### Key CHNA Findings:

- Smaller proportions of adults in Tri-Valley cities had routine annual check-ups compared to all Californian adults.
- Smaller proportions of Tri-Valley cities’ adults with high blood pressure were taking medication to manage their condition compared to their peers statewide.
- CHNA participants said there was a shortage of health care providers in the Tri-Valley.
- Key informants pointed to an income gap impacting the ability of many to access care.
- Key informants also highlighted inequities in access to care among low-income, Black, and LGBTQ+ populations and called for diverse and culturally competent providers.

Goal	Health Care Access and Delivery Strategies	Anticipated Impact
C.1 Improve access to affordable, high-quality health care services for vulnerable community members	i. Allocate resources to support: <ul style="list-style-type: none"> <li>a. Participation in government-sponsored programs for low-income individuals (i.e., Medi-Cal Managed Care)</li> <li>b. Provision of Charity Care to ensure low-income individuals obtain needed medical services</li> <li>c. Increased health insurance coverage<sup>26</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Reduced health care cost barriers for vulnerable populations</li> <li>b. Improved affordability of health care services</li> <li>c. Improved health insurance rates</li> <li>d. Reduced avoidable emergency department and hospital utilization</li> <li>e. Improved access to medical home</li> </ul>
	ii. Support wellness strategies (e.g., health fairs, education, screening) that improve equitable health outcomes <sup>27, 28</sup>	<ul style="list-style-type: none"> <li>a. Increased awareness of preventive care</li> <li>b. Increased use of medical home, including preventive care services</li> <li>c. Reduced avoidable emergency department and hospital utilization</li> <li>d. Improved health outcomes, particularly related to health disparities</li> </ul>

Goal	Health Care Access and Delivery Strategies	Anticipated Impact
	<ul style="list-style-type: none"> <li>iii. Support equitable access and delivery efforts such as:               <ul style="list-style-type: none"> <li>a. Street medicine<sup>29, 30</sup></li> <li>b. Care coordination interventions<sup>31, 32, 33, 34, 35</sup></li> <li>c. Advocacy for telehealth reimbursement</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>a. Reduced avoidable emergency department and hospital utilization</li> <li>b. Improved access to medical home</li> <li>c. Increased use of preventive care services</li> <li>d. Improved health outcomes, particularly related to health disparities</li> <li>e. Improved housing and economic security by addressing physical health conditions that contribute to housing instability</li> <li>f. Improved equitable access to telehealth</li> </ul>

## D. HEALTHY LIFESTYLES

### Key CHNA Findings:

- The Tri-Valley built environment is not optimal for healthy lifestyles:
  - A larger percentage of Tri-Valley community members have low access to grocery stores than their statewide peers.
  - There are half as many supercenters and club stores in the Tri-Valley per 1,000 people than there are statewide.
  - The walkability index in the Tri-Valley is worse than the California average.
- A smaller proportion of youth in some Tri-Valley cities are healthy (not overweight/obese, engaging in regular physical activity) compared to their counterparts across the state.
- There are ethnic disparities in heart disease deaths and child fitness statistics in the Tri-Valley, with BIPOC community members doing worse than non-BIPOC community members.

Goal	Healthy Lifestyles Strategies	Anticipated Impact
D.1 Increase healthy eating and active living among children, youth, and adults in the Tri-Valley area	i. Support efforts such as: <ul style="list-style-type: none"> <li>a. Supporting schools in promoting healthy eating and physical activity<sup>36,37,38</sup></li> <li>b. In-kind support of community health workers for health education, and as outreach, enrollment, and information agents to increase healthy behaviors<sup>39,40</sup></li> <li>c. Programs of education and support for healthy lifestyles across various populations (e.g., older adults, new mothers)<sup>41, 42, 43, 44</sup></li> </ul>	<ul style="list-style-type: none"> <li>a. Increased knowledge about healthy behaviors</li> <li>b. Increased access to physical activity</li> <li>c. Increased access to healthy foods</li> <li>d. Increased physical activity</li> <li>e. Increased consumption of healthy foods</li> <li>f. Reduced consumption of unhealthy foods</li> <li>g. More policies/practices that support increased physical activity and improved access to healthy foods</li> </ul>
	ii. Participate in collaborations and partnerships to promote healthy eating and/or active living, such as health fairs for screening and education <sup>27, 28</sup>	<ul style="list-style-type: none"> <li>a. Increased knowledge about healthy behaviors</li> <li>b. Increased physical activity</li> <li>c. Increased consumption of healthy foods</li> <li>d. Reduced consumption of unhealthy foods</li> </ul>

## VIII. EVALUATION PLANS

As part of Stanford Health Care Tri-Valley's ongoing community health improvement efforts, Stanford Health Care Tri-Valley partners with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through its triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or provide information that justifies the need for and effectiveness of the proposed program strategies.

Stanford Health Care Tri-Valley 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, Stanford Health Care Tri-Valley will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

## IX. HEALTH NEEDS THAT STANFORD HEALTH CARE TRI-VALLEY DOES NOT PLAN TO ADDRESS

As described in Section VI(A) of this report, the Executive Team was careful to select 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; therefore, Stanford Health Care Tri-Valley does not plan to address them at this time.

**Cancer:** Stanford Health Care Tri-Valley is better positioned to address drivers of this need via strategies related to healthy lifestyles, and education about this need via health care access and delivery strategies. Additionally, cancer was of lower priority to the community than the needs selected to be addressed by Stanford Health Care Tri-Valley.

**Climate and Natural Environment:** This topic is outside of Stanford Health Care Tri-Valley's core competencies (i.e., Stanford Health Care Tri-Valley has little expertise in this area), and the hospital feels it cannot make a significant impact on this need through community benefit investment. Also, this need was of lower priority to the community than the needs that Stanford Health Care Tri-Valley selected.

**Community Safety:** This need was of lower priority to the community than the needs selected to be addressed by Stanford Health Care Tri-Valley. Although Stanford Health Care Tri-Valley lacks the expertise to address this health need, behavioral health issues such as substance use, stress, and anxiety have been shown to be drivers of bullying and violence. Thus, Stanford Health Care Tri-Valley

believes that strategies intended to address the community's behavioral health need have the potential to address community safety as well.

**Heart Disease and Stroke:** This need was of lower priority to the community than the needs selected to be addressed by Stanford Health Care Tri-Valley. Moreover, Stanford Health Care Tri-Valley is better positioned to address drivers of this need via strategies related to education about healthy lifestyles and health care access and delivery.

## APPENDIX A: IMPLEMENTATION STRATEGY REPORT IRS CHECKLIST

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

Federal Requirements Checklist	Regulation Subsection Number	Report Section
The Implementation Strategy is a written plan which includes:		
(1) Description of <b>how the hospital facility plans to address</b> 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
(2) Description of why a hospital facility is <b>not addressing</b> a significant health need identified in the CHNA. <i>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.</i>	(c)(3)	IX
(3) For those hospital facilities that adopted a joint CHNA report, a <b>joint implementation strategy</b> 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
(4) An authorized body <b>adopts the implementation</b> strategy on or before January 15 <sup>th</sup> , 2023, which is the 15 <sup>th</sup> 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)	General Information
<b>Exceptions:</b> Our hospital does not qualify for any exception described in Section (D) for acquired, new, transferred, and terminated facilities.	(d)	N/A

## APPENDIX B: ENDNOTES

- <sup>1</sup> Chuang, E., Pourat, N., Haley, L. A., O'Masta, B., Albertson, E., & Lu, C. (2020). Integrating health and human services in California's Whole Person Care Medicaid 1115 waiver demonstration: An overview of a California demonstration program focused on improving the integrated delivery of health, behavioral health, and social services for certain Medicaid beneficiaries. *Health Affairs*, 39(4), 639-648. Retrieved from <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01617>
- <sup>2</sup> Olson, J. R., Benjamin, P. H., Azman, A. A., Kellogg, M. A., Pullmann, M. D., Suter, J. C., & Bruns, E. J. (2021). Systematic review and meta-analysis: Effectiveness of wraparound care coordination for children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 60(11), 1353-1366. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0890856721001556>
- <sup>3</sup> Satcher, D., & Rachel, S. A. (2017). Promoting mental health equity: the role of integrated care. *Journal of clinical psychology in medical settings*, 24(3), 182-186.
- <sup>4</sup> 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. *Health Home Information Resources Center*. Retrieved from [https://www.chcs.org/media/HH\\_IRC\\_Collaborative\\_Care\\_Model\\_052113\\_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf) See also: Wong, W., Anderson, K. M., Dankwa-Mullan, I., Simon, M. A., & Vega, W. A. (2012). The patient-centered medical home: a path toward health equity?. *NAM Perspectives*. Retrieved from <https://nam.edu/wp-content/uploads/2015/06/PatientCenteredMedicalHome.pdf>
- <sup>5</sup> Ginsburg, S. (2008). Colocating health services: a way to improve coordination of children's health care? *The Commonwealth Fund*, July 2008. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2008/jul/colocating-health-services-way-improve-coordination-childrens>
- <sup>6</sup> Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H., Randolph, F., Blasinsky, M., Fontana, A., Calsyn, R., & Teague, G. (1998). Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness. *American Journal of Public Health*, 88(11): 1610-1615. Retrieved from <https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.88.11.1610>
- <sup>7</sup> Weaver, A., & Lapidus, A. (2018). Mental health interventions with community health workers in the United States: a systematic review. *Journal of Health Care for the Poor and Underserved*, 29(1), 159-180. Retrieved from [https://web.archive.org/web/20190429000716id\\_/https://muse.jhu.edu/article/686958/pdf](https://web.archive.org/web/20190429000716id_/https://muse.jhu.edu/article/686958/pdf)
- <sup>8</sup> Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing community health workers to address mental health disparities for underserved populations: a systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(2), 195-211. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803443/>
- <sup>9</sup> Kaslow, N.J., Friis-Healy, E.A., Cattie, J.E., Cook, S.C., Crowell, A.L., Cullum, K.A., Del Rio, C., Marshall-Lee, E.D., LoPilato, A.M., VanderBroek-Stice, L. and Ward, M.C. (2020). Flattening the emotional distress curve: A behavioral health pandemic response strategy for COVID-19. *American Psychologist*, 75(7), 875.
- <sup>10</sup> 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>

- 
- <sup>11</sup> Palar, K., Napoles, T., Hufstедler, L.L., Seligman, H., Hecht, F.M., Madsen, K., Ryle, M., Pitchford, S., Frongillo, E.A., & Weiser, S.D. (2017). Comprehensive and medically appropriate food support is associated with improved HIV and diabetes health. *Journal of Urban Health*, 94(1): 87-99. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5359179/>. See also: Berkowitz, S.A., Delahanty, L.M., Terranova, J., Steiner, B., Ruazol, M.P., Singh, R., Shahid, N.N., & Wexler, D.J. (2019). Medically tailored meal delivery for diabetes patients with food insecurity: a randomized cross-over trial. *Journal of general internal medicine*, 34(3): 396-404.
- <sup>12</sup> The Community Guide. (2019). *Obesity: Multicomponent Interventions to Increase Availability of Healthier Foods and Beverages in Schools*. Retrieved from <https://www.thecommunityguide.org/findings/obesity-multicomponent-interventions-increase-availability-healthier-foods-and-beverages>
- <sup>13</sup> Centers for Disease Control and Prevention. (2011). *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Atlanta: U.S. Department of Health and Human Services. Retrieved from [www.cdc.gov/obesity/downloads/FandV\\_2011\\_WEB\\_TAG508.pdf](http://www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf)
- <sup>14</sup> Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 689-695.
- <sup>15</sup> Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836-851.
- <sup>16</sup> See, for example, Sieck, L., Chatterjee, T., & Birch, A. (2022). Priming the pipeline: inspiring diverse young scholars in the radiologic sciences begins during early childhood education. *Journal of the American College of Radiology*, 19(2), 384-388. Retrieved from [https://www.jacr.org/article/S1546-1440\(21\)00852-8/fulltext](https://www.jacr.org/article/S1546-1440(21)00852-8/fulltext)
- <sup>17</sup> Poremski, D., Rabouin, D., & Latimer, E. (2017). A randomised controlled trial of evidence based supported employment for people who have recently been homeless and have a mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(2), 217-224.
- <sup>18</sup> Bretherton, J., & Pleave, N. (2019). Is work an answer to homelessness?: Evaluating an employment programme for homeless adults. *European Journal of Homelessness*, 59-83. Retrieved from [https://eprints.whiterose.ac.uk/145311/1/13\\_1\\_A3\\_Bretherton\\_v02.pdf](https://eprints.whiterose.ac.uk/145311/1/13_1_A3_Bretherton_v02.pdf)
- <sup>19</sup> Hope, H. (2022). Accessory dwelling units promoted as a strategy to increase affordable housing stock at White House event. *Smart Growth America*. Retrieved from <https://smartgrowthamerica.org/white-house-adus-event/> See also: California Department of Housing and Community Development. (2021). *Accessory Dwelling Units (ADUs) and Junior Accessory Dwelling Units (JADUs)*. Retrieved from <https://www.hcd.ca.gov/policy-research/accessorydwellingunits.shtml>
- <sup>20</sup> Benton, A. L. (2014). *Creating a Shared Home: Promising Approaches for Using Shared Housing to Prevent and End Homelessness in Massachusetts*. Retrieved from <https://ash.harvard.edu/files/ash/files/3308562.pdf?m=1637364880>
- <sup>21</sup> Schapiro, R., Blankenship, K., Rosenberg, A., & Keene, D. (2022). The effects of rental assistance on housing stability, quality, autonomy, and affordability. *Housing Policy Debate*, 32(3), 456-472. Retrieved from [https://www.nlihc.org/sites/default/files/Effects\\_of\\_Rental\\_Assistance.pdf](https://www.nlihc.org/sites/default/files/Effects_of_Rental_Assistance.pdf) and see Pfeiffer, D. (2018). Rental housing assistance and health: Evidence from the survey of income and program participation. *Housing Policy Debate*, 28(4), 515-533. Retrieved from [http://www.nlihc.org/sites/default/files/Rental-Housing-Assistance-Health-Evidence\\_Survey-of-Income-Program-Participation.pdf](http://www.nlihc.org/sites/default/files/Rental-Housing-Assistance-Health-Evidence_Survey-of-Income-Program-Participation.pdf). See also Liu, L. (2022). *Early Effects of the COVID Emergency Rental Assistance Programs: A Case Study*. Available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=4095328](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4095328)
- <sup>22</sup> Holl, M., Van Den Dries, L., & Wolf, J. R. (2016). Interventions to prevent tenant evictions: a systematic review. *Health & Social Care in the Community*, 24(5), 532-546. Retrieved from <https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/hsc.12257>. See also Cassidy, M. T., & Currie, J. (2022). The Actionable Insights, LLC • Stanford Health Care Tri-Valley FY 2023–2025 IS Report

---

effects of legal representation on tenant outcomes in housing court: Evidence from New York City's Universal Access Program (No. w29836). *National Bureau of Economic Research*. Retrieved from [https://www.nber.org/system/files/working\\_papers/w29836/w29836.pdf](https://www.nber.org/system/files/working_papers/w29836/w29836.pdf)

<sup>23</sup> Rog, D. J. (2004). The evidence on supported housing. *Psychiatric Rehabilitation Journal*, 27(4), 334.

<sup>24</sup> McHugo, G.J., Bebout, R.R., Harris, M., Cleghorn, S., Herring, G., Xie, H., Becker, D. and Drake, R.E. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, 30(4), 969-982. Retrieved from [https://www.researchgate.net/profile/Gregory-Mchugo/publication/7786047\\_A\\_Randomized\\_Controlled\\_Trial\\_of\\_Integrated\\_Versus\\_Parallel\\_Housing\\_Services\\_for\\_Homeless\\_Adults\\_With\\_Severe\\_Mental\\_Illness/links/004635190e3121c6e9000000/A-Randomized-Controlled-Trial-of-Integrated-Versus-Parallel-Housing-Services-for-Homeless-Adults-With-Severe-Mental-Illness.pdf](https://www.researchgate.net/profile/Gregory-Mchugo/publication/7786047_A_Randomized_Controlled_Trial_of_Integrated_Versus_Parallel_Housing_Services_for_Homeless_Adults_With_Severe_Mental_Illness/links/004635190e3121c6e9000000/A-Randomized-Controlled-Trial-of-Integrated-Versus-Parallel-Housing-Services-for-Homeless-Adults-With-Severe-Mental-Illness.pdf)

<sup>25</sup> Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A.H., Arya, N., & Hannigan, T. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PloS One*, 15(4), p.e0230896. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0230896>

<sup>26</sup> 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." U.S. Department of Health and Human Services. (2019). Strategic goal 1: Reform, strengthen, and modernize the nation's healthcare system. Retrieved from [http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj\\_a](http://www.hhs.gov/about/strategic-plan/strategic-goal-1/#obj_a)

<sup>27</sup> Health fairs and similar community events must include follow-up: Williams, M. (2012). Follow-up resources are key to health fairs' success. *American Medical News*, [amednews.com](https://amednews.com/article/20120312/profession/303129958/5/). Retrieved from <https://amednews.com/article/20120312/profession/303129958/5/>

<sup>28</sup> Access to influenza vaccine increases uptake of vaccination: Alessandrini, V., Anselem, O., Girault, A., Mandelbrot, L., Luton, D., Launay, O., & Goffinet, F. (2019). Does the availability of influenza vaccine at prenatal care visits and of immediate vaccination improve vaccination coverage of pregnant women? *PloS one*, 14(8), e0220705. Retrieved from <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0220705>

<sup>29</sup> Withers, J. (2011). Street medicine: an example of reality-based health care. *Journal of Health Care for the Poor and Underserved*, 22(1), 1-4. Retrieved from [http://www.clinicians.com/images/upload/01\\_HPU22.1ACU.pdf](http://www.clinicians.com/images/upload/01_HPU22.1ACU.pdf)

<sup>30</sup> Community Preventive Services Task Force. (2015). Interventions to improve access to primary care for people who are homeless: A systematic review. *The Community Guide*. Retrieved from [www.ncbi.nlm.nih.gov/pmc/articles/PMC4832090/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4832090/)

<sup>31</sup> 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. *Health Home Information Resources Center*. Retrieved from [https://www.chcs.org/media/HH\\_IRC\\_Collaborative\\_Care\\_Model\\_052113\\_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf)

<sup>32</sup> Richards, D. A., Hill, J. J., Gask, L., Lovell, K., Chew-Graham, C., Bower, P., Cape, J., Pilling, S., Araya, R., Kessler, D., Bland, J. M., Green, C., Gilbody, S., Lewis, G., Manning, C., Hughes-Morley, A., & Barkham, B. (2013). Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*, 2013(347):f4913.

<sup>33</sup> Wodchis, W. P., Dixon, A., Anderson, G. M., & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care*, 15(6). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628509/>

- 
- <sup>34</sup> Community Preventive Services Task Force. (2019). Mental health and mental illness: Collaborative care for the management of depressive disorders. *The Community Guide*. Retrieved from <https://www.thecommunityguide.org/findings/mental-health-and-mental-illness-collaborative-care-management-depressive-disorders>
- <sup>35</sup> Health and Medicine Division of the National Academies of Sciences, Engineering, Medicine. (2011). *Report brief: Improving access to oral health care for vulnerable and underserved populations*. Retrieved from: <http://www.nationalacademies.org/hmd/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations/Report-Brief.aspx>
- <sup>36</sup> Centers for Disease Control and Prevention. (2011). *School Health Guidelines to Promote Healthy Eating and Physical Activity*. MMWR 2011; 60 (No. RR-5):1-76. Retrieved from [www.cdc.gov/mmwr/pdf/rr/rr6005.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6005.pdf)
- <sup>37</sup> The Community Guide. (2019). *Obesity: Meal or Fruit and Vegetable Snack Interventions to Increase Healthier Foods and Beverages Provided by Schools*. Retrieved from <https://www.thecommunityguide.org/findings/obesity-meal-fruit-vegetable-snack-interventions-increase-healthier-foods-beverages-schools>
- <sup>38</sup> The Community Guide. (2019). *Obesity: Multicomponent Interventions to Increase Availability of Healthier Foods and Beverages in Schools*. Retrieved from <https://www.thecommunityguide.org/findings/obesity-multicomponent-interventions-increase-availability-healthier-foods-and-beverages>
- <sup>39</sup> Community Preventive Services Task Force. (2017). Diabetes management: Interventions engaging community health workers. *The Community Guide*. Retrieved from [thecommunityguide.org/findings/diabetes-management-interventions-engaging-community-health-workers](https://www.thecommunityguide.org/findings/diabetes-management-interventions-engaging-community-health-workers)
- <sup>40</sup> Brownstein, J. N., Chowdhury, F. M., Norris, S. L., Horsley, T., Jack Jr, L., Zhang, X., & Satterfield, D. (2007). Effectiveness of community health workers in the care of people with hypertension. *American Journal of Preventive Medicine*, 32(5), 435-447. See also: Khetan, A. K., Purushothaman, R., Chami, T., Hejjaji, V., Mohan, S. K. M., Josephson, R. A., & Webel, A. R. (2017). The effectiveness of community health workers for CVD prevention in LMIC. *Global Heart*, 12(3), 233-243.
- <sup>41</sup> Centers for Disease Control and Prevention. (2011). *Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*. Atlanta: U.S. Department of Health and Human Services. Retrieved from [www.cdc.gov/obesity/downloads/FandV\\_2011\\_WEB\\_TAG508.pdf](http://www.cdc.gov/obesity/downloads/FandV_2011_WEB_TAG508.pdf)
- <sup>42</sup> Hartman, M. A., Hosper, K., & Stronks, K. (2011). Targeting physical activity and nutrition interventions towards mothers with young children: a review on components that contribute to attendance and effectiveness. *Public health nutrition*, 14(8), 1364-1381. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK91967/>
- <sup>43</sup> Cunningham-Sabo, L., Lohse, B., Smith, S., Browning, R., Strutz, E., Nigg, C., Balgopal, M., Kelly, K., & Ruder, E. (2016). Fuel for fun: a cluster-randomized controlled study of cooking skills, eating behaviors, and physical activity of 4th graders and their families. *BMC Public Health* 16(444). Retrieved from <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-016-3118-6>
- <sup>44</sup> Van der Bij, A. K., Laurant, M. G., & Wensing, M. (2002). Effectiveness of physical activity interventions for older adults: A review. *American Journal of Preventive Medicine*, 22(2), 120-133.