Scottsdale Healthcare
2013 Community Health Needs Assessment
Implementation Plan
Thompson Peak Hospital

SCOTTSDALE HEALTHCARE®

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Scottsdale Healthcare
Community Health Needs Assessment Implementation Plan 2013-2016
Executive Summary

The Scottsdale Healthcare (SHC) 2013 -2016 Community Health Needs Assessment Implementation Plan (CHNAIP) addresses priorities identified in the 2012 Community Health Needs Assessment (CHNA) and responds to other previously identified community health needs that will improve the health and well-being of our community. As required by federal law, individual CHNAs and CHNAIPs have been developed for each of the four SHC licensed hospitals: Osborn Medical Center, Greenbaum Surgical Specialty Hospital, Shea Medical Center and Thompson Peak Hospital. The CHNAIPs will be submitted with the SHC Form 990s in August 2014, following SHC Board approval in 2013.

SHC Community Health Services led the development of the 2012 CHNA and the SHC organization-wide CHNAIPs. A project Steering Committee was formed with representation across SHC. Consistent with best practice, input also was provided by an external Community Stewardship Advisory Council.

The first step in the development of the CHNAIP was to inventory the programs and services SHC organization-wide that impact the five focus areas identified in the 2012 CHNA: 1) Cardiovascular Disease 2) Heart Failure 3) Diabetes 4) Obesity and 5) Cancer. The inventory was based on a Continuum of Care framework:

Prevention → **Early Screening/ Diagnosis** → **Disease State Management** → **Acute Care** → **Post-Acute Care** → **Palliative Care**

Next, we evaluated if the inventory of programs and services for each of the five Focus Areas met the needs of the highest Priority Group and other identified key segments. This segmentation approach was designed to ensure that we maximize SHC and community resources by addressing the population segments with the greatest need and/or opportunity, especially in the areas of prevention and early screening/diagnosis.

We need to ensure that the programs and services meet the needs of each segment in two ways. First, we assessed the Continuum of Care coverage. Programs and services across the Continuum of Care must be relevant and accessible to the highest Priority Group and other key segments, sufficiently covering the Continuum of Care for each Focus Area. Second, based on the size of each segment, the relevant and accessible programs and services must have enough capacity to make a significant impact.

On an ongoing basis, SHC will reallocate resources or identify additional resources in the community to address gaps in the Continuum of Care coverage and/or capacity constraints. Internally, we will monitor program effectiveness through a combination of process and outcome measures against baseline data presented in the CHNA.

Scottsdale Healthcare Thompson Peak Hospital
Community Health Needs Assessment Implementation Plan 2013-2016

Background

Scottsdale Healthcare is a nonprofit, community-based health system and Scottsdale's largest employer. Founded in 1962, it is now one of the largest health systems in Arizona with 834 licensed beds, serving 275,000 total patients annually. The vision of Scottsdale Healthcare is setting the standard for excellence in personalized healthcare. Our values include integrity, caring, accountability, respect and excellence. The non-profit community-based mission is to provide the highest quality and most compassionate care for all individuals.

Scottsdale Healthcare Thompson Peak is a 64-bed hospital, committed to the health of the community they serve and one of four facilities in the Scottsdale Healthcare system, including Greenbaum Surgical Specialty Hospital, Osborn Medical Center and Shea Medical Center.

Our 2013 Community Implementation Plan outlines our community focused programs and services and summarizes the plans for Scottsdale Healthcare Thompson Peak to sustain and develop new community benefit programs that 1) address prioritized needs from the 2012 Community Health Needs Assessment (CHNA) and 2) respond to other identified community health needs to improve the health and well-being of our community.

How the Implementation Strategy was Developed

The Thompson Peak CHNAIP was developed based on the findings from the CHNA and review of Scottsdale Healthcare's current community benefit activities and services.

The Community Health Services (CHS) Department provided leadership for the 2012 CHNA through the SHC CHNA Steering Committee (Appendix 1). The Steering Committee responded to each of the priority needs and developed and monitored action plans and goals for each need. Additionally, a Community Stewardship Advisory Council (Appendix 2), including representatives from agencies and organizations providing services and programs in the community, had been formed in 2008 to guide community benefit activities at Scottsdale Healthcare

Focus Areas were reviewed and approved by both the Advisory Council and the Steering Committee.

Major Needs and How Priorities Were Established

Focus Areas

Using Focus Areas selection criteria (Appendix 3) as a guide, the SHC CHNA Steering Committee established the priority community needs for Scottsdale Healthcare Thompson Peak Medical Center. Focus Areas were identified:

1) Cardiovascular Disease
2) Heart Failure
3) Diabetes
4) Obesity
5) Cancer

Description of What Scottsdale Healthcare Thompson Peak Will Do To Address Community Health Needs

Priority Groups and Key Population Segments

With the five Focus Areas identified, the next steps were to determine the highest Priority Groups and other key population segments. This segmentation approach was designed to ensure that we maximize SHC and community resources by addressing population segments with the greatest need and/or opportunity.

Priority Groups were identified for each disease state, utilizing primary and secondary data sources, and zip codes within the service area. For most Focus Areas, residents age 65 and over living in selected zip code areas and making less than $40,000/year were identified as the most in need.

To identify additional key segments of the population that would warrant a more targeted focus in our Implementation Plan, program managers, service line leaders and clinicians within Scottsdale Healthcare were queried. Through an examination of population data as well as the clinical expertise of this team, key population segments were delineated. Priority Groups and key population segments for each Focus Area can be found in Appendix 4.

Continuum of Care Coverage

The SHC CHNA Steering Committee developed a Continuum of Care framework to assess current SHC programs and services. The Steering Committee involved the service line directors, physicians and other key leaders that aligned with the five Focus Areas. Using information

obtained through departmental surveys and face-to-face interviews, programs were inventoried for each of the five Focus Areas.

The Continuum of Care aligns closely with widely used preventive medicine strategies. Prevention, screening and disease management involve the three levels of prevention- primary, secondary and tertiary. Primary prevention attempts to prevent the disease (such as counseling or immunizations). Secondary prevention involves screening and early detection (such as PAP smears and mammograms). Tertiary prevention involves managing the disease to prevent further complications.

The Continuum of Care begins with an emphasis on prevention and early screening/diagnosis:

Prevention → **Early Screening/ Diagnosis** → **Disease State Management** → **Acute Care** → **Post-Acute Care** → **Palliative Care**

Early screening is a strategy used to identify an unrecognized disease in individuals without signs or symptoms. This can include individuals with pre-symptomatic or unrecognized symptomatic disease. As such, screening tests are somewhat unique in that they are performed on persons apparently in good health. Screening interventions are designed to identify disease in a community early, thus enabling earlier intervention and management in the hope to reduce mortality and suffering from a disease.

For each Focus Area, a Program/Service Inventory (Appendix 5) captured programs and services currently offered by Scottsdale Healthcare or through various community partners.

For all five Focus Areas across the Continuum of Care, strategic partnerships were identified which assist Scottsdale Healthcare Thompson Peak in meeting the healthcare needs of the community. (Appendix 6). As we move forward, Scottsdale Healthcare will expand programs which meet the identified needs and establish new partnerships in the community.

The Programs/Services Inventory was evaluated for each of the five Focus Areas to determine if they covered the needs of the highest Priority Group and other identified key population segments. Use of this framework assisted Scottsdale Healthcare to identify current programs that are relevant and accessible. Where relevant and accessible programs were not available, it was determined that a gap existed.

Capacity Analysis

Based on the size of each segment, the relevant and accessible programs and services must have enough capacity to make a significant impact over a three-year period. Where programs and services were determined to have enough capacity to reach the key population segments, they

were deemed to be sufficient. Where programs and services did not have the capacity or meet the population needs, services were identified as lacking in scale.

Where relevant and accessible programs/services existed, but were not currently being targeted to the identified population segment, they were identified as needing a broader range of targeted communication efforts.

Programs will be assessed on an ongoing basis to ensure that capacity needs are being met for all population segments across the Continuum of Care. In addition, this will allow the SHC Steering Committee to identify opportunities for program expansion and partnerships.

Introduction to the Focus Area Matrices

An analysis of Continuum of Care and capacity determined that for most High Priority groups, programs and services were sufficient. For most larger-size population segments, scale (capacity) was lacking.

With a focus on prevention and screening/diagnosis, an analysis of programs/services was conducted for each population segment across the Continuum of Care:

1. Sufficient: We believe that the programs/services have enough scale based on the estimated population segment size to make a significant impact on the health of our community over a three year time horizon.
2. Gap: There are currently no relevant and accessible programs/services in place to meet the needs of the identified population segment.
3. Scale: Programs/services currently exist for this population segment, however there is likely currently not enough scale (capacity) to make a significant impact.
4. Communication: There are relevant and accessible programs/services but they are not currently being targeted to the population segment.
5. N/A: Programs/services are not applicable to this key population segment.

Please review the following matrices for a detailed view by Focus Area:

1. Cardiovascular Disease Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: Age 65+ • TPK ZIP: 85022,85027 • And Income <$40 k per year	slightly less than 3,500	Sufficient	Sufficient	Sufficient	Sufficient	Sufficient	Sufficient
Hypertension: untreated and uncontrolled population age 40-64	slightly less than 47,000	Scale	Scale	N/A	Scale	Scale	N/A
Overweight and physical inactivity: address age group 30-64	slightly more than 43,000	Scale	Scale	N/A	N/A	N/A	N/A
Smoking: prevention for middle school to age 21	5,000	Scale	N/A	N/A	N/A	N/A	N/A
Smoking: cessation for adults	32,000	Scale	N/A	N/A	N/A	N/A	N/A

Cardiovascular Disease Key Learnings:

• Programs/services across the Continuum of Care are sufficient for the High Priority groups with the exception of the need for increased capacity High Priority group of Cardiovascular Disease.

• For all other population segments, there is a need to increase capacity of programs/services.

2. Heart Failure Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: Age 65+ • TPK ZIP: 85022, 85262,85054 • And Income <$40 k per year	slightly less than 2,500	Sufficient	Scale	Sufficient	Sufficient	Sufficient	Sufficient
Hypertension: untreated and uncontrolled population age 40-64	slightly less than 47,000	Scale	Scale	Scale	Sufficient	Scale	N/A
Overweight and physical inactivity: address age group 30-64	slightly more than 43,000	Scale	Scale	N/A	N/A	N/A	N/A
Smoking: prevention for middle school to age 21	5,000	Scale	N/A	N/A	N/A	N/A	N/A
Smoking: cessation for adults	32,000	Scale	N/A	N/A	N/A	N/A	N/A

Heart Failure Key Learnings:

• Heart Failure is a type of a Cardiovascular Disease. Progression of Heart Failure can be minimized with treatment. A risk factor of Heart Failure is hypertension. Increasing program capacity in prevention, screening, disease management, and post-acute care is needed.

• Prevention and screening/diagnosis programs are available for identified population segments that are overweight; however, there is a need to increase the capacity. Smoking prevention for middle school to age 21 and smoking cessation for adults exist in the community; however, increase in capacity of the programs is needed.

• SHC will expand partnership with agencies to add scale of programs/services in prevention and screening for the population segment that is overweight and physical inactivity age 30-64 and hypertension untreated and uncontrolled age 40-64.

3. **Diabetes Matrix**

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Age 65+ (TPK: also 55-64) • TPK: 85022, 85027 • And Income <$40 k per year	slightly less than 3,500	Sufficient	Sufficient	Sufficient	Sufficient	Sufficient	N/A
Undiagnosed Type 2 school age children and their parents	less than 81,000	Scale	Scale	N/A	N/A	N/A	N/A
Undiagnosed Type 2 young adults (who just turned 18 and living independently)	26,000	Scale	Scale	N/A	N/A	N/A	N/A
Diabetic Type 1 & 2: young adults (who just turned 18 and living independently)	3,000	Communication	N/A	Communication	Sufficient	Scale	N/A
Diabetics Type 1 and 2: age 30+	slightly more than 20,000	Scale	N/A	Scale	Sufficient	Scale	N/A
First time mothers (pre-conception)	less than 62,000*	Scale	Scale	N/A	N/A	N/A	N/A
Pregnant women	less than 62,000*	Scale	Scale	N/A	N/A	N/A	N/A

*'Women of child bearing age' statistic was used in lieu of 'first time mothers' and 'pregnant women' statistic.

Diabetes Key Learnings:

• For the High Priority group, we need to add scale to our current Disease Management programs/services.

• For Type 1 and 2 diabetics who just turned 18 and living independently, improved communication efforts need to be made to target this population on importance of nutrition, physical activity, medication and AIC level.

• For all other population segments, there is a greater need to increase scale for the current programs/services.

• Having the opportunity to partner with Scottsdale Health Partners will allow for growth of the needed programs/services. Additionally, the Neighborhood Outreach Access to Health (NOAH) Centers will continue to provide access to care.

4. **Obesity Matrix**

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Former Smokers; Eat Fast Food At Least Once in a Week; Do Not Exercise • TPK ZIP: 85022, 85027 • And Income <$40 k per year	slightly less than 600	Sufficient	Sufficient	N/A	N/A	N/A	N/A
Children (boys and girls)	less than 81,000	Scale	Scale	N/A	N/A	N/A	N/A
First time mothers (pre-conception)	less than 62,000*	Communication	Communication	N/A	N/A	N/A	N/A
Pregnant women	less than 62,000*	Scale	Scale	N/A	N/A	N/A	N/A
Women perimenopause	39,000	Communication	Communication	N/A	N/A	N/A	N/A
Men age 30+	slightly more than 88,000	Communication	Communication	N/A	N/A	N/A	N/A
Seniors men and women age 65+	36,000	Scale	Scale	N/A	N/A	N/A	N/A

Obesity Key Learnings:

• Educational and screening programs to address obesity are sufficient for the High Priority groups.

• There is a greater need to increase capacity of obesity prevention and screening programs for children, pregnant women, and seniors age 65+.

• Improving communication about programs/services targeted towards first time mothers (pre-conception), women perimenopause, and men age 30+ will be addressed through partnerships, awareness campaigns, and online education.

5. Cancer

Continuum of Care coverage: The Virginia G. Piper Cancer Center at Scottsdale Healthcare ensures that our community has access to comprehensive cancer care which includes cancer-related information, education and support and ongoing monitoring and improvement of care. This coordinated delivery of care is provided with collaborators such as the Arizona Cancer Center, Arizona State University and the University of Arizona. Through the Cancer Center and Community Health Services, disease specific education, tobacco prevention and cessation classes and community outreach programming provide ongoing cancer prevention initiatives; however, deficiencies do exist for various programs/services. These communication and capacity issues will be addressed according to cancer site.

Lung Cancer Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Income <$40 k per year • TPK ZIP: 85022, 85027 ▪ Age 65+	slightly less than 5,000	Sufficient	N/A	Sufficient	Sufficient	Sufficient	Sufficient
Smoking: prevention, middle school to age 21	4,000	Sufficient	N/A	N/A	N/A	N/A	N/A
Smoking: Cessation for adults	26,000	Scale	N/A	N/A	N/A	N/A	N/A
Smoking: secondary exposure, children and adults	no data	Scale	N/A	N/A	N/A	N/A	N/A

Lung Cancer Key Learnings:

• Programs/services across the Continuum of Care are sufficient for the High Priority Groups are sufficient.

• Programs addressing adult smoking cessation and secondary exposure risk for children and adults need greater capacity. The Maricopa County Health Department has identified lung cancer as a need to address. Scottsdale Healthcare will partner with the Maricopa County Health Department to increase awareness of additional programs focused on lung cancer prevention.

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Breast Cancer Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Income <$40 k per year • TPK ZIP: 85022, 85027 • Age 55+	slightly less than 8,000	Sufficient	Scale	Sufficient	Sufficient	Sufficient	Sufficient
Family history, all ages, first degree relatives	no data	N/A	Communication	N/A	N/A	N/A	N/A
Benign breast condition all ages	no data	N/A	Communication	N/A	N/A	N/A	N/A
Women who had more menstrual cycles	no data	Communication	Communication	N/A	N/A	N/A	N/A
Women using oral contraceptives	no data	Communication	Communication	N/A	N/A	N/A	N/A
Women post-menopausal	slightly more than 39,000	Communication	Communication	N/A	N/A	N/A	N/A
Women with excessive alcohol consumption	4,000	Communication	Communication	N/A	N/A	N/A	N/A
Women age 50-69 (mammogram, education)	slightly more than 39,000	Scale	Scale	N/A	N/A	N/A	N/A

Breast Cancer Key Learnings:

• Programs/services across the Continuum of Care for the High Priority groups are sufficient with the exclusion of screening/diagnosis, where a need to increase scale exist.

• Women of all ages need improved communication about prevention efforts relative to risk factors for breast cancer such as age of menarche, use of excessive alcohol/oral contraceptives and menopause. Greater capacity is needed in prevention/screening series for women age 50-69.

• Through partnerships with community organizations, SHC will look at expanding screening/diagnostic services to those with lower incomes and women age 50-69.

Skin Cancer (Melanoma) Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Income <$40 k per year • TPK ZIP: 85022, 85027 • Caucasian	slightly less than 26,000	Scale	Scale	Sufficient	Sufficient	Sufficient	N/A
Tanning booths users	no data	Communication	Communication	N/A	N/A	N/A	N/A
Fair skin, freckling, light hair	no data	Communication	Communication	N/A	N/A	N/A	N/A
Have moles	no data	Communication	Communication	N/A	N/A	N/A	N/A
Caucasian parents	110,000	Communication	Communication	N/A	N/A	N/A	N/A
Caucasian preteens and teens	10,000	Communication	Communication	N/A	N/A	N/A	N/A
Caucasian young adults	20,000	Communication	Communication	N/A	N/A	N/A	N/A

Skin Cancer (Melanoma) Key Learnings:

• There is a need to increase scale for skin cancer prevention and screening/diagnosis for High Priority groups.

• There is opportunity for better communication about prevention and screening for all the other population segments.

• Additional partnerships, Primary Care Providers, and awareness campaigns are ways to increase scale of needed programs/services and communication for the population segments.

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Colorectal Cancer Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Income <$40 k per year • TPK ZIP: 85022, 85027 • Age 50+	slightly less than 8,000	Scale	Gap	Scale	Sufficient	Scale	Sufficient
Personal history (IBD, polyps, cancer)	no data	N/A	Communication	N/A	N/A	N/A	N/A
Inherited gene defects, all ages*	no data	N/A	Communication	N/A	N/A	N/A	N/A
Adults age 50-74	78,000	Scale	Scale	Scale	Scale	Scale	Scale
Family history, all ages, first degree relatives	no data	N/A	Communication	N/A	N/A	N/A	N/A

Colorectal Cancer Key Learnings:

• Current efforts for High Priority groups are in need of increased scale for prevention, disease management and post-acute care programs/services. Historically there has been a gap in screening for those with lower incomes. With health care reform, we anticipate changes that will result in closure of this gap.

• Communication about risk assessment screenings for those with a personal history (IBD, polyps, cancer), inherited gene defects, and family history is an identified need. To meet this need, additional efforts for online education and campaigns will be reviewed.

• There is a need to increase scale for prevention, disease management, and post-acute care for the High Priority group and across the Continuum of Care for adults age 50-74. Additional partnerships and expanded educational services will be addressed.

*Genetic screening, while an identified need for those with a personal/family history or inherited gene defect, and a service currently available through the Virginia G. Piper Cancer Center, will not be further addressed at this time due to the allocation of resources that would be required. Resources will be directed to prevention and screening initiatives aimed at reaching a wider audience with a greater potential for risk reduction and behavior change.

Prostate Cancer Matrix

Key Population Segments	Estimate of Group Size	Prevention	Screening/ Diagnosis	Disease Management	Acute Care	Post-Acute Care	Palliative Care
High Priority: • Income <$40 k per year • TPK ZIP: 85022, 85027 • Men age 50+	slightly less than 4,000	Sufficient	Scale	Sufficient	Sufficient	Sufficient	Sufficient
African Americans, all ages (make up about 2% of SHC population)	6,500	Communication	Communication	Sufficient	N/A	N/A	N/A
Family history, all ages, first degree relatives	no data	N/A	Communication	N/A	N/A	N/A	N/A
Smoking: Prevention for middle school to age 21	5,000	Scale	Scale	N/A	N/A	N/A	N/A
Smoking: Cessation for adults	32,000	Scale	Scale	N/A	N/A	N/A	N/A

Prostate Cancer Key Learnings:

• The High Priority is identified as groups for which prevention programs are sufficient. There is need to increase scale to our current screening programs.

• Smoking prevention for middle school to age 21 and smoking cessation programs for adults are population segments identified as needing increase of scale for prevention and screening/diagnosis programs.

• For remaining population segments, targeted communication efforts need to be directed toward African Americans and those with a family history on the importance of screening/diagnosis for prostate cancer.

• Partnership with Scottsdale Healthcare Medical Group will provide additional Primary Care Providers. Additional partnerships that offer smoking prevention and cessation programs are needed for the community.

Other Initiatives and Programs

During the program assessment process, initiatives and programs were identified which do not fall within the five Focus Areas, yet are programs which will be continued as they serve the greater needs of the community. These are identified in Appendix 5, Other Initiatives and Programs tab. The CHNA Steering Committee, nonetheless, acknowledges the importance of those other needs and plans to collaborate with community partners to address them. Programs such as childhood and adult immunizations, flu vaccinations, well-child visits, dental care, behavioral health services and assisting children with disabilities will be sustained throughout the system toward the betterment of the community's health and well-being.

Resource Management

On an ongoing basis, SHC will reallocate resources or identify additional resources in the community to address gaps in the Continuum of Care coverage and/or capacity constraints.

Appendix 1

CHNA Steering Committee

Wendy Armendariz Executive Director Neighborhood Outreach Access to Health (NOAH)	**Marialena Murphy** Clinical Director, Perioperative Services Scottsdale Healthcare
Gary Baker Executive Vice President, Healthcare Operations Scottsdale Healthcare	**Chris O'Mara, MSN, RN** Supervisor, Community Health Services Scottsdale Healthcare
David Barber Vice President, Marketing Scottsdale Healthcare	**Michelle Pabis** Executive Director, Gov. & Public Affairs Scottsdale Healthcare
Marvin Bell, M.D., MPH Associate Director, Family Practice Scottsdale Healthcare	**Kimberly Post, DNP, MBA/HCM, RN, NEA-BC** Vice President, Administration Thompson Peak Hospital
James Burke, M.D., M.B.A. Senior Vice President, Chief Physician Executive Scottsdale Healthcare	**Bobbi Presser, MPH** Executive Director, Clinical Integration Scottsdale Healthcare
Evonda Copeland, MLIS Supervisor, Library Services & HealthConnect Scottsdale Healthcare	**Peggy Reiley, RN, Ed.D.** Executive Director, Clinical Integration Scottsdale Healthcare
Jess DeJesus, Pharm. D., MBA/HCM Associate Vice President, Department of Pharmacy Scottsdale Healthcare	**Irving M. Rollingher, M.D.** Chief Medical Information Officer Scottsdale Healthcare
Karen Ford, RN, MSN Director, Case Management Scottsdale Healthcare	**Lisa Sandoval, MPH** Director, Marketing Scottsdale Healthcare
Pauline Hrenchir, BS, MSN, MSL, RNC, RNFA Clinical Director, Women's Services Scottsdale Healthcare	**Tracey Schalscha, MPH** Consultant Scottsdale Healthcare
Mary Kopp, RN, BSN, MS Associate Vice President, Administration Scottsdale Healthcare Shea	**Richard Silver, M.D.** Vice President, Chief Medical Officer Scottsdale Healthcare
Renae Larcus, Ph.D. Manager, Community Health Services Scottsdale Healthcare	**Brian Steines, CPA** Vice President of Finance Scottsdale Healthcare
Diane Legum, MHA Director, Ambulatory Services Scottsdale Healthcare	**James Stelzer** Executive Director Scottsdale Health Partners
Jim Marshall Director, Human Resources Scottsdale Healthcare	**Dean Thomas, MBA, MHSA** Vice President, Clinical Services Scottsdale Healthcare
Barbara Martindale, MS-NL, RN Project Manager, Community Health Services Scottsdale Healthcare	**Lindsay Thomas, RN, MSN, OCN** Director, Cancer Center Scottsdale Healthcare
Peggy Morehouse, RN, BSN, MSL Director, Clinical Nursing Services Scottsdale Healthcare	

Appendix 2

Community Stewardship Advisory Council

Wendy Armendariz Executive Director Neighborhood Outreach Access to Health (NOAH)	**Milissa Sackos** Executive Director Student and Community Services Scottsdale Unified School District (SUSD)
David Barber Vice President, Marketing Scottsdale Healthcare	**Tracey Schalscha, MPH** Consultant Scottsdale Healthcare
Marvin Bell, M.D., MPH Associate Director, Family Medicine Scottsdale Healthcare	**Brian Steines, CPA** Vice President, Finance Scottsdale Healthcare
James Bertz, DDS, M.D. Oral/Maxillofacial Surgery	**Brent Stockwell** Director, Strategic Initiatives City of Scottsdale
Tim Bray President Southwest Community Resources	**Trisha Stuart** President, Giving Solutions
Evonda Copeland, MLIS Supervisor, Library Services & HealthConnect Scottsdale Healthcare	**Toby Urvater, M.S.W.** Administrator, Community Health Action Maricopa County Health Dept. of Public Health
Jan Gehler, Ed.D. President Scottsdale Community College	
Laura Grafman Executive Vice President Scottsdale Healthcare Foundation	
Bruce Johnson Pastor Scottsdale Presbyterian Church	
Virginia Korte, Chair City Council Member, City of Scottsdale President/CEO-STARS Scottsdale Training & Rehabilitation Services	
Christine Kovach Community Activist McDowell Sonoran Conservancy	
Renae Larcus, Ph.D. Manager, Community Health Services Scottsdale Healthcare	
Barbara Martindale, MS-NL, RN Project Manager, Community Health Services Scottsdale Healthcare	
Michelle Pabis Director, Government Relations Scottsdale Healthcare	

Appendix 3

FOCUS AREA SELECTION CRITERIA

- Magnitude: number of people impacted
- Severity: risk of morbidity/mortality associated with the problem
- Historical trends
- Alignment of the problem with the organization's strengths and priorities
- Impact of the problem on vulnerable populations
- Importance of the problem to a community
- Existing resources addressing the problem
- Relationship of the problem to other community issues
- Feasibility of change, availability of tested approaches
- Value of immediate intervention vs. any delay, especially for long term or complex threats

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Appendix 4

High Priority Groups & Key Population Segments

Area of Focus	High Priority Group	Key Population Segments

Cardiovascular	• Age 65+
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 85022, 85027
	• And Income <$40 k per year
		1. Hypertension: address untreated and uncontrolled population age 40-64
		2. Overweight and physical inactivity: address age group 30-64
		3. Smoking: address prevention for junior high to age 21
		4. Smoking: address cessation for adults

Heart Failure	• Age 65+
	• ZIP
	  ○ Osborn: 85256, 85257, 85251
	  ○ Shea: 85258, 85263, 85268
	  ○ TPK: 85022, 85054, 85262
	• And Income <$40 k per year
		Same as CVD

Diabetes	• Age 65+ (Osborn: also 55-64)
	  ○ Osborn: 85256, 85257
	  ○ Shea: 85032, 85264
	  ○ TPK: 85022, 85027
	• And Income <$40 k per year
		1. Prediabetic Type 2: focus on nutrition and physical activity for school age children and their parents
		2. Prediabetic Type 2: focus on nutrition and physical activity for young adults (who just turned 18 and living independently)
		3. Diabetic Type 1 & 2: focus on nutrition, physical activity, medication, and A1C level for young adults (who just turned 18 and living independently)
		4. Diabetics Type 1 and 2: education on nutrition, physical activity, A1C, medication, and blood pressure level for age 30+
		5. First time mothers (pre-conception): focus on importance nutrition and physical activity on disease prevention
		6. Pregnant women: focus on importance nutrition and physical activity on disease prevention

Obesity	• Former Smokers; Eat Fast Food At Least Once in a Week; Do Not Exercise
	• ZIP
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 85022, 85027
	• And Income <$40 k per year
		Nutrition and Physical Activity:
		1. Children (boys and girls)
		2. First time mothers (pre-conception
		3. Pregnant women
		4. Women perimenopause
		5. Men age 30+
		6. Seniors men and women age 65+

Lung Cancer	• Income <$40 k per year
	• ZIP
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 85022, 85027
		1. Smoking: address prevention for junior high to age 21
		2. Smoking: Cessation for adults
		3. Smoking: Risk of secondary exposure for children and adults

Breast Cancer	• Income <$40 k per year
	• ZIP
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 8022, 85027
		1. Family history, all ages, first degree relatives
		2. Benign breast condition all ages
		3. Women who had more menstrual cycles
		4. Women using oral contraceptives
		5. Women post-menopausal
		6. Women with excessive alcohol consumption
		7. Women age 50-69 (mammogram, education)

Melanoma Skin Cancer	• Income <$40 k per year
	• ZIP
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 85022, 85027
		1. Tanning booths users
		2. Fair skin, freckling, light hair
		3. Have moles
		4. Caucasian parents
		5. Caucasian preteens and teens
		6. Caucasian young adults
		7. Caucasian other?

Colorectal Cancer	• Income <$40 k per year
	• ZIP
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 85022, 85027
		1. Personal history (IBD, polyps, cancer)
		2. Inherited gene defects, all ages
		3. Adults age 50-74
		4. Family history, all ages, first degree relatives

Prostate	• Income <$40 k per year
	• ZIP
	  ○ ZIP Osborn: 85256, 85257, 85281
	  ○ Shea: 85260, 85032
	  ○ TPK: 85022, 85027
		1. African Americans, all ages
		2. Family history, all ages, first degree relatives
		3. Smoking: Prevention for junior high to age 21
		4. Smoking: Cessation for adults

Appendix 5

Heart Failure Initiatives/ Program Care Continuum

Organizational	Prevention	Screening/Diagnosis	Disease State Management	Acute Treatment	Post-Acute	Palliative
Community Health	1. Tobacco Cessation-Adults 2. Walking club adults-TPK 3. Heart Math 4. Nibbles of Nutrition 5. Tobacco Prevention-Youth 6. CPR Heartsave, First Aid, AED Class 7. Fitness Seniors 8. Matter of Balance	1. CVD and Stroke Screening (includes BP, BMI checks) 2. Blood Pressure Checks 3. Cholesterol/Glucose Screenings	1. Heart Math 2. Chronic Disease Self- Management		N/A	N/A
NOAH Osborn and TPK	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Promotora	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease Management (in progress) 4. Behavioral Health Education 5. Nutrition Education and	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Family
Corporate Health	1. WellPath Program (Salt River Pima Rsv)	1. Cholesterol/Glucose Screenings	N/A	N/A	1. Occupational Health Clinic	N/A
Service Line	1. SHC Website Education-all areas 2. Heart and Vascular Community Lectures 3. Chest Pain Recognition-Activating 911 4. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 5. Essential Touch Workout Center (Shea) 6. The Heart of a Woman Forum (Shea)	1. Heart Rhythm Center (Shea & Osborn) 2. Heart Health Screening (Shea) 3. SHC Mobile Health Unit 4. Women's Wellness Program (Shea)	1. Cardiac Rehab Center (Shea) 2. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 3. The Heart of a Woman Forum (Shea) 4. Cardiac Rehab Support Group (Shea) 5. TeleHealth Case Management Monitoring 6. Cardiac Rehab Heart Healthy Education Classes (Shea)	1. Heart Rhythm Center (Shea & Osborn) 2. Structural Heart Program (Shea & Osborn) 3. SHC Inpatient Case Management Team 4. ADHS SHARE program for treatment of Cardiac Arrest 5. ICA Echo Accreditation 6. Chest Pain Accredited Center	1. Clinical Trial Research 2. Area Agency for Aging Region 1 3. ED 2 Home 5. Cardiac Rehab Fitness Center (Shea)	
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Community Outreach/Sponsorships/ Marketing						
Sponsorships - Community Benefit						
Community Partnerships/Alliances	1. Foothills Caring Corp 3. Foothills Community Foundation 4. School Districts 5. Senior Centers (COS) 6. Stonegate Community Center	1. Fountain Hills Screening Center 2. Senior Centers (COS) 3. School Districts 4. Stonegate Community Center	1. Nuture	1. Partnership Mayo Clinic Transplant/LVAD Support	1. Skilled Nursing Agencies 2. Rehab Agencies 3. Group Homes 4. Hospice	1. Hospice Coordination

SCOTTSDALE HEALTHCARE®

Cardiovascular Disease Initiatives/Program

Care Continuum

Organizational Area/Dept.	Prevention	Screening/Diagnosis	Disease State Management	Acute	Post-Acute Treatment	Palliative Care
Community Health	1. Tobacco Cessation-Adults 2. SHC Fitness (Osborn) 3. Nibbles of Nutrition 4. Tobacco Prevention-Youth 5. Walking Club Adults-TPK 6.Heart Math 7. Matter of Balance 8. Fitness Seniors 9. Early Childhood Programs 10.Silverstone-Corporate Retirement Center (TPK) 11. Zumba Dancing	1. CVD and Stroke Screening (includes BP, BMI checks) 2. Blood Pressure Checks 3. Cholesterol/Glucose Screenings	1. Chronic Disease Self-Management	N/A	N/A	N/A
NOAH Osborn and TPK	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Promotora	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease management (In progress) 4. Behavioral	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management
Corporate Health	1. Corporate Challenges 2. Lunch and Learn 3. CPR Heartsave, first Aid, AED Class	1. WellPath Program (Salt River Pima RSV) 2. Cholesterol/Glucose Screenings	N/A	N/A	1. Occupational Health Clinic	N/A
Service Line	1. SHC Website Education 2. Heart and Vascular Community Lectures 4. Body, Mind and Spirit exercise class (Shea, Osborn Yoga Only) 5. Essential Touch Workout Center (Shea) 6. The Heart of a Woman Forum (Shea)	1. Heart Health Screening (Shea) 2. Body Composition Screening (Shea) 3. Heart Health Bus Unit 4. Women's Wellness Program (Shea)	1. Heart of a Woman Forum (Shea) 2. Stroke Survivor and Caregiver Education and Support Group (Osborn) 3. Cardiac Rehab Center (Shea) 4. Body, Mind and Spirit Exercise Class (Shea except yoga is offered at Osborn)	1. Chest pain Accredited Center 2. ADHS Share program for treatment of Cardiac Arrest 3. Structural Heart program (Osborn and Shea) 4. SHC Inpatient Case Management Team 5. ICA Echo Accreditation	1. Clinical Trial Research 2. Area Agency for Aging Region 1 3. ED 2 Home 4. Care coordination Community Case Management 5. Cardiac Rehab Fitness Center (Shea)	N/A
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Community Outreach/Sponsorships/Marketing	1.AHA "Go Red for Women"" 2.H&V Civic/Municipality Participation and Education					
Sponsorships - Community Benefit			1.American Heart			
Community Partnerships/Alliances	1. Foothills Caring Corp 3. Foothills Community Foundation 4. School Districts 5. Senior Centers (COS) 6. Stonegate Community Center	1. Fountain Hills Screening Center 2. Senior Centers (COS) 3. School Districts 4. Stonegate Community Center	1. Nuture	1. Partnership Mayo Clinic Transplant/LVAD Support 2. Heart Health Bus Unit	1. Skilled Nursing Agencies 2. Rehab Agencies 3. Group Homes 4. Hospice	1. Hospice Coordination

SCOTTSDALE HEALTHCARE®

Diabetes Initiatives/Programs

Care Continuum

Organizational	Prevention	Screening/Diagnosis	Disease State Management	Acute	Post-Acute Treatment	Palliative
Community Health	1. SHC Fitness-Osborn (Osborn) 2. Walking club adults 3. Nibbles of Nutrition 4. Fitness Seniors 5. Nutrition Classes-children & Adults 6. Grand Canyon Trekkers-children 7. Silverstone-Corporate Retirement	1. CVD and Stroke Screening (includes BP and glucose checks) 2. BMI Screenings 3. Cholesterol/Glucose Screenings	1. Chronic Disease Self-Management	N/A	N/A	N/A
NOAH	1.Diabetes Center Certification Site (in progress) 2. Promotora 3. Access to care 4. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease Management (in progress) 4. Behavioral Health Education 5. Nutrition Education and Management 6. Dental Services 7. Podiatric exams,	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Diabetes Group Classes 2. Dental Services 3. Access to care 4. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Family Education
Corporate Health	1. Corporate Challenges 2. Lunch and Learn	1. Cholesterol/Glucose Screenings 2. WellPath Program (Salt	N/A	N/A	N/A	N/A
Service Line	1. Pre-Diabetes Class (Shea) 2. Gestation Diabetes Class (Shea) 3. Essential Touch Workout Center (Shea) 4. Early Childhood Programs	1. Body Composition Screening (Shea) 2. Heart Health Screening (Shea) 3. SHC Mobile Health Unit	1. Comprehensive Diabetes Classes (Shea) 2. The Heart of a Woman Forum (Shea) 3. Cardiac Rehab Center (Shea) 4. TeleHealth Case Management	1. SHC Inpatient Case Management Team	1. Diabetic Individual Counseling and Behavioral Management (Shea) 2. ED 2 Home	**N/A**
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care Coordination	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care Coordination	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online tracking	1. Wellness Screening	1. Disease Management			
Community Outreach/Sponsorships / Marketing						
Sponsorships - Community Benefit						
Community Partnerships/Alliances	1. Pine Towers Senior Center 2. Arizona Diabetes Coalition 3. ADA 4. JDRF 5. School Districts	1. School Districts 2. Senior Centers	1. ADA-Type 1 & 2 2. JDRF-Focus on Type 1			

SCOTTSDALE HEALTHCARE®

Cancer Initiatives/Programs

Care Continuum

Organizational Area/Dept.	Prevention	Screening/Diagnosis	Disease State Management	Acute	Post-Acute	Palliative
Community Health	1. Tobacco Cessation-Adults 2. Tobacco Prevention-Youth 3. Heart Math	1. Skin Screenings 2. BMI Screenings 3. Silverstone-Corporate Retirement Center	N/A	N/A	N/A	N/A
NOAH Osborn and TPK	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Promotora	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease Management (in progress) 4. Behavioral Health Education	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Family Education
Corporate Health	1. Tobacco Cessation-Adults 2. Tobacco Prevention-Youth	1. Skin Screenings	N/A	N/A	N/A	N/A
Service Line	1. Cooking/Nutrition Programs (Shea) 2. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 3. Disease Specific-Community Lectures at the Cancer Center (Shea) 4. Essential Touch Workout Center (Shea)	1. Cancer Screenings (Shea) 2. Body Composition Screening (Shea) 3. Cancer Genetic Screening 4. Lung screening	1. Radiation Oncology (Shea & Osborn) 2. Cancer Care Coordinator (Shea) 3. Body, Mind and Spirit exercise class (Shea, Osborn Yoga only) 4. Exercise Rehabilitation (Shea)	1.Surgical Oncology 2.Medical Oncology 3.Radiation Oncology (Shea & Osborn) 4. Bone Marrow Transplant Infusion (Shea)	1. Cooking/Nutrition (Shea) 2. Cancer Clinical Trials (Shea) 3. Out-Patient Infusion (Shea)	1. Cancer Care Coordinator (Shea) 2. Hospice of the Valley Grief Support Group.
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care Coordination	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease management) 4. Quality Care Coordination	1. Access to Care 2. Patient Centered Medical Home
Employee Wellness	1. Purewellness online	1. Wellness screenings	1. Disease Management			
Sponsorships - Marketing	1. Undy 5000 (Colon Ca) 2. Parada del Sol 3. Night for Life					
CommunityOutreach/ Sponsorship/Community/Benefit			Komen "Race for the Cure",			
Community Partnerships/Alliances	1. Academy of Dermatology 2. American Cancer Society 3. Ashline (Tobacco Cessation) 4. Bosom Buddies 5. Desert Cancer Foundation 6. Good Sheppard of the Hills Episcopal Church 7. Leukemia & Lymphoma Society 8. Lymphoma Research Foundation 9. Maricopa County Smokeless Tobacco Coalition 10. POP-prostate onsite project (prostate education and prevention) 11. School Districts	1. Academy of Dermatology 2. MOM-mammography 3. Colon Cancer Alliance 4. Community Dermatologist	1. Susan G. Komen			1. Hospice of The Valley

SCOTTSDALE HEALTHCARE®

Obesity Initiatives/Programs

Care Continuum

Organizational Area/Dept.	Prevention	Screening/Diagnosis	Disease State Management	Acute	Post-Acute	Palliative
Community Health	1. SHC Fitness (Osborn) 2. Nutrition Classes-Children 3. Fit Club 4. Walking Club Adults-TPK 5. Nibbles of Nutrition 6. Matter of Balance 7. Grand Canyon Trekkers-Children 8. Early Childhood Programs 9. Fitness Seniors 10.Silverstone-Corporate Retirement Center (TPK) 11. Zumba Dancing	1. BMI Screenings	N/A	N/A	N/A	N/A
NOAH	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (In progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Disease management (In progress) 4. Behavioral Health Education 5. Nutrition Education and	1. Access to care 2. Patient Centered Medical Home (in progress)	1. Access to care 2. Patient Centered Medical Home (in progress) 3. Care Coordination Community Case Management
Corporate Health	1. Corporate Challenges 2. Lunch and Learn	1. WellPath Program (Salt River Pima RSV)	N/A	N/A	N/A	N/A
Service Line	1. SHC Website Education 2. Gestational Diabetes Class (Shea) 3.Pre-Diabetes Class (Shea) 4.Nutrition Programs-Cancer (Shea) 5. Essential touch Workout Center (Shea) 6. Heart and Vascular lectures 7. The Heart of a Woman Forum (Shea)	1. Bariatric Seminars 2. Body Composition Screening (Shea) 3. Heart Health Screening (Shea) 4. Women's Wellness Program (Shea) 5. PMR/Bariatric Coordinator Presentations	1. Heart of a Woman Forum (Shea) 2. Cardiac Rehab Heart Healthy Education Classes (Shea) 3. Cardiac Rehab Center (Shea) 4. Comprehensive Diabetes Classes (Shea)	1. Gastric Surgery (Shea)	1.Cardiac Rehab Fitness Center (Shea)	N/A
Scottsdale Health Partners	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1.Access to Care 2.Patient Centered Medical Home 3. Care Management (Disease Management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease Management)	1. Access to Care 2. Patient Centered Medical Home
Scottsdale Healthcare Medical Group	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease Management)	1. Access to Care 2. Patient Centered Medical Home	1. Access to Care 2. Patient Centered Medical Home 3. Care Management (Disease Management) 4. Quality Care Coordination	1. Access to Care 2.Patient Centered Home
Employee Wellness	1. Purewellness online tracking	1. Wellness screenings	1. Disease Management			
Community Outreach/Sponsorships/Marketing						
Sponsorships - Community Benefit	Saguaro Track Boosters					
Community Partnerships/Alliances	1. AZ Dept of Education 3. Best Pals Preschool 4. Boys and Girls Club 5. La Petite Child Care Center 6. McCormick Ranch Preschool 7. Paiute Neighborhood Center (COS) 8. Parks and Recreation (COS) 9. City of Scottsdale 10. School Districts 11. Senior Centers	1. Foothills Community Foundation 2. Paiute Neighborhood Center (COS) 3. School Districts				

SCOTTSDALE HEALTHCARE®

Other Initiatives/Programs

Care Continuum

Organizational Area/Dept.	Prevention	*Screening/Diagnosis*	Disease State Management	Acute	Post-Acute	Palliative
Community Health	1. 2Fit2Fall					
NOAH	1.Immunizations (children and adults) 2.Children with Disabilities 3.Physicals/Well Visits 4.Significant Family History-Evidence based testing 5.Patient and Family Education 6.Podiatric exams (Diabetics) 7.Optometric exams (Diabetics) Family History Patient and Family Education 8.Pain Management: Physicals Family History Patient and Family Education	*1.Follow-up appointments* *2.Patient and Family Education* *3.Behavioral Health* *4.Asthma/COPD-Pulm Function Test* *5.Chest x-ray(not a screening tool)* *6.Lab* *7.Physical Exam* *8.Diagnostic testing* *9.Physical Exam*	1.Medication monitoring 2.Supplies 3.Follow-up Appointments 4.Action plan 5.Medication 6.Follow-up Appointments 7.Scheduled Screenings 8.Behavioral Health Counseling 9.Close Monitoring 10.Follow-up Appointments 11.Patient Education 12.Behavioral Health Counseling 13.Pain Contract 14.Referral Management	1.Asthma Action Plan 2.Transport to ER 3.Follow-up Appointment 4.Referral Management 5.Update, adjust /start medications 6.Follow up appointments 7.Behavioral Health Counseling 8.Update, adjust /start medications 9.Transport to ER 10.Follow-up appointments 11.Close Monitoring 12.Referral Management	1.Follow-up appointments 2.Patient and Family Education 3.Behavioral HealthCounseling 4.Scheduled Screenings 5.Follow up appointments 6.Behavioral HealthCounseling 7.Follow up Appointments 8.Patient and family education 9.Behavioral Health Counseling 10.Referral Management	1.Family Education 2.Resources (identified & presented) 3.Family Education 4.Resources (identified & presented) 5.Family Education 6.Resources (identified and presented)
Corporate Health	1. Flu Vaccinations	1.Occupational Health Medical Surveillance Programs 2.TB Skin Testing		N/A	1.Post exposure Follow-up for TB	N/A
Service Line						
Scottsdale Health Partners						
Scottsdale Healthcare Medical Group						
Employee Wellness						
Community Outreach/Sponsorships/Marketing						
Sponsorships - Community Benefit						
Community Partnerships/Alliances	1.ASU (Clinical Preceptors) 2. AZ Dept. of Health Services (Immunizations) 3. Balsz USD 4. Coordinated School Health State Program (Tdap Immunization) 5.Drowning Prevention Coalition of AZ 6. GCU (Clinical Preceptors) 7. Interfaith Group 8. New Focus Partnership 9. PV USD (Immunizations Clinic) 10. Safe Kids Coalition of Maricopa County 11. SCC (Clinical Preceptors) 12. Scottsdale Childcare and Learning Center 13. Scottsdale Fire (Safety, 2Fit2Fall) 14. Senior Centers (COS) 15. Southeast Human Development (Behavioral Health) 16. St. Joseph the Worker 17. Stonegate Community Center (Fall Prevention) 18 .The Goddard School 19. Tutor-Time 20. U of A (Clinical Preceptors) 21. Vista del Camina (LOS) - Food Bank					

SCOTTSDALE HEALTHCARE®

To Be Determined/Programs

Care Continuum

Organizational	Prevention	Screening/Diagnosis	Disease State	Acute	Post-Acute	Palliative
Community Health	COPE Emergency Preparedness Safe Sitters		Community Case Management			
NOAH						
Corporate Health						
Service Line	Chest pain Recognition-Activating 911				Support groups/ Bariatric	
Scottsdale Health Partners						
Scottsdale Healthcare Employed Medical Group						
Employee Wellness						
Community Outreach/Sponsorships, Marketing						
Sponsorships - Community Benefit						
Community Partnerships/Alliances						

Appendix 6

Strategic Community Partnerships

1) Academy of Dermatology
2) American Cancer Society
3) Apria Healthcare
4) Arizona Dept. of Education
5) American Diabetes Association
6) American Heart Association
7) Arizona Diabetes Coalition
8) Arizona Living well Institute
9) Arizona Smokers' Helpline (ASHline)
10) Arizona State University
11) AT Still University
12) Best Pals Preschool
13) Boys and Girls Club
14) Cave Creek Unified School District
15) City of Carefree
16) City of Cave Creek
17) City of Scottsdale - Human Resources (Employee benefits and wellness programs)
18) City of Scottsdale – Parks and Recreation
19) City of Scottsdale – Human Services (including Paiute Neighborhood Center, Vista del Camino, Granite Reef Senior Center, Via Linda Senior Center)
20) City of Scottsdale Public Library
21) City of Scottsdale Fire Department
22) City of Scottsdale Police Department
23) Colon Cancer Alliance
24) Community Dermatologist
25) Desert Cancer Foundation
26) Duet-Parish Nurses
27) Foothills Caring Corp
28) Foothills Community Foundation
29) Fountain Hills Screening Center
30) Fountain Hills Unified School District
31) Gateway Community College
32) Grand Canyon University
33) Institute of HeartMath
34) Jewish Family Services
35) Juvenile Diabetes Research Foundation
36) Keogh Health Connection
37) La Petite Child Care Center

38) LDS-Camelback Stake
39) Lymphoma Research Foundation
40) Leukemia & Lymphoma Society
41) Maricopa County Health Department
42) Maricopa County Smokeless Tobacco Coalition
43) McCormick Ranch Preschool
44) Mesa Fire Department
45) MOM-mammography
46) New Faces
47) Northern Arizona University
48) Nurtur
49) Our Lady of Perpetual Help Catholic Church
50) Paradise Valley Unified School District
51) Phoenix Fire Department
52) Pine Towers Senior Center
53) POP-Prostate Onsite Project (prostate education and prevention)
54) PureWellness
55) Rural Metro Fire Department
56) Scottsdale Chamber of Commerce
57) Scottsdale Community College
58) Scottsdale Unified School District
59) Scottsdale/PV Community YMCA
60) Southwest Human Development
61) Sprouts
62) St. Patrick's Catholic Community
63) Stonegate Community Center
64) Susan G. Komen Foundation
65) The Wellness Community
66) The Mollen Foundation
67) University of Arizona
68) Valley Presbyterian
69) Women of Scottsdale

* Sponsorships are subject to change