



# Opportunity Knocks for Community Health Centers: Increasing the Use of Clinical Preventive Services by Older Adults

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**SUMMARY:** This policy note examines the role that community health centers can play to increase the use of clinical preventive services by adults age 50 and older. Successful strategies include partnerships with other community organizations, a person-centered and holistic team approach, and the appropriate use of technology and personnel to coordinate and monitor the use of clinical preventive services. This note includes real world examples and links to resources that can help community health centers initiate similar efforts in their own communities. Related opportunities to provide clinical preventive services for aging services providers, state, local and tribal public health departments and nonclinical community organizations are the focus of other briefs in this “[Opportunity Knocks for Preventive Health](#)” series<sup>1</sup> which highlights the promise of collaboration between diverse types of community-based organizations to improve the health of older Americans.

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By 2015, one in five Americans will be between the ages of 50 and 64. Over the next few decades, the population of those age 65 and older is projected to more than double – from 40 million in 2010 to more than 88 million by 2050.<sup>2</sup> Meeting the health needs of this growing population is increasingly critical from both a public health and health care cost containment perspective. The use of clinical preventive services (CPS) – health care services that prevent disease or detect it at a very early stage when it is most treatable – can play an important role in meeting this goal.<sup>3</sup>

Adults age 50 and older are at increased risk for a number of diseases that can be prevented or treated early through CPS, such as influenza and pneumococcal vaccinations, colorectal cancer screening, and for women, breast and cervical cancer screening. The U.S. Preventive Services Task Force (USPSTF) publishes [a list of all recommended services](#).<sup>4</sup> These services vary with age, gender and risk factors.

Despite the effectiveness of potentially life-saving CPS, only 25% of adults ages 50 to 64,<sup>5</sup> and fewer than 40% of adults age 65 and older,<sup>6,7</sup> are up to date on a core set of recommended services. This is true despite the fact that these services are paid for by nearly all insurance plans, including Medicare and Medicaid. [The Affordable Care Act eliminates most remaining financial barriers](#),<sup>8</sup> but additional efforts are needed to increase CPS use.

Adults 50+ can obtain a broad range of clinical health services from community health centers (CHCs), which include federally qualified health centers (FQHCs) funded by Section 330 of the Public Health Service Act, FQHC look-alikes, migrant clinics, free clinics and mobile clinics. While there is variation across CHCs, they are ideally positioned to advance prevention efforts in the community. By offering CPS in places where people routinely live, work, pray and play, CHCs can reduce the effort and inconvenience incurred by seeking CPS, and can increase awareness and interest in obtaining the set of recommended services.

### **Why Community Health Centers?**

Community health centers are an essential component of the United States health care safety net and, with the comprehensive health care reform advanced by [the Affordable Care Act \(ACA\)](#),<sup>9</sup> will soon provide care to an additional 32 million Americans. CHCs provide high-quality, affordable primary and preventive care services to medically underserved areas in lower income rural and inner-city communities. Most health centers and all Federally Qualified Health Centers are governed by a board of directors, the majority of whom are patients from the community. This governance allows CHCs to self-evaluate and make changes to their everyday operations to fulfill the specific health needs of their communities and improve health outcomes. CHCs are often prepared to provide culturally-appropriate health care and also provide care regardless of the patient's ability to pay. These characteristics make CHCs particularly well suited to provide clinical preventive services to adults 50+.

Having CHCs take the lead in efforts to increase CPS use by older adults is a smart, long-term investment for communities. CHCs provide a broad array of essential health services with limited funds and reduce the need for expensive emergency, in-patient and specialty care. A recent study found that Medicaid patients who are seen at FQHCs use hospital services much less than those seen by private providers.<sup>10</sup> In addition, there is evidence that the cost of health care services provided through CHCs is lower than comparable services provided through hospitals or private offices. Specifically, a Medical Expenditure Panel Survey study found that patients who received the majority of their ambulatory care in CHC settings had 25% lower ambulatory care expenditures, and had 24% lower total annual expenditures, compared with patients who received most of their care in other primary care settings.<sup>11</sup> Medically underserved individuals who do not get care early on are more likely to seek care in the emergency room (ER) and/or when the condition is at an advanced stage. Researchers in Georgia found that rural counties with a community health center had 25% fewer uninsured ER visits than those without a health center site.<sup>12</sup> By providing recommended and timely CPS, community health centers can help to reduce the medical and human costs associated with failing to detect or prevent a health condition in its early stages.

### **Benefits of Clinical Preventive Services**

Many benefits can be realized by community health centers that lead or participate in the provision of CPS. By advancing CPS, they are taking an important step towards fulfilling their mission which is [“To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations”](#).<sup>13</sup> Leading efforts to increase uptake furthers their potential to make a positive impact by reducing disparities in the receipt of CPS.

Historically, most CHCs have predominantly served a Medicaid population (mostly low-income women and children), and a much smaller proportion of the older Medicare population (people age 65 and over). Now, given the rapidly changing demographics produced by the “baby boomer” generation, many CHCs are anticipating substantial growth in their older population over the next decade. As one CHC provider in an urban area of California notes, “...we have always done some senior care as part of our routine primary care services. [However], we are looking to expand our role in senior care services [by] internally looking to increase our skills and abilities to take care of complex cases.”

All CHCs are already engaged in the delivery of clinical preventive services, making it feasible to target and increase existing services to the older adult population. The ACA is scheduled to bring CHCs increased funding of \$11 billion over the five-year period of FY2011-FY2015. By expanding efforts to reach and serve adults 50+, CHCs have the potential to increase revenues by providing additional services that are reimbursable through Medicaid and/or Medicare.

### **Building on the Strengths of Community Health Centers**

Community health centers have a number of strengths that position them to lead efforts to increase the use of CPS among community-dwelling older adults. First, CHCs have a core mission to meet the health needs of the communities they serve. This commitment and passion to serve often translates to a positive and progressive organizational culture. As the president and CEO of one inner-city CHC states, “*This care and emotion which guides our practice and decisions has resulted in dramatic improvements in the health of patients who access services at [our organization] – located throughout the poorest and most underserved neighborhoods...*”

CHCs are also open to making changes that can benefit their patients. For example, when one urban CHC switched from paper to electronic medical records (EMRs), they found they were able to more accurately track the rate of return of colorectal cancer screening stool cards. Prior to the EMR implementation, only positive results were recorded. By implementing this change, the CHC learned that two-thirds of fecal occult blood tests (FOBTs) issued were being returned. The CHC used these data to increase their accountability by developing a flow chart system that identified patients in need of outreach, referrals and/or follow-up for FOBT screenings.

Many CHCs engage individuals in areas designated as Medically Underserved by the Federal government. The location of CHCs in lower income rural and inner-city communities enables them to provide clinical services to the most vulnerable individuals, including older adults. One urban CHC in Seattle purposefully situates clinics in neighborhoods that have the greatest health disparities. In addition, they extend their reach by employing health educators, eligibility specialists, counselors and nurses (sometimes physicians, nurse practitioners and licensed clinical social workers as well) to provide care in various other community sites including community centers, churches, shelters and individuals’ homes.<sup>14</sup> The medical director of one rural CHC explained, “*Just putting an office there doesn’t solve problems in high risk communities... We have looked at the linkage component and used navigators to help accomplish our cancer screening... On average, they contact a patient on the phone 8 times for an average of 15 minutes each contact [i.e., an average of 120 minutes of navigation per patient] and have a 98% success rate with completed colonoscopies.*”

Many CHC providers echo the notion that community member involvement is essential to successful outreach efforts, and many include members of the community as part of their health care teams. These patient navigators (also known as promotores or community health workers) have the potential to significantly contribute to CPS engagement, delivery and follow-up through peer influence, education and counseling. The use of peer support may be especially important for older adults who tend to have lower health literacy levels<sup>15</sup> and belong

to a generation that may be less likely to advocate for themselves. In addition, many older adults have multiple chronic conditions and generally more complex health care needs that make navigating the health care system and receiving recommended CPS even more challenging.

### Clinical Preventive Services Provision Strategies

Community health centers are engaged in a number of efforts to increase the use of CPS by adults 50+. Recognizing that human and fiscal resources vary widely across CHCs, this section highlights strategies involving CPS engagement, delivery and/or follow-up activities, including: partnering with other community-based organizations to provide CPS; advancing a team approach to deliver patient-centered and coordinated care; and having the right tools and personnel in place to exchange health information, and develop a referral infrastructure.

#### Productive Partnerships with Other Community Organizations

##### *Real world example:*

CHCs are typically engaged in a number of collaborative arrangements with other community organizations; these relationships can be leveraged to increase the provision of CPS to older adults. For example, a rural county health department in Montana partnered with a local college pharmacy program, tribal health authorities, community pharmacies, county agricultural extension agents and FQHCs to develop an initiative called [Improving Health Among Rural Montanans \(IPHARM\)](#).<sup>16</sup> IPHARM trained pharmacists and students to administer clinical screening tests for osteoporosis, hyperlipidemia and hypertension to individuals residing in remote areas by using screening equipment transported in motor homes. During the first two years of the project, IPHARM pharmacists traveled approximately 14,000 miles, conducted 72 clinics in 17 counties and performed 5,100 screening tests for more than 3,100 people. Over 70% of those screened lived in rural or frontier communities. More than 80% were age 65 or older.

##### *Real world example:*

The [SPARC](#) (Sickness Prevention Achieved through Regional Collaboration)<sup>17</sup> model provides an important example of the success of collaborative strategies to increase the uptake of CPS in the community.<sup>18</sup> This national model is specifically dedicated to increasing the provision of CPS by employing community collaboration and the facilitation of convenient delivery mechanisms, and has been shown effective in increasing rates for several types of CPS. CHCs can use SPARC as a gold standard when designing collaborative efforts to increase CPS rates among aging adults. One of the advantages of using a collaborative model is that the clear delineation of leadership roles and responsibilities assigned to key partners creates an infrastructure that elicits accountability. As observed by the president of [SPARC](#), Dr. Doug Shenson, “Increasing CPS is a team sport!” A [SPARC Action Guide](#)<sup>19</sup> has been developed to support the implementation of SPARC, with critical steps outlined.

#### Person-Centered and Holistic Team Approach

Many CHCs have adopted a health care team approach intended to more holistically manage patient care through shared skills and knowledge. In addition to increasing the quality of care, these teams offer increased efficiency by reducing the cost of services through use of qualified mid-level providers. For instance, some CHCs use standing orders (i.e., written instructions provided by the medical practitioner) which authorize qualified mid-level practitioners, such as physician-assistants and registered nurses, to provide specific CPS.

This is a practical approach, given that mid-level practitioners are qualified to provide certain preventive services, such as immunizations, that do not require the high skill level and cost of a physician. It is also responsive to shortages of medical practitioners found particularly in rural and underserved areas.

A growing number of CHCs are incorporating the tenets of the [Patient-Centered Medical Home \(PCMH\)](#)<sup>20</sup> into their practice. A PCMH emphasizes “a reorganization of the traditional primary care model to highlight fundamental attributes: a comprehensive approach to primary care, a personal relationship with a physician-led team that has collective responsibility for the patient’s needs in a manner that is coordinated and enhanced with supporting systems, and a reimbursement approach that pays the cost of these systems.” The design and philosophy of the PCMH supports efforts to increase the uptake of CPS among adults 50+ because it encourages patient access and continuity of care, and has the potential to address the full range of evidence-based preventive health needs.

### Appropriate Use of Technology and Personnel

Community health centers can adapt electronic medical records to systematically track and support CPS utilization. EMRs often contain provider alerts, evidence-based guidelines and practice management support. Combined with patient demographics, these EMRs can increase the likelihood of timely and appropriate CPS delivery, as the recommended age for cancer screening varies by the type of cancer. The use of EMRs also can improve the referral process and increase opportunities for follow-up. CHCs that have transitioned from paper to electronic medical records note that they are now engaged in more accurate monitoring that has resulted in increased cancer screening rates. One urban CHC that implemented EMRs six years ago reports that they now monitor the progression of CPS delivery and can more effectively implement appropriate and timely plans for follow-up care. Many health centers also use disease registry technology systems to track key screenings and tests, and to provide reminders to clinicians.

#### *Real world example:*

It is also essential to set up personal health data systems that can be shared across provider organizations. The importance of cross-provider communication is illustrated by the [Wisconsin Health Information Exchange \(WHIE\) project](#),<sup>21</sup> which improved communication between emergency departments and FQHCs in the Milwaukee area “by providing real-time access to patient historical-encounter data and establishing the foundation for expanded communication.”<sup>22</sup> This project demonstrated that negative outcomes, including death, could be avoided each year with effective communication and a comprehensive history, especially for those people age 50 and older who may be at increased risk of an adverse reaction. Patient registries are also important for tracking cancer screenings and immunizations at the population level. In addition to exchanging health information between health care providers, WHIE has partnered with local public health officials to conduct public-health surveillance activities to identify outbreaks such as the flu-like illnesses (H1N1 for example).

Electronic medical records provide an important tool, but individuals are still central to the process of information exchange that can facilitate the provision of CPS to older adults. Some CHCs have hired full-time referral coordinators whose major responsibility is to connect patients to the next phase of care, whether to attain a recommended screening or treatment. Referral coordinators also work to identify free or discounted services for uninsured or underinsured patients. Similar to care managers, these coordinators navigate their patients through all stages of CPS engagement, delivery and follow-up. As expressed by one CHC director in an urban South Georgia town: “[We need to] help [patients] navigate the complex medical village that’s on the other side of the hall so when we do a screening study for colon cancer or do a pap smear, and it’s positive we get them through that complicated maze of specialties.”

## Putting It All Together to Provide CPS in the Community: “Coming of Age” with Community Health Centers

[LifeLong Medical Care](#)<sup>23</sup> in Oakland, California has a deep commitment to innovative geriatric care that traces back to 1976 with the founding of its first clinic, the [Over 60 Health Center](#).<sup>24</sup> Today, LifeLong helps more than 4,000 older adults optimize their health, stay connected to their communities and reach their goals. Here, we highlight the work of LifeLong’s Over 60 Health Center which specializes in older adult care.

The Over 60 Health Center has approximately 15 medical providers and several mental health and support professionals who see more than 1,800 patients each month. The clinic offers preventive, educational and supportive services to keep older adults active and independent as well as to support those who need more assistance. Older adults who receive services from LifeLong’s other family or adult medicine clinics have the choice to continue with the same doctor or switch to one of the specialized geriatric practices once they turn 60 and “come of age.”

The Over 60 Health Center also engages older adult patients in a number of locations outside of their clinics and in the community. A registered nurse regularly visits senior centers and residences, and throughout the year, staff members offer educational classes on prevention and host clinics that deliver preventive services for older adults, including a weekly hypertension clinic and an annual flu clinic. For those who need extra support to live at home, LifeLong’s Adult Day Health Centers provide daytime nursing care, social activities and therapeutic exercise. And for patients who are too functionally impaired or ill to attend the Over 60 Health Center, staff members provide in-home or hospital visits to facilitate the continuity of care.

There are multiple factors that make LifeLong successful at delivering CPS to their older adult patients. First, the clinic’s philosophy and mission underscore the importance of partnerships, collaborations and working as part of one health care team. Their collaborative vision seeks to identify the best ideas, capabilities and research available, whatever the source. As Lifelong’s CEO explains it, “...*excellent in-house talent and resources are one of the pillars of our LifeLong success, but at the same time, we're excited about the opportunities that exist to collaborate. Great work is being done in all corners of the world and in multiple settings. Our goal is to find it, advance it, and put it to work for our patients who need it.*”<sup>25</sup>

Because LifeLong attributes such value to partnerships, they devote time and resources to employing dedicated, experienced teams and individuals to ensure partnership successes. They have developed a straightforward process that enables them to establish partnerships that serve multiple purposes. For example, LifeLong partners with Alameda County’s Area Agency on Aging to reach patients beyond their clinic doors. A registered nurse from the Over 60 Health Center visits senior centers and residences to provide foot care, and check blood pressure and blood sugar levels. Accompanied by a medical assistant, the nurse is also available to answer patients’ questions, particularly about their medications.<sup>26</sup>

The LifeLong Medical Care philosophy that embraces the value of collaborations with outside organizations also guides their internal practice. As expressed by one LifeLong employee, “*Within the clinic, we all consider ourselves part of one health care team. ...We meet as a team on a regular basis - all the psychosocial and medical providers - and talk about our most challenging cases and do group problem solving and talk about how to collaborate, what may be the best approach to take...Internally, we do not see a division and we try to make this clear to our patients.*”

## Conclusion

There are a number of provisions in the [Affordable Care Act](#)<sup>27</sup> that support the collaborations detailed in this policy note and offer points of entry for CPS. These provisions include the creation of [Accountable Care Organizations](#),<sup>28</sup> [Patient-Centered Medical Homes](#),<sup>20</sup> [Medicaid Health Homes](#),<sup>29</sup> and the [Community-based Care Transitions Program](#).<sup>30</sup> [The Chronic Care Model](#)<sup>31</sup> informed a number of these ACA provisions and also holds great promise to support CPS engagement, delivery and follow-up in the community while functioning as a driver of cost savings. Finally, a systems approach will be needed to achieve the national goals and standards put forth by the U.S. Department of Health and Human Services' [Healthy People 2020](#),<sup>32</sup> [Action Plan to Reduce Racial and Ethnic Health Disparities](#),<sup>33</sup> and [National Prevention Strategy](#).<sup>34</sup> Partnerships with other community providers will be critical for leveraging the financial and human capital needed to initiate and sustain these efforts to improve the health of older Americans.

## Methodology

Researchers from the UCLA Center for Health Policy Research conducted a literature review and 43 telephone interviews with a diverse group of community-based stakeholders representing public health, aging services, community health centers, and other community organizations and retailers (such as the YMCA and pharmacies) in 2011. A stakeholder meeting was then convened to identify opportunities to advance the provision of clinical preventive services to older adults in the community. Krist and colleagues (2012) presented a landscape paper that conceptualizes the provision of CPS in three stages: engagement (identifying need, making referrals), delivery (administering, counseling and supporting adoption), and/or follow-up (documenting and referring to additional services or treatment).<sup>35</sup> Stakeholders then formed small groups to discuss implications for their involvement in the provision of CPS to older adults. This policy note draws upon the Krist et al. paper, the literature review, the telephone interview data and the stakeholder discussions to identify specific opportunities for community health centers to provide CPS, and to illustrate how they may benefit from expanding their role and increasing CPS uptake among adults 50+.

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## Funder Information

This publication was supported by Grant/Cooperative Agreement Number U58DP002759-01 from the Centers for Disease Control and Prevention ("CDC"). Contractor acknowledges the contribution of the National Association of Chronic Disease Directors (NACDD) to this publication. Its contents are solely the responsibility of the authors and do not necessarily reflect the view of the CDC or NACDD.

## Acknowledgments

We are grateful for the contributions of the many who made this paper series possible, including the stakeholders who were interviewed and/or participated in the roundtable meetings, Amy Slonim, CDC-AARP Liaison, William Benson, Health Benefits ABCs, Consultant to CDC Healthy Aging Program, Lynda Anderson, Director, CDC Healthy Aging Program and other members of the research team at the UCLA Center for Health Policy Research: Tabashir Sadegh-Nobari, Ashley V. Parks, and Delight E. Satter. We also want to thank Marty Lynch, Leslie A. Best and Anna Davis for their helpful reviews.

## Suggested Citation

Leos R, Kietzman KG, Wallace SP. *Opportunity Knocks for Community Health Centers: Increasing the Use of Clinical Preventive Services by Older Adults*. Los Angeles, CA: UCLA Center for Health Policy Research, 2012.

## Endnotes

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<sup>13</sup><http://www.nachc.com/client/SPR29FINAL.pdf>

<sup>14</sup><http://www.neighborcare.org/sites/default/files/Annual%20Report%202010%20for%20FY2009%20FINAL.pdf> (p. 7)

<sup>15</sup>Centers for Disease Control and Prevention. *Improving Health Literacy for Older Adults: Expert Panel Report 2009*. Atlanta: U.S. Department of Health and Human Services, 2009.

<sup>16</sup><http://www.innovations.ahrq.gov/content.aspx?id=2260>

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<sup>20</sup>Patient-Centered Medical Home: <http://www.ncqa.org/itabid/631/Default.aspx>

<sup>21</sup>Wisconsin Health Information Exchange: <http://www.whie.org>

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<sup>23</sup><http://www.lifelongmedical.org/>

<sup>24</sup><http://lifelongmedical.org/patient-guide/locations/over-60-health-center>

<sup>25</sup><http://lifelongmedical.org/about-us/partnerships>

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<sup>27</sup>The Affordable Care Act of 2010: <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

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<sup>29</sup>Medicaid Health Home: <http://www.kff.org/medicaid/upload/8136.pdf>

<sup>30</sup>Community-Based Care Transitions Program: <http://www.healthcare.gov/compare/partnership-for-patients/care-transitions/index.html>

<sup>31</sup>The Chronic Care Model: [http://www.improvingchroniccare.org/index.php?p=the\\_chronic\\_care\\_model&s=2](http://www.improvingchroniccare.org/index.php?p=the_chronic_care_model&s=2)

<sup>32</sup>Healthy people 2020: [http://www.healthypeople.gov/2020/TopicsObjectives2020/pdfs/HP2020\\_brochure\\_with\\_LHI\\_508.pdf](http://www.healthypeople.gov/2020/TopicsObjectives2020/pdfs/HP2020_brochure_with_LHI_508.pdf)

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