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1. “Determining Mental Health Need and Access to Mental Health Services for Diabetic and Hypertensive Patients through the Alameda County Health Coach Program”

Omonivie Agboghidi, H4A Fellow, 2015

Background: Racial and ethnic minorities bear a disproportionate burden of chronic diseases such as hypertension and diabetes. Poor chronic disease management impairs stress management skills and coping strategies, increasing susceptibility to mental health issues like depression. Minority groups have experienced difficulties in gaining access to mental health care and are underrepresented among patients receiving mental health services and underutilize services. Disparities in the use of mental health services by racial and ethnic minority groups prevent accurate diagnosis and treatments of depression or depressive disorders. The Alameda County Health Coach Program (ACHCP) (<http://www.acphd.org/healthcoach>) uses culturally sensitive Health Coaches to empower patients to successfully self-manage their chronic disease and advocate for their health needs. **Objectives:** Measure the prevalence of new clients enrolled into ACHCP experiencing depression from a convenience sample of 19 using the PHQ-9 Quick Depression Assessment. Test a tailored approach that identifies clients’ need for mental health services or stress management activities and connects clients to mental health services. Increase utilization of clinic-based and community-based mental health services and stress management activities. **Methods:** Need for Mental Health Service: PHQ-9 Quick Depression Assessment determined depression severity for depressive disorders; Health Coach-administered intake assessment to determine client’s current need for mental health services, past usage of mental health services, current stress management skills, and coping strategies. Mental Health Service Use: Data on the use of mental health services in the months following the intake assessment are based on the Health Coaches’ Case Management Log including: (1) action plans for stress management activities/coping strategies; (2) clinic-based mental health services; and (3) community-based support groups. **Key Learnings:** Implementation of PHQ-9 Assessment tool allowed health coaches to identify and address mental health needs along with other health concerns. Alameda County outsources 85% of behavioral health care services to organizations across the county. Partnerships and collaborations should be in place to facilitate the referral process and improve successful linkages to services. **Milestones:** March 2015: Attended Alameda County Mental Health Board Forum Town Hall Meeting to network and obtain mental health resources. June 2015: Two-way partnership established with Street Level Health Project to refer clients for free mental health counseling. Health Coach Reflection: “[Client] seemed at ease during the conversation, sharing personal stories and difficulties; she appeared to be fully engaged. [Support Group Leader] leads the class with enthusiasm and listens closely to participants’ comments and concerns. Will continue to attend classes with [Client]. Afterwards she expressed she felt less alone and would not have attended if I hadn’t gone with her.” **Limitations:** Small sample size (n=19); Infrequent survey administrations (4); short program duration of 6 months; lack of control group; convenience sampling method: participants were selected from a disease management program aimed at improving health and connecting low-income patients to resources. **Next Steps:** PHQ-9 administrations will be adopted into ACHCP intake process as a routine screening tool;

continue evaluating PHQ-9 questionnaires to observe any decrease in depression score over time; I would recommend that screening for mental health need be made a priority for health coaches to provide early in clients' participation in the Alameda Health Coach Program and mental health education should be shared with clients and their families to help reduce stigma around mental illness and increase awareness about mental health.

2. "Recruitment and Retention Strategies Used by Researchers in Clinic and Community Settings"

Beatriz Anguiano, H4A Fellow, 2015, Cati Brown-Johnson, PhD,
Judith Prochaska, PhD, MPH

Background: Recruitment & Retention (R&R) strategies are vital to research success. Stanford Prevention Research Center's (SPRC) Wellness Living Laboratory (WELL) initiative aims to recruit 10,000 participants in both Santa Clara County and China. R&R of large cohorts over time is critical to WELL's success. Ideal recruitment strategies increase both overall numbers of study participants and representation. Sufficient recruitment is needed to meet the sample size and power requirements of research studies. Retaining participants in a study includes increasing response and follow-up rates. Typically, < 5% losses of participants has minimal bias. 20% losses of participants can threaten trial validity. CDC states 70% success rate at follow-up for studies to be representative of target population. **Objectives:** To collect information on the experiences with R&R from researchers actively involved in community and/or clinical research. Specifically, inform R&R best practices for WELL using an online survey. **Methods:** Created a survey with Redcap during Feb/March 2015. Collected information on respondents': type of research (e.g., lab-based, intervention, cross-sectional, cohort/longitudinal, case control, randomized control trials); typical study sample size, retention rates, and follow-ups; age groups, ethnic groups, and special populations; messages or tag lines used for recruitment; effectiveness of recruitment strategies (e.g., referrals, social media); incentives used for retention (e.g., cash, gift cards, food) and success rate. Received feedback on survey from SPRC colleagues Abby King, PhD and Sandra Winter, PhD; obtained Institutional Review Board (IRB) approval in April 2015. Email snowball sampling began in April/May 2015 with outreach to various listservs: SPRC, Stanford Education Planning Initiative (SEPI), Society for Research on Nicotine and Tobacco (SRNT), and Society of Behavioral Medicine (SBM). Weekly email reminders to listservs to complete the survey: 92 survey respondents started the survey. Eliminated 10 survey respondents who did not put their age, 6 under 18 years old, 1 repeat, and 1 who answered the first choice for every question. Of a total of 74 survey respondents, 33 (45%) completed the survey in entirety. Data analyzed using SPSS including frequencies and mean and standard deviation; removed "Variable 1=Have not tried" from mean scale because it was counted as missing. **Key Findings:** The most successful recruitment and retention strategies were based on social media and technology, but were infrequently used by many survey respondents (e.g., Instagram, LinkedIn, TV-paid, and YouTube). The most frequently used recruitment strategies that were relatively highly ranked by survey respondents included clinical referrals and email lists. Frequently used recruitment strategies that were ranked relatively low by survey respondents included family/friend referrals, flyers, word of mouth, community health events, posters, postal mailing list,

and study websites. The most frequently used retention strategies that were relatively highly ranked by many survey respondents included methods that involved staff members (e.g., dedicated staff, emails, periodic calls). Frequently used retention strategies that were ranked relatively low by survey respondents included collaterals, letters, and post cards. The most successful incentives that were relatively highly ranked and frequently used by survey respondents included cash, reimbursed travel cost, and food. Successful incentives that were relatively highly ranked and infrequently used by survey respondents were gift cards and money orders. “All comers” was the priority group highly ranked by survey respondents for the focus of the WELL initiative. **Next Steps & Future Directions:** Use the results to inform WELL recruitment and retention strategies. Share the results with Stanford research community. Continue to gather data.

3. “New Beginnings: Partner-Supported Technology-Mediated Lifestyle Intervention for Overweight or Obese Primiparous Postpartum Women”

Marjorie Brent H4A Fellow, 2015, Veronica Luna¹, Nancy Wittels¹,

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Purpose: New Beginnings (NB) is a home-based partner-supported lifestyle intervention for overweight or obese first time mothers. Through increased physical activity and healthy diet, NB will facilitate weight loss for a mother, her partner, and ultimately impact her child’s weight. NB capitalizes on the primiparous period as a uniquely “teachable moment” while introducing the novel component of partner-supported weight loss. The study will be fielded at the Palo Alto Medical Foundation (PAMF). **Background:** Postpartum Obesity Implications: Prevalence of overweight/obese women during childbearing years in the US is nearly 50%. Maternal obesity is correlated with increased incidence of preeclampsia, antepartum stillbirth, and cesarean delivery. Children born to obese mothers have increased risk of childhood obesity and developmental delays. Family environment shapes children’s eating, activity, and growth patterns, especially during infancy and early childhood. NB is Based on Successful Lifestyle Interventions: University of Pittsburgh Diabetes Prevention Program (DPP) is a lifestyle intervention program promoting clinically significant modest weight loss (5 - 10%) through moderate-intensity physical activity and healthy eating. Group Lifestyle Balance (GLB) is an up-to-date adaptation of the successful DPP lifestyle intervention. Benefits conferred by GLB are persistent in diverse populations and settings 10 years and longer after program completion. Social Cognitive Theory emphasizes the relationship between the individual, the environment, and behavior. Self-efficacy is enhanced through social support and gradual mastery of self-regulation skills (e.g. goal setting and self-monitoring). **New Beginnings Pilot Study objectives:** Assess the acceptability and feasibility of recruiting and delivering NB to postpartum women. Evaluate novel component of partner-supported lifestyle changes. Lessons learned: applied to grant resubmission July 2015. **Objectives:** New Beginnings Program objectives: reduction in obesity in postpartum women, a partner, and child two years postpartum versus normal care. Goal: 5% weight loss versus pre-pregnancy weight. Intervention Development: with study collaborators, created twelve weekly partner activities to promote novel partner-support component of NB study while recognizing the changes a new mom experiences,

for example: Week #1: Give the gift of time: two hour window for self-care (remember to care-take new mom); Week #2: As a team, review the partners' food passions and find healthy food choice substitutions; Week #3: As a team, make weekly dinner meal plans that efficiently reduced meal preparation; Week #6: With the NB partner, do an internet search to find ideas to encourage/increase sleep. Collaborated with PAMF Research Institute (PAMFRI) interventionists to adapt/create materials for NB binders. Identified PAMFRI requirements for fielding intervention (IRB and communications compliance, etc.). Adapted/created standard emails for bi-weekly communication with study participants. **Pilot Study Milestones:** Developed project plan for Pilot Study Program. Created NB logo. Created NB materials for intake session and ongoing participant use. Created 12 weekly partner activities with input from study collaborators. Created/adapted REDCap questionnaires and survey instruments. Tested obstetrician involvement/participation in patient recruiting process. Collaborated with PAMF interventionists for leader training for initial intake sessions. Fielded 20 study participation invitations via REDCap. Screened and recruited participants via telephone. Conducted intake session for NB participant. **Key Findings:** Recruitment: Securing obstetrician participation for patient pre-approval cycle is cumbersome; patient recruiting process needs to expand beyond emailing: flyers, website, multiple exposures. **Intervention development:** Materials used for other interventions need not be specifically adapted for NB pilot study. Need for increased focus on partner component for screening. Need for increased focus on child-centered benefits (new moms have new focus of family). **Pilot Study Process:** Identified initial intake questionnaires that are not relevant for study (reflecting unique postpartum period). Intake visit needs to be streamlined. Identified a need to expand eligibility requirement to longer postpartum period. **Future Considerations:** Patient approval process improvements: Survey obstetricians to identify alternatives to streamline patient pre-approval process; alternatively, remove obstetrician from approval process, directly contact EHR pre-screened patients; contact patients in 3rd trimester to introduce NB and get early measure of interest. **Increase awareness, acceptability and reach of NB Program:** Involve PAMF staff (nurses, administrators) for intervention promotion to increase awareness; involve Sutter Health more broadly for promoting NB (Department heads of Obstetrics and Pediatrics); promote study participation by highlighting the benefits of NB being conferred to child; develop NB education materials for placement in obstetrics clinics to support recruiting efforts; develop NB website for potential Sutter Health staff and patients to learn about NB program.

4. “Visualizing the Food Environment Using ArcGIS in Santa Clara County: Accessibility of Ethnic Food Outlets”

Donna Bui, H4A Fellow, 2015 and Sandra J. Winter, PhD, MHA

Background: The environment in which people live and spend their time can affect their health and their physical activity. The food environment can influence decisions people make about their diet. Differences in the neighborhood food environment can contribute to the health of the population. The availability of fresh fruits and vegetables within the home are influenced by access to shops, restaurants, and grocery stores. **Objectives:** To identify healthy and unhealthy food outlets within Santa Clara County using ESRI

Business Analyst. To visualize the ethnic markets and grocery stores within the area using ArcGIS (Geographic Information System). To analyze the distribution of food establishments, both healthy and unhealthy, over maps of socioeconomic status, namely income level from 2010 US Census. To examine the neighborhood food environment at the tract level. **Methods:** Mapping: the project used ArcGIS to geocode and map the various food establishments. Food establishments are identified through an ESRI Business Analyst. This tool provides information on existing businesses and their spatial location. Note: The data found in ESRI Business Analyst does not include all food establishments in Santa Clara County. Food establishments: Healthy Food Outlets are identified on the availability of fresh fruits and vegetables and healthy food options, or greater proportion of healthy foods. This includes supermarkets and grocery stores (chain and independent) and farmer's markets. Farmer's market locations are found from Santa Clara County Department of Agriculture. Unhealthy Food Outlets are identified by the availability of food products high in energy and high in fat, or lesser proportion of healthy foods. Included in this dataset are convenience stores, liquor stores, fast-food restaurants, cafes, and bakeries. Ethnic markets are identified through the types of food products provided. The ethnic categorizations are for Hispanic and Asian markets. Each food establishment is searched through Google to identify the products that are sold at the market. Socioeconomic status: socioeconomic status was determined by household income from 2010 Census. Using the ArcGIS program, the income levels are broken down into 3 breaks from 'low', 'medium,' and 'high' median household incomes. **Results and Reflections:** There are large territories of Santa Clara County that show no food outlets because they are open land reserves and/or public open land. Ethnic markets are located at tracts where the ethnic groups are most densely populated. The differences in the number of healthy (n=810) and unhealthy food outlets (n=759) are not large, but this is only representative of one dataset, ESRI Business Analyst. Previous literature shows that lower income areas tend to have more unhealthy food outlets than higher income areas. Mapping the healthy vs. unhealthy food outlets' locations on a map of income level attempts to visually represent this phenomena in Santa Clara County. There are 19 tracts with 6-11 unhealthy food outlets in the respective tract, and likewise, there are 24 tracts with 6-12 healthy food outlets in the respective tracts. **Potential Next Steps:** Most people do not use the nearest grocery store or market in their area, but they will, instead, travel farther distances to go to a market they prefer for various reasons. It may be interesting to explore these reasons through community engagement. While this project only explores datasets of consumer-based outlets, it may be useful to incorporate free or subsidized food resources within the county, such as locations that accept SNAP (Supplemental Nutrition Assistance Program), soup kitchens, and food banks. This project only looked at one database of food establishments. There are many other resources that can add to the project's current dataset and create a fuller picture of the food environment. **Limitations and Benefits:** Learning how to use the ArcGIS program, obtaining data sets, and editing and sorting the data is time consuming. However, visualizing areas of need and examining food outlet densities portray the data in a rich and compelling manner. Previous literature frequently examines food environment as cohort studies, but they do not evaluate them at a community or county level. ArcGIS allows for a perspective of the food environment at a higher level.

5. “Mind Full, or Mindful? A Pilot Study on Meditation Strategies Among 3rd-8th Grade Students in Religious Education Classrooms”

Maria Cabe, BS, H4A Fellow, 2015; Maria Ong, Religious Education Coordinator, St. Mark Catholic Church; Cati Brown-Johnson, PhD, Stanford Prevention Research Center

Background: Mindfulness and Meditation: Childhood stress is a precursor to adult stress and a risk factor for later disease. Mindfulness-based stress reduction (MBSR) reduces stress, cultivates compassion, and can take the form of meditation. Mindfulness and wellness are interconnected and promote unity for body and mind. The Roman Catholic Archdiocese of San Francisco, Office of Religious Education, and Youth Ministry advocates the implementation of Christian meditation in religious education programs. St. Mark Catholic Church (Belmont, CA) provides religious education for 1st-8th grade students. Christian meditation is used as a form of prayer and is one of the oldest prayer forms in the Catholic tradition. **Objectives:** assess whether meditation can decrease stress levels and promote overall wellness for students. Create and administer a survey tailored for elementary and middle school students to assess baseline scores for stress, self-compassion, and quality of life. Engage teachers in introducing different meditation techniques in their classrooms. Provide awareness to students about positive effects of meditation, both in spirituality and health, and different meditation techniques. Cultivate inner space to help students experience the presence of God. **Methods:** teachers were trained in meditation using a train-the-trainer approach. Meditation included: prayer word (“Maranatha”) and breathing, rosaries, guided imagery, and music. From February to April 2015, 3rd-8th grade students (n=35) practiced meditation for 5 minutes weekly in the classrooms. Students were surveyed on quality of life, perceived stress, and self-compassion before and after the intervention. Teachers recorded weekly feedback from students and also asked students to write down brief thoughts or comments after each experience. **Next Steps and Future Directions:** Use focus groups to identify age-specific stressors. Debrief with students and teachers about their first meditation experiences. Continue to tailor intervention and surveys with feedback from students. Support teachers with mid-semester training/refreshers. Adapt intervention to include parents.

6. “Culturally Tailored Food Tastings as Part of a Diabetes Prevention Program for Latinos.”

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Prevention Research Center⁴

Background: There are 50.5 million Latinos living in the US. 63% of Latinos are of Mexican descent. California has largest Latino population with 14 million total (11.4 million are of Mexican descent). The prevalence of overweight and obesity is higher among the Latino population with 77%, in comparison to Non-Hispanic Whites with 68%. High serum cholesterol, blood pressure levels, obesity, hyperglycemia/diabetes, and cigarette smoking are 5 major cardiovascular disease risk factors found within the Latino population. The Diabetes Prevention Program (DPP) trial demonstrated that lifestyle changes were more likely than metformin and the placebo to decrease incidence of diabetes and cardiovascular risk factors among multiethnic high risk adults. Following

this trial, the DPP researchers developed the Group Lifestyle Balance (GLB) curriculum to adapt the DPP trial for a group. The Palo Alto Medical Foundation Research Institute, PAMFRI, designed the ELITE study to examine the effectiveness of GLB in a primary care setting. The ELITE Study showed similar results as the DPP-GLB trial. **ELITE Latinos Study Main Objectives:** To culturally adapt the GLB curriculum for Latinos and examine the effectiveness compared to usual care among Latino patients at PAMFRI. **“Food Tastings” Main Objectives:** Develop and implement “Food Tastings” where participants will learn new healthy recipes or healthier alternatives to favorite dishes. Evaluate the success of each recipe by analyzing: Participant Survey Results - measures enjoyment, satisfaction, barriers, willingness to try again and share with family, perception of how healthy recipe is; Staff Survey Results - measures cost of the ingredients, cooking time, feasibility to make this dish on a typical workday; evaluates if the “Food Tastings” have encouraged more cooking and/or implementing of our “Food Tasting” recipes at home. **Methods:** Step 1: Identified potential participants through the Electronic Health Record using pre-specified criteria; Primary Care Providers reviewed potential participants and approved them for the study; a letter and an email were sent to potential participants as an introduction to the study; then, participants were screened by phone and if eligible, they were invited to attend the 5 focus groups. The eligibility criteria included: Latino, overweight or obese, and at risk for diabetes or other cardiovascular disease. Step 2: Total of 34 participants attended 5 Focus Groups. Participants engaged in a discussion about culture, food, physical activity, and provided feedback on “Food Tastings”. Participants’ feedback guided in the decision making of the session times and locations. Focus Group participants were recruited for the ELITE Latino patient advisory board. Step 3: 11 participants, primarily of Mexican descent, provided feedback about GLB and attended the intensive 12 GLB pre-testing sessions for 2 hours each. Step 4: get participants’ feedback on their favorite meals and the types of meals they hope to learn to cook healthier; adapt the recipe list to include participants’ feedback; look for healthier cooking recipes, and meet with team weekly to discuss the week’s recipe; adjust the recipe for 15 servings; buy ingredients and prepare part or entire meal the day before. Step 5: organize supplies, set up, and heat up the food; provide a copy of the recipe to the participants; explain to the participants why the recipe was chosen and how we cooked it healthier; ask participants to fill out the survey; fill out the staff survey. Step 6: review participants’ surveys; look for any trends and analyze the surveys; create a recipe book. **Results and Reflections:** Meal Analysis/Characteristics: Smoothies: received the lowest score overall; low ratings were a reflection of participants’ desire for heavier meals; as a result, we decided to provide them with dinners. Latin Food: Chicken Tacos: one of the most satisfying dishes for the participants. Ceviche: One of the most time-consuming dishes due to all the vegetable chopping, but it was the lowest calorie meal; on the other hand, the participants thought it was one of the unhealthiest meals (one participant expressed concern for the cholesterol found in shrimp). Bean Soup: beans are a signature of Latin American dishes; it was one of the least expensive meals and rated the highest for willingness to “share with family”. Veracruzano Fish: although ranked as the healthiest meal, participants rated it as one of the meals less likely to be shared with their family; depending on the region where Latinos are from, fish may not be a common dish. Sopes: One of the most satisfying dishes and the highest rated; this fish offered alternative ingredients for healthier sopes.

Sandwiches: This meal received the highest score. The participants had three sandwiches to pick from, which added variety. Spaghetti: Overall the participants expressed a high rating for this meal, with the exception of 1 participant who rated it very low due to the “beef” meatballs that were actually turkey. Stir Fry: It was the most satisfying dish, but participants weren’t as likely to try this again in comparison to the other meals; 1 participant expressed they were not a fan of Chinese food and 2 participants found this dish salty. Paella: This dish received the lowest scores for trying again, sharing with family, and having access to the ingredients. The majority of the participants are of Mexican descent or from Latin America; some of them had never been exposed to paella and as a staff member finding the ingredients was challenging. **Key Learnings:** For Patients: Adding some component of “do-it-yourself”, since our top rated recipes were easy to prepare; it is best for the “Food Tasting” to complement the theme of the session; it is important to keep in mind cost, feasibility, and variation in meal types; adding an educational component (ex: using My Plate to divide meals for a potluck). For Staff: Choosing the right recipe takes time and it is important to keep in mind: the amount of vegetable chopping needed; the amount of time it would take to make a total of 15 servings; the location in which the meal will be cooked and how it will be transported to PAMFRI; the possibility of reusing left over ingredients for future recipes; having one person cooking the main dish and someone else making the side dish is ideal. **Next Steps:** Apply the information learned through the group sessions to the ELITE Latinos Study; finalize menu for clinical trial based on pre-test results; make recipe book.

7. “The Built Environment: Using ArcGIS to Identify Physical Activity Resources for Children in Santa Clara County”

Kristopher Hart, H4A Fellow, 2015; Sandra Winter, PhD, MHA

Background: According to the 2008 Physical Activity Guidelines for Americans, children and adolescents should engage in 60 minutes or more of moderate to vigorous physical activity everyday. Among children, the factors in the neighborhood environment that affect physical activity are: Walkability, access/proximity to recreation facilities, traffic speed/volume, land-use mix, and residual density. In Santa Clara County (population = 1.8 million), 60% of middle and high school students do not attend daily physical education class and 44% do not engage in daily physical activity. Block groups with a higher level of socioeconomic status have shown a greater likelihood to have any type of physical activity facility. The lack of availability of facilities that enable and promote physical activity may, in part, add to the lower levels of activity seen among populations of low socioeconomic status and minority backgrounds. **Objectives:** Learn and apply ArcGIS, a geographic information system, to illustrate the distribution of physical activity resources throughout Santa Clara County; create a data set of all the physical activity facilities in Santa Clara County (categorized as Free, Subsidized, and Fee-based facilities); geocode the addresses of the data into ArcGIS, and onto a map of Santa Clara County; incorporate map layers of population density and median household income (to represent socioeconomic status) into the mapping data to see patterns of distribution for physical activity resources throughout the county; calculate the geographical distance to the nearest facility (free or fee-based) to identify areas with the fewest local resources. **Methods:** Attended ArcGIS training classes at Stanford Branner

Library; gathered data for physical activity facilities from Business Analyst and major company websites. Plotted and categorized physical activity facilities in 3 categories: Free (parks and schools), Subsidized (community centers, YMCAs), Fee-based (commercial gyms, yoga studios, golf courses); used 2010 Census data from ESRI for population density and US schools and parks; used 2010 median household income data from the National Historical Geographic Information System (NHGIS) to measure socioeconomic status throughout the county. **Results + Reflections:** Santa Clara County: The most densely populated tracts in Santa Clara County are in the northwest part of the county, i.e. West San Jose and Sunnyvale. The income distribution is often highest in tracts bordering densely populated areas, and often lowest in tracts with the highest population density. Free Physical Activity Facilities: Over half of the parks are located in areas where the median income is between \$75,000 - \$130,000. There are fewer parks in the densely populated tracts of low median income (less than \$75,000), than in the less populated tracts. The most populated tracts in the county are all within 2 miles of a free facility (not including schools). Subsidized Facilities: There is a disproportionately low (less than 1/3) amount of total subsidized facilities in the tracts with the lowest median household income (below \$75,000). Fee-based Facilities: The majority of the fee-based facilities (more than half) are in the middle category of household income (\$75,000-130,000). The fee-based facilities are more concentrated in the areas of high population, compared to free facilities, throughout the county. However, there are some densely populated areas (such as West San Jose) where the closest fee-based facility is 1-5 miles.

Next Steps and Future Directions: Incorporate new layers of data onto the maps, including data on other associations between the neighborhood environment and physical activity among children, such as walkability and traffic speed/volume; incorporate demographic information to see the availability of physical activity resources for populations of minority backgrounds; compare access to the closest physical activity resource with body mass index rates in Santa Clara County. Most of the data used (median household income, parks, schools) are from national datasets, and could be used for mapping the accessibility of free physical activity facilities throughout the US. **Limitations:** ArcGIS software is not compatible with Apple products; some of the parks crossed into tracts with different median household income (only counted for one in table); eight fee-based facilities were unable to be geocoded into ArcGIS and into the maps; limited data on Business Analyst for independently owned physical activity facilities in Santa Clara County; unable to acquire a list of schools in Santa Clara County that participate in the Joint Use Agreement program, and instead mapped all schools in the county.

8. The Culinary (Health) Literacy Project: Salt & Beyond

Where Delicious Meets Health: Chefs Cultivating Flavor Profiles in a Post-Salt Era

Sue Kim MD, MS, H4A Fellow, 2015,

Christopher Gardner PhD, Stanford Prevention Research Center

Background: The Health Issue: Hypertension (“high blood pressure”) is a chronic condition increasingly common among U.S. adults with 2/3 now affected with related condition: 1/3 adults with documented hypertension; additional 1/3 with “pre-hypertension”. Causes are multifactorial but excess dietary sodium/salt intake is

contributor in many individuals. Restaurant dining is major source of dietary sodium for many Americans. The Need: Restaurant dining continues to rise among the American public despite slow-food campaigns. Fast-casual and full-service dining is increasingly popular, with fast food dining on the decline. Fast-casual and full-service restaurants provide menu items with the highest sodium-density, averaging 2,090 mg sodium/1,000 calories in sit-down restaurants vs. 1,848 mg sodium/1,000 calories in fast-food restaurants and 1,500/1,000 calories for processed store-bought foods. The Barriers: Conventional, well-founded public health initiatives have been less than successful due to lack of comprehensive approach. Varying perceptions regarding assigning responsibility related to sodium intake and health factor of food (individual vs. industry vs. government) hampers large-scale efforts, and lack of comprehensive approach in community challenges individual efforts. Restaurateurs and culinary community are not typically included in the dialogue around food and health, and standard culinary training and culture are not currently designed to provide adequate knowledge and skills. **Objectives:** We utilized a Design-Thinking (Chef-driven) approach to confront the issue of excessive use of sodium in the fast-casual restaurant setting. Our objectives were three-fold: to increase awareness and interest among a Chef/culinary community (employed by partner corporate dining service organization working on-site at local technology firm) about the relationship between excess dietary sodium/salt and adverse health outcomes; to impart knowledge and familiarity with popular “medical diets” such as the “Dietary Approaches to Stop Hypertension” (“DASH”) Diet and the Mediterranean Diet as part of the management of health conditions related to high blood pressure and associated diagnoses; to review common sources of sodium in foods, condiments, and the food/restaurant industries generally; to gain a better understanding of the issues and barriers that have worked to hinder prior initiatives in this domain; to have Chefs able to talk and work through those barriers in a collaborative setting; to inspire Chef participants to pursue, develop, & propagate “culinary (health) literacy” about the use of sodium in food preparation techniques; to have Chefs better able to “eyeball” condiment quantities in relation to sodium content as it pertains to “nourishment factor” of foods; to cultivate inherent creativity of Chefs through exploration of alternative food preparation techniques and flavor profile expansion “beyond salt (sodium)”. **Methods:** The Community Partners: Bay Area Corporate Dining Organization, Silicon Valley-Based Technology Firm. The Study Population: Chefs employed by partnered corporate dining organization currently working at onsite restaurants owned by partnered local technology firm. Study Design: pilot study using a convenience sample from onsite Chefs (n=13). Recalls (Chefs): 24-hour dietary recalls; Recipe recalls. Surveys: Assess sodium utilization via “top 5” condiments; assess baseline knowledge of sodium + health + culinary sources. Kick Off focus session: introduce study; determine areas of interest and gaps in knowledge about sodium. Information Session: sodium & health; sources of sodium in the culinary kitchen. Workshop: experiment with flavor enhancement techniques that “spare sodium”; work through common low-sodium pitfalls. Participant-driven activities: additional Chef-initiated workshops; Iron Chef ® style competition. Recent Recalls & Surveys: 24-hour dietary, condiment, & recipe recalls. **Early Results, Key Learnings + Future Considerations:** Potential Strengths of Our Approach: utilizes Chef (participant)-driven approach to implement (public) health initiatives for health promotion in the culinary community; diminishes potential for suspicion and dismissive

mindset about efforts to optimize healthful factor of menu items (Chefs and in the public eye); low-maintenance approach may confer easily reproduced methods in other community settings. Seeking Out Sustainable Change: while bringing together leadership of large organizations under a shared commitment to health may require upfront investment of time and preparatory activities, one benefit may be the transfer of ownership of such initiatives from researchers to the organizations themselves--which may in turn result in profound changes to the larger corporate culture. **Future Directions:** If successful, our approach might be applied easily to other aspects of culinary technique (e.g. use of sugar and optimal use of fats, etc.) in a way that can be replicated and personalized to best suit the setting.

9. “Evaluations of a Meal Service Survey Completed by Head Start Staff and Parents in San Mateo County”

Nancy Lam, H4A Fellow, 2015

Background: San Mateo County’s Head Start programs are administered to 804 children by the Institute for Human and Social Development (IHSD). Their services include childcare centers, family care homes, and home-visit programs. IHSD also encourages parents and guardians to take part in classroom activities, make decisions on program content, review their child’s development, and play an active role in their child’s learning. Head Start programs encourage children to learn healthy eating habits, try new foods, and portion themselves through Head Start’s Family-Styled meal service, which fulfills the United States Department of Agriculture’s (USDA)’s Child and Adult Care Food Program (CACFP) meal pattern. Obesity among children in the United States age 2 to 5 years has decreased to 8.4% in 2011-2012. However, low-income children are still almost twice as likely to be obese as their middle/upper-income peers and, once established, childhood obesity typically persists and predicts many future health problems. Learning healthy eating habits is an important approach to preventing and improving childhood obesity. IHSD serves a population that is majority low-income and over 80% of Hispanic/Latino origin. **Primary Objectives:** Assess Head Start (HS) staff and parent/guardian attitudes and perceptions towards meal service given daily to HS students on site. Meal service provides 1/3 to 2/3 of the daily nutritional needs for each child depending on the length of the program. **Secondary Objectives:** Assess HS staff use of non-mandated Go, Glow, Grow nutrition curriculum, developed for preschoolers, in their classrooms. **Methods:** Help recruit HS parents/guardians to join or contribute feedback to a HS nutrition committee that aims to brainstorm revisions to the meal service survey created at IHSD. Meal service survey is designed to gather feedback about meal service and perspectives on meeting HS nutritional needs. Modify existing meal service survey: make more user friendly and quantifiable; add questions to meal service survey that measure staff use of Go, Glow, Grow curriculum. Distribute modified meal service surveys to parents/guardians and staff through internal mail. Convert collected paper survey results from a convenience sample of parents/guardians and staff into digital data: expected parent survey, N=160; expected group teacher survey, N= 13. Review and analyze the qualitative feedback provided by the parents/guardians and staff about the meal service: identify areas of potential improvement for future iterations of meal service implementation; compare qualitative feedback to prior themes found in past survey

results. **Key Learnings and Reflections:** Establishing credibility in a new organization takes a large time investment as one learns about the organization's structure and culture. Many of the comments from the latest meal service survey (e.g., adding more variety in fruit) are similar to the comments from the previous surveys and have been evaluated and discussed before, but options to respond are still limited due to budget/resource constraints. Comments from parents/guardians and staff suggest that some believe that food is geared to appeal more to adults rather than children. Novel meals added to the menu are an area that can be explored to see if there can be more balance in keeping foods kid-friendly and introducing new foods. The relatively high frequency of other mandated reviews, assessments, and documentation in IHSD may contribute to a significant respondent burden that fatigues staff and parents, which may make it more difficult to get high-quality responses on the meal service survey. Many survey answers were incomplete but the majority of the teachers report using the Go, Glow, Grow curriculum and encouraged children to try new foods and form healthy habits. **Limitations:** The small convenience sample of Head Start parents surveyed may not be a representative reflection of the entire population of families served. Barriers found in data collection include: respondent burden and fatigue among staff, incomplete data results from surveys, limited time/resources available to put towards quality survey gathering. Cannot make any statistical inferences from the survey data due to answer omissions in data and small, non-random sample of parents, guardians and staff that completed the survey without error. Parent/guardian surveys with errors & omissions N=20/159. Teacher surveys with errors & omissions N=2/13. **Next Steps and Future Directions:** Discuss what IHSD can respond to from comments from staff and parents/guardians; explore what proposed changes in CACFP required meal pattern could mean for possible foods that could be provided and reimbursed for IHSD children during meal service; work with meal service vendor to see how meals can be tailored to pair along with Go, Glow, Grow curriculum; research options to bring meal service survey online to make it easier for parents/guardians and staff to fill out completely and consistently. Easing the survey-taking process and bringing it online will help to gather better quality data to make more valid conclusions from the collected data; conduct focus groups or more key informant interviews on effectiveness of Go, Glow, Grow curriculum in a Head Start setting or integrating with meal service.

10. “Leading Change: A Community Based Model of Physical Activity Health Behavior Outcomes and Motivational Assets for Theory Based School Health Improvement Programming – Needs Assessment and Process Design”

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Background: 70% of elementary age youth do not meet national physical activity health recommendations in King County, WA. 95% of US youth regularly meet within the behavior setting of schools where policies mediate health interventions and the amount and type of physical activity. Psychological mediators (e.g. motivational assets) present within the social environment of a particular behavior setting could influence health

outcomes and the etiology of physical disease. A need exists for measuring organizational readiness as a determinant of health behavior change outcomes. **Objectives:** To what extent do organizational need and motivational assets of key site-based decision makers influence the development, adoption, implementation, and monitoring of healthier physical activity policies and practices? Develop a user friendly, low cost, evidence-based school health and wellbeing needs assessment tailored to the unique behavior setting of a school and its decision makers. Increase rates of self-assessment and monitoring of physical activity at the school site while honoring motivational assets and readiness to change. Create an impetus for school community health and wellbeing changes amongst key decision makers. **School-Centered Methods:** 1. Established school as co-investigator: school developed initial tailored advisory wellness committee of both in-person and online participants. 2. Designed, built and analyzed online evidence-based organizational needs assessment survey of physical activity health behaviors, practices, and policies. 3. Tailored and built online motivational assets to change health behavior survey and issued to community-defined key decision makers. 4. Analyzed Intent and Readiness to Act Measure on proposed site-selected physical activity health behavior improvement targets. **Reflection on Process Design:** Development: Building Trust, Online Communication, Tailored Approaches. Adoption: Multi-level Organizational Involvement Respectful of Organizational Mission, Continued Tailoring of Survey Design. Implementation: Adoption and Understanding of Organizational Mission and Personal Story Potentially Influences Decisional Interest to Implement. **Results:** 80% Faculty Staff Scoring 4.0 or Higher on Readiness to Change; 64% of Faculty Staff Ready to Change, prioritize Employee Health as Organizational Health Behavior Improvement Target; Raising levels of Perceived Threat on Principles of Healthy Living may raise total organizational readiness and organizational physical activity percent meeting recommendations. **Next Steps and Future Directions:** Develop and run Relative Risk Markov Simulation to complement results of organizational needs assessment survey tools. Re-measure and analyze motivational assets (particular interest in raising levels of perceived threat), intent and readiness to act of organizational decision makers prior to implementing organizational health behavior intervention. Qualify Evidence-Based Healthy Lifestyle Programming for Professional Continuing Education Units for Educators; incorporate biometric screening option. Examine inter-relationship and potential effects of healthy lifestyle programming/professional development for school decision makers regarding: organizational obesogenic behaviors, biometrics, health benefit expenditures and self-reported measures of wellness. Examine under which motivational conditions (e.g. social climate), settings (e.g. public vs. private), and for whom (e.g., racial/ethnic and/or socioeconomic groups) are school policy strategies and health improvement programs more likely to be effective in changing obesogenic behaviors as they exist within the organizational climate of schools. Continue learning and pursuing vision of professional teaching staff and schools as motivated agents of change in improving community health.

11. “Dejar de Fumar con Twitter (Quit smoking with Twitter)”

Christina McFadden, MS, H4A Fellow, 2015, Ricardo F. Muñoz PhD,
Connie Pechmann, MS, MBA, PhD, Marily Oppedo, MS, RD, PhD,
Lisa Goldman Rosas, PhD, MPH, Judith Prochaska, PhD, MPH

Background: 1 in 8 Latino adults smokes cigarettes. Smoking is the largest preventable cause of disease and premature death in the US. 49% of Latino cell phone users access social media on their phones vs. 36% of Non-Latino Whites. 68% of Latinos speak English only at home (11% increase since 2000). 17.3% of Latino men smoke and 7% of Latino women smoke. **Objectives:** Work with experts and community leaders for input to develop and implement a bilingual quit-smoking intervention using cell phones and social media with adult Latinos in Santa Clara and San Mateo counties. This intervention will set-up a private Twitter group and provide daily tweets supporting the efforts to be smoke free while the participants also encourage each other. **Methods:** Institutional Review Board (IRB) - Apply for IRB with Stanford and follow up on subsequent modifications (December 2014 – ongoing); Discipline Team Meetings - Meet with experts from various academic backgrounds including marketing, psychology, nutrition, epidemiology, statistics, online messaging, and prevention research for input on developing the study (February 2015 – March 2015); Materials development - Consent forms, flyers, questions for community leader interviews, focus group questionnaire and moderator guide (February 2015 – ongoing); Website Development - Meet with third-party vendor for website planning (April 2015 – ongoing); Community Outreach - Meet with community members for guidance on how to reach out to Latino smokers who want to quit (May 2015 – ongoing); Focus Group Training - Attend facilitation training on leading focus groups (May 2015); Interviews with Community Leaders - Gather community expertise for the focus groups and intervention (May 2015); Media Plan - Gather a list of media outlets and social media advertising reaching Latinos in Santa Clara and San Jose counties (May 2015); Community Meeting Locations - Schedule meeting spaces with community partners to host focus groups (May 2015 – June 2015). **Intervention Timeline: Study Start up:** Institutional Review Board > Discipline Team Meetings > Materials Created > Community Outreach and Partners > Focus Group Training > Community Leader Interviews > Media Plan > Focus Groups > Online Message Testing > Intervention. **Latinos and Social Media:** “[E]ven my Dad has Facebook!”- Community Leaders Interviews; “I am from a small town in Mexico and everyone knows everyone. We don’t have a newspaper but we have a Facebook page and this is like our newspaper. All the events are posted. There are active members of the community who post. My parents love to visit the Facebook page so they can see what is happening back in our town.” - Community Leaders Interviews; “Texting is the newer way to communicate, we don’t use a phone anymore. I come from a traditional Mexican family and we use texting more than phones. We are not super tech savvy but we use all this technology. Instead of reading a book, some of us prefer Facebook or Instagram.” - Community Leaders Interviews; “Someone said [on Facebook] that if my uncle gets 10,000 votes he will quit smoking and he did. So he quit. I liked it and I am a not even friends with whoever posted it.” - Community Leaders Interviews. Who Uses Social Networking Sites (USA): 73% Black/Non-Latino; 79% Latino; 72% White/Non-Latino

Next Steps: Focus Groups - Host 2-4 bilingual focus groups to gather input on how to support adult Latino smokers to quit; Online Messages - Develop and test online messages that will be sent to study participants to support quit-smoking efforts; Intervention - 100 day intervention with three randomized groups of 20 adult Latinos using group text to support each other in their efforts to be smoke free.

12. “Views from Job-Seeking Unemployed Tobacco Users in the Bay Area: A Photovoice Adaptation Project”

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Background: State and national surveys indicate smoking and unemployment are associated. Job-seeking unemployed Californians have the highest smoking prevalence (21%) relative to the non-job-seeking unemployed (16%), and the employed (15%). Photovoice is an innovative approach to community-based participatory research (CBPR). It is a data collection process where participants take photographs and share corresponding narratives. Photovoice has been successful in providing a platform for participants to communicate their experiences, stories and views about their community, especially for participants with limited power. In CBPR, Photovoice can be used to give community members the opportunity to shape and develop the study intervention. **Project Aims:** To implement a Photovoice adaptation data collection method to inform an intervention for a community-based participatory research project focused on job-seeking unemployed tobacco users in the San Francisco Bay Area. **Methods:** Participants were recruited from the San Francisco Employment Development Department after completing a larger study on tobacco and job seeking. Participants consented to this project and were asked to take 27-30 photographs related to their use of tobacco and job seeking for one week using a study-provided disposable camera or their own personal smart phone. 20 prompts were provided for structure. Examples included asking participants to take pictures of: “Triggers to use tobacco (e.g., cigarettes, e-cigarettes, chew, cigars)”; “What could or does inspire you to want to quit using tobacco”; “What in your environment has help/hindered you in finding work”. Photo release consent forms were provided to participants in case they wanted to take a photo of another person. Participants were asked to review the photos and provide audio-record narratives, which will be coded to uncover themes. **Results:** Participant Recruitment: 8 male participants were enrolled from May 13th to June 3rd 2015. Demographics: 6 African Americans, 2 Caucasians; Ages 48-63. Participant Retention/Project Progress: 4 returned disposable cameras and are scheduled to provide narratives. 2 reported taking photos but have not turned anything in. 1 dropped out of the study due to personal life events. 1 provided unreliable contact information and has been unreachable. Photo Results: The 4 participants who returned cameras took a total of 55 legible photos. 36 additional photos did not develop most likely due to the participants improperly using the flash. The legible photos were categorized into themes. 33 photos captured tobacco related content; the most popular subject was littered cigarette butts (n= 16). Fewer photos captured job-seeking content, although narratives could reveal that more photos were related. Themes from Participant Photos: Commute; People and Pets; SF EDD; Education; Worksites; Portraits of Smoking; Personal Tobacco; Littered Packs; Littered Cigarettes;

Miscellaneous (miscellaneous category included: a Smoke Shop; a Coffee Shop; a Coca Cola Ad; a Religious Statue; Ghirardelli Square; and a Night Club). **Next Steps & Future Directions:** Continue recruitment (n=10); extend timeline for taking photos to 2 weeks; Collect and code audio-recorded narrative data to uncover themes. Invite participants to present their photos and narratives to the Community Advisory Board for the intervention study. Incorporate participant photographs into intervention study website. **Reflections & Limitations:** Combining passions for photography and community-based participatory research was both insightful and rewarding. Participants were enthusiastic about sharing their world through photography. Disposable cameras require more training on using flash and special developing centers. The participants enrolled into this project as of June 4th 2015 have all been male, chronically unemployed, and mostly all African American. It would be ideal to enroll a more representative sample.

13. “Health Communication Project: Focus on Aspirin”

Nazanin Naghshineh, Pharm D, H4A Fellow, 2015, Randall S. Stafford, MD, PhD

Background: Preventing cardiovascular diseases (CVD) and cancer are two of the major public health priorities in the world. Given the beneficial effects of aspirin in the secondary prevention of major vascular events, the question was asked whether this inexpensive drug could prevent the first heart attack or stroke as well as cancer. The Council on Aspirin for Health and Prevention (CAHP), organized by Altarum Institute (a public health non-profit), serves as a forum for scientific review and guidelines development in order to activate aspirin counseling practices aimed at broader appropriate use of aspirin and disseminate evidence-based guidelines related to appropriate use of aspirin through presentations and publications for health care providers and the public. Good health communication is a major part of a successful healthcare system, but it is most often not well addressed. The US Preventive Services Task Force (USPSTF) works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. The next USPSTF recommendations on aspirin use will likely be released in 2016. **Objectives:** Work with CAHP to fulfill the following objectives: increase knowledge about the safety and risk of aspirin use for primary prevention of cardiovascular disease as well as cancer; increase the communication between patients and primary care providers about aspirin use, through enhancement of an existing CAHP website (aspirinproject.org) and other methods; and disseminate evidence-based guidelines related to appropriate use of aspirin through publications for healthcare providers and the public. **Methods:** Overall methods focused on literature search for impactful articles on aspirin and cancer prevention that were reviewed and summarized. After revision based on CAHP member review, prepared final version of article summaries for placement on aspirinproject.org. For a provider audience, prepared draft of 3 page Aspirin and Cancer Prevention Fact Sheet based on article summaries and overall literature review. Prepared a simplified webpage version of the Fact Sheet content aimed at providers. Developed a Fact Sheet with graphics for consumers at 10th grade reading level, and prepared a simplified webpage version for consumers. Following revisions after CAHP review, placed webpages and Fact Sheets on aspirinproject.org. **Results & Reflections:** Aspirin Benefit in Cancer Prevention Fact

Sheet, Aspirinproject.org. Aspirin and Cancer Prevention: Cancer killed close to 590,000 Americans in 2014, accounting for 1 in 4 deaths. While aspirin reduces the risk of developing heart attacks in men and strokes in women, this inexpensive medication also shows promise to prevent certain cancers. Cancer cases are expected to increase by 57% worldwide in the next 20 years. Half of all cancers are preventable and could be avoided by fully implementing current guideline-based recommendations; Simple strategies for lowering the risk of heart disease also help prevent many types of cancer. New efforts are required to put this knowledge into practice. Aspirin and cancer: The benefits of aspirin in secondary prevention of heart attacks are well documented. Individuals at high risk for a first heart attack or stroke benefit as well. New evidence suggests that aspirin is also useful in cancer prevention. While the evidence for aspirin is strongest for prevention of colorectal cancer, the benefits of aspirin appear to apply to other types of cancer. Scientific data to support cancer prevention by aspirin come from: clinical trials of aspirin originally conducted to study heart disease and stroke prevention, including long term follow-up after trial completion; clinical trials of aspirin in pre-cancerous conditions, such as polyps in the colon; clinical trials of aspirin in patients with familial cancer syndromes, such as Lynch syndrome; long-term observational studies of aspirin use in populations; and case-control studies of specific cancer types. Mechanisms proposed for the action of aspirin in cancer prevention: Blocking inflammation: inflammation is a normal response to tissue injury or infection that helps clear infection or helps heal injured tissue. Over time, however, chronic inflammation can cause DNA mutations and promote tumor development and growth. Aspirin reduces chronic inflammation and the production of inflammatory proteins (prostaglandins) that may promote cancer. Inhibiting platelet function: platelets can promote cancer spread by shielding cancer cells from the immune system. Aspirin may interfere with platelets' shielding effect and make cancer cells less likely to metastasize. Aspirin Benefits: aspirin reduces some cancers by 18% overall. Aspirin may be especially effective in preventing colorectal cancer, prostate cancer, breast cancer, melanoma, and ovarian cancer. Aspirin and cancer prevention: What's the evidence? Data from several clinical trials whose primary endpoints were vascular events, shows that aspirin taken daily for 4 or more years was associated with an 18% reduction in overall cancer deaths. This risk reduction was due mainly to fewer cancer deaths among participants who took aspirin for at least 5 years. Long term follow-up of a large aspirin clinical trial showed a 20% reduction in risk of colorectal cancer over extended follow-up. Long-term follow-up of patients with a hereditary cancer syndrome (Lynch) showed a 30-40% reduction in risk of new cancers over extended follow-up. Long-term daily aspirin use (≥ 325 mg/day for ≥ 5 years) is associated with reduced incidence of colorectal cancer compared with non-users. Clinical trials using 75-325 mg per day of aspirin for 3 years reduced the risk of recurrence of precancerous colorectal polyps by 17%. The use of aspirin for 5 years or longer reduced the incidence and mortality of colorectal cancer by 30%-40% after 20 years of follow-up. Use of a daily low dose aspirin lowers the risk of ovarian cancer by about 20%. A 2014 study found that women who took aspirin on a regular basis reduced their risk of developing melanoma by 21%. Mounting evidence supports the use of aspirin for the primary prevention of certain cancers. Aspirin prescription should be based on careful evaluation of individual risk factors and potential harms from bleeding. Aspirin Prescribing: How to Decide: Universal use of aspirin is not recommended even in high-

risk populations. Aspirin has potential harms, especially the risk of bleeding. The decision to prescribe aspirin should be individualized. Before prescribing aspirin, consider the balance of potential benefits vs. potential harms and discuss this with your patient. Aspirin Harms: Excessive bleeding is the greatest potential harm from aspirin, including gastrointestinal bleeding and hemorrhagic stroke. These harms increase with age and are greater for men than women. Harms are more strongly related to dose than duration of aspirin use. In women and men without risk factors for gastrointestinal bleeding, the rate of excess serious bleeding associated with aspirin is as follows: Bleeding Events per 1,000 Person –Years: age 60-69: Women 1.2; Men 2.4; Age 70-79: Women: 1.8; Men 3.6; Age >79: Women: 3.0; Men 6.0. Aspirin dose and other factors affecting the impact of aspirin on cancer: actors that affect aspirin’s impact on cancer include: population characteristics, aspirin dose, and duration of use. Most studies have not seen a sizable difference in the benefits from aspirin between low-dose aspirin (e.g., 81 mg) and higher doses. Certain genetic and lifestyle factors impact the extent to which aspirin can reduce cancer risk or cancer progression, but these factors are still under investigation. In addition to the population characteristics, certain cancer subtypes may show greater potential benefit from aspirin. For example, in colorectal cancer patients, aspirin treatment was particularly effective in patients with overexpression of tumor COX-2 (an enzyme that triggers inflammation). The benefits of aspirin in cancer prevention increase with duration of use. Aspirin should be considered for those at high risk of colorectal cancer. New US Preventive Services Task Force (USPSTF) recommendations on aspirin use will likely be released in 2016 (updating their 2009 guidelines). Until new guidelines are available, it may be appropriate to consider aspirin’s cancer prevention benefits, particularly in patients who are at very high risk for colorectal cancer and who are at moderate-high risk for a first heart attack or stroke who are not already taking aspirin. There is a strong positive relationship between the healthcare team member’s communications skills and the patient’s capacity to follow through with the recommendations. (www.Healthcarecomm.org) Strengthening health professionals’ knowledge and training in this field is essential to the success of delivery of patient-centered care. **Next Steps & Future Directions:** In order to find the best way to communicate healthcare issues to the public, there must be some pilot programs in place. One of our objectives in the future is to test ad-like messages in public locations such as medical clinics.

14. “Perceptions About Hard-To-Reach Residents and Collective Impact Partnership in San Francisco’s Tenderloin District”

Oriana Reyes, H4A Fellow 2015;
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Background: San Francisco’s Tenderloin District is home to more than 33,000 residents, and stands out as one of the city’s most densely populated and diverse neighborhoods. The physical environment includes a high density of single-room occupancy (SRO) hotels, supportive housing, and social services. Health disparities are well documented; geographic equity analysis reveals that the Tenderloin has the second highest rates of preventable hospitalizations and ER visits in San Francisco. In 2012, the San Francisco Department of Public Health, UCSF, and the city’s non-profit hospitals established a

formal collaboration with community residents and stakeholders to create a Community Health Improvement Plan for San Francisco (SFHIP). A complementary neighborhood-level initiative, the Tenderloin Health Improvement Partnership (Tenderloin HIP), was established in 2014. Both SFHIP and Tenderloin HIP are guided by a collective impact approach, where multi-sector partnerships are established to address complex social issues, such as health equity, through sustainable and effective collaboration between not-for-profit agencies, local government agencies, residents, community stakeholders, and private sector allies. The mission of Tenderloin HIP is to address the social determinants of health in order to decrease health disparities and inequities among residents of the Tenderloin. Tenderloin HIP is governed by a Community Advisory Committee (CAC), whose members represent the multiple sectors of the partnership. Support infrastructure is provided by the Saint Francis Foundation and Saint Francis Memorial Hospital's Community Benefit leadership staff. **Objectives:** Lacking institutional approval to survey Tenderloin residents directly, members of CAC representing direct-service organizations in the Tenderloin were identified as appropriate key informants with regard to HTR resident subpopulations. As a result of initial exploratory conversations with both the Vice President and Manager of Community Benefit at Saint Francis Memorial Hospital, the following research objectives were identified: 1. Primary objective: a) Identify the hard-to reach resident subpopulations in the Tenderloin through key informant interviews with CAC members. b) Identify major themes in CAC member responses to the question, "How can Tenderloin HIP improve outreach and preventive service utilization among HTR populations?" 2. Secondary objective: Identify major themes in CAC members' perspectives and attitudes regarding collective impact by performing major theme analyses of key informant interviews and quotes from CAC meetings. **Methods:** Key Informant Interviews (n = 7): The following organizations were represented: Boys & Girls Club of San Francisco (1 representative); Central City SRO Collaborative (1 representative); Curry Senior Center (1 representative); Mercy Housing (2 representatives); Reality House West, Inc. / Cadillac Hotel (2 representatives). Observed four CAC Meetings: January, February, April, & May 2015. **Results:** CAC member responses to the question, "Who are the hard-to-reach (HTR) resident subpopulations in the Tenderloin?" Responses (by category): Mental illness (n=5); Disabled/Special Needs (n=4); Substance Abuse/Drug Users/Alcohol users/Addiction (n=4); Residents who live in isolation (n=4); Immigration Status/Undocumented Immigrants (n=3); Seniors/Elderly (n=3); Residents with language barriers (n=3); Residents who do not trust (n=2); Residents who work long hours outside of the Tenderloin (n=2); Children/Families (n=1); Residents at borderline low-income levels who are disqualified from free services (n=1); Residents with criminal records (n=1). **Key Learnings:** Residents may be classified as "hard to reach" (HTR) for various reasons. There are multiple perspectives about how to define the Tenderloin's HTR subpopulations. Census data does not fully capture the complex demographics of the neighborhood. CAC member responses to the question, "How can Tenderloin HIP improve outreach and preventive service utilization among HTR populations?" Responses (by category): Tenderloin HIP as a communication hub/tool (n=3); Connection to residents (n=2); On-the-ground impact (n=2). Responses varied widely among CAC members. Responses were consistently focused on CAC members' perspectives and attitudes regarding Tenderloin HIP and collective impact. Due to the non-repetitiveness of responses, major theme analysis was not conducted.

Select quotes from CAC members: “[Our organization} surveyed 500 of our residents, and their comments mirrored conversations in Tenderloin HIP [CAC]. There is a major fear of displacement, which causes people to retreat when they should really be engaged. We have to figure this out.” “As a group, we need to figure out what our connections are to residents.” “I’m here to make sure that we are not doing things on paper, but that we actually reach the grassroots folks on the ground.” **Limitations:** Sampling method: convenience; Small sample size (n = 7). Key informant interviews were conducted in a conversational manner, without strict adherence to a script. As a result, question phrasing and prompts may have varied, contributing to response variation. Responses observed during CAC meetings also lacked uniform prompts. Key informant interviews and CAC meetings were documented and recorded by hand; no recording devices were used. **Reflections:** Each CAC member/partner organization has unique relationships with different residents/community members/subpopulations. Each CAC member/organization performs a unique role within the community. Understanding each Tenderloin HIP partner’s community networks and their connection to residents, including hard-to-reach residents, can contribute valuable knowledge to the partnership and help to establish sustainable communication channels between residents and Tenderloin HIP. **Next Steps & Future Directions:** Evaluation: An independent health care & organizational consultant has been hired to develop an evaluation framework for Tenderloin HIP. Development of program measures and shared measurement systems is necessary for standardized data collection among all Tenderloin HIP partners. The evaluation framework is scheduled to be finalized in July 2016. Social Network Analysis & Mapping: Social networks are dynamic, and the Tenderloin HIP evaluation framework will seek to measure partner organization/stakeholders’ community network at baseline. By determining which aspects of partnerships are important to measure over time, changing partnership dynamics can be mapped for the benefit of effective collaboration. Mapping can be used to create a visual & conversational platform to share and analyze social networks within Tenderloin HIP.

15. “Improving the Peer Leader Program in a Suburban K-8 School in San Mateo County: A Needs Assessment”

Danielle Rossoni, H4A Fellow, 2015

Background: Recess in elementary school is important for physical activity, learning, and developing social skills. In schools around the country, principals report that increasing the number of staff to monitor recess would improve recess. A K-8 elementary school in San Mateo County has a program in which middle school students (6th-8th grade) have the opportunity to sign up as peer leaders. Peer leaders volunteer at least one day a week to eat lunch and spend recess playing with younger students. The Peer Leader Program has been through several iterations since its inception in 2009. It has operated through the student council or under the guidance of various administrators and staff. In its current iteration, the middle school principal directly oversees the Peer Leader Program. The administrators of this school value the program and decided it needs more attention in order to harness its potential. They wanted to know if the program was doing its part in getting all students engaged at recess (e.g. participating in games, talking with friends). I was tasked with assessing the needs of the program by locating potential areas

of improvement. **Objectives:** To determine the specific responsibilities of Peer Leaders and assess the program's accountability systems. To assess the needs and expectations of the Administration, Middle School Peer Leaders, and Yard Duty Monitors. To assess Peer Leader readiness to fulfill expectations of the Peer Leader Program. **Methods:** January 2015: Interview Administrators in charge of Peer Leaders about hopes and expectations for the Peer Leader Program, N=2. January 2015: Interview Staff on K-5th grade Yard Duty about expectations and observations of Peer Leaders (N=4, 40% of staff on K-5th grade yard duty). February 2015: Hold Focus Group meeting with selected group of Peer Leaders to assess how they understand their responsibilities (N=10, 29% of Peer Leaders). February 2015: Conduct Literature Review to create survey. March 2015: Administer survey to assess Peer Leaders' self-efficacy in fulfilling responsibilities with a survey (N=35, 100% of Peer Leaders). March 2015: Conduct Literature Review to determine effective methods to train Peer Leaders. April 2015: Conduct Training Sessions based on internal Social and Emotional Learning curriculum (N=2 training sessions). **Methods Timeline:** January 2015: Interview each Administrator individually; Interview each Yard Duty Monitor individually. February 2015: Hold Focus Group meeting with a Sample of Peer Leaders; Conduct Literature Review; create survey; March 2015: Administer Survey to Peer Leaders; Analyze results; Conduct Literature Review on effective methods to train Peer Leaders. April 2015: Conduct Training Sessions Peer Leaders with Administrator. May 2015: Conduct Follow Up Interviews with Administrators and Yard Duty Monitors. July 2015: Administrators take findings into account for future of Peer Leader Program. **Results + Reflections: Limitations:** Convenience sample for Focus Group; material used for training sessions comes from school materials and may not be applicable to other schools; no post survey administered following training sessions; responses were recorded by hand. I interviewed the Administrators and Yard Duty Monitors individually. In the Focus Group, I asked a questions and students would answer one by one around the table. **Reflections:** Administrator 1 talked mostly about the role of the Peer Leader during recess. Administrator 2 talked about their role during recess as well as traits he hoped Peer Leaders would develop as part of the program. The Yard Duty Monitor for 2nd and 3rd grade is in charge of most of the equipment and organizes many of the recess activities. She had the most to say about how Peer Leaders could be helpful and could improve. The survey was designed to measure how confident middle school students felt in carrying out tasks outlined by the administrators in their interviews. I received guidance on the survey from an administrator and an H4A faculty member. On average, students scored between 8 and 10 on each question, with 10 being most confident. The lowest scored items, on average, were brainstorming activities (8.7), identifying students often in conflict (8.7), and resolving conflict (8.8). **Next Steps and Future Directions:** As suggested by the survey, the Peer Leaders feel ready and confident in meeting the expectations outlined by the administrators in charge of the program. During follow up with Yard Duty Monitors, it became clear that the problem to be resolved was not Peer Leaders' knowledge or preparedness, but in ensuring Peer Leaders showed up to their assigned places. There was also a lack of communication between the administrators and Yard Duty Monitors. At the conclusion of my internship, I brainstormed with one of the administrators regarding ways to foster accountability in the Peer Leader Program and increase communication between administrators, Yard Duty Monitors, and Peer Leaders.

We came up with an hours card that the Peer Leaders would be responsible for getting signed by the Yard Duty Monitor for their assigned area. At the end of the trimester, the Peer Leaders would turn this in to the Administrator to get credit for community service hours. The Peer Leader program is still going through changes, and my findings and suggestions will be presented in the all-staff meeting that launches the next school year.

16. “Tweet4Wellness: Message Testing to Build a Physical Activity Social Media Intervention”

Kathleen Yang, H4A Fellow, 2015; Marily Oppezzo, PhD, MS, RD;
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Background: Social media platforms allow users to communicate peer-to-peer, providing virtual social support in real time. Research is needed to inform best practices for advancing health in virtual communities via smart and connected technologies. Tweet4Wellness will measure the effectiveness of social support in promoting physical activity through a partnership with the Stanford Women’s Heart Health Clinic. Eligible participants will be randomly assigned to private Twitter groups to receive daily automated tweets to encourage group sharing, discussions, and goal setting. Seeded tweets will alternate between 3 literature-based, theory-driven categories: implementation intention guidance, mindfulness prompts, and emotional support. Message testing is needed to identify relevant, compelling, response-generating tweets. **Objectives:** Twitter Content Research: Observe current Twitter content related to Tweet4Wellness (physical activity, wellness, women support) to help formulate tweets for message testing. Tweet Message Testing Survey: Assess feedback on potential tweets/texts that will be used in the study to optimize message effectiveness. **Methods:** Twitter Content Research: Explored Twitter platform through searching various terms related to Tweet4Wellness (physical activity, women, mindfulness, exercise, support); narrowed to 4 search terms, capturing the category types the auto-messages in Tweet4Wellness will embody along with the study’s primary aim; from the 4 search terms: “women health support”, “exercise goals”, “mindfulness”, and “exercise buddy”, the 10 most recent tweets were recorded from the top 5 accounts relevant to the study. These tweets were then exclusively coded as promotional, informational, referral, sharing, motivational, or irrelevant; tweets were coded independently by another coder to attain interrater reliability. Tweet Message Testing Survey: Formulated ~100 tweets based on three category types informed by behavior change literature: implementation intention, mindfulness, and emotional support. Designed message testing surveys with Qualtrics and coded scales to evaluate the tweets’ impact. Participants assessed messages by answering four questions: Likert scale questions: How likely would you be to respond to this text message? How relevant is this message to you? How likely would you be to benefit from responding to this message or hearing others’ responses to this message? (for Mindfulness and Emotional Support) How likely would you be to follow through with this action statement? (for Implementation Intention) and open-ended question “Why or why not?” Administered four versions of the message testing survey with a) Stanford’s Heart Health Fair participants, b) patients in waiting room at the Stanford Women’s Heart Health Clinic, c) research team’s social network, and d) Stanford’s Research Registry; applied results from each survey iteration to inform modifications.

Used means from survey ratings as well as open-ended responses from survey versions 1-3 to edit and guide final message testing survey. **Key Learnings:** Tweet Content Research: Twitter platform does not offer a lot of personalized emotional support in regards to health behavior change, specifically to increase physical activity and wellness; majority of health related content is related to promoting a service or product and sharing of informational facts and articles; most health related tweets do not seed discussions amongst followers. Message Testing Surveys: survey building is an iterative process requiring time and high attention to detail; survey participants respond more positively when taking survey with researcher close by. Common positive feedback on messages: daily messages serve as a good reminder to maintain healthy lifestyle; messages hold participants accountable to their goals; hearing others' responses will be valuable; good way to try something new. Common criticism on messages: message is too wordy or confusing; message request is too constraining; messages that involve sharing a goal or experience with another person can be difficult since not everyone has a friend physically present; message request is too time confining; message requires long answer; message is too abstract and cheesy. Overall Takeaways: keep messages concise and tasks easy to do; allow participants flexibility in goal setting for the day; have group members serve as accountability partners rather than involving outside people; make messages practical and relevant. **Next Steps + Reflections:** Administer final message testing survey to Stanford Research Registry; analyze quantitative data by calculating and assessing means; edit and finalize messages for launch of Tweet4Wellness; assess effectiveness of messages during Tweet4Wellness. **Reflections:** Will be interesting to see how participants respond to the different theory driven messages; will be great to find a positive effect on improving wellness through common, cost-effective platforms of communication (texting, social media).

17. “What are the Obstacles to Providing Intensive Behavioral Therapy for Obesity in a Primary Care Setting?”

A Needs Assessment Based on Research and One-on-One Interviews”

Charles Young, Health 4 All Fellow 2015

Background: On March 6, 2012, Medicare began coverage of Intensive Behavioral Therapy for Obesity (Obesity IBT) and waived coinsurance and the Medicare Part B deductible. The Centers for Medicare and Medicaid Services (CMS) began reimbursing primary care providers for Obesity IBT based on the recommendation of the United States Preventive Medicine Task Force (USPSTF), which evaluated the evidence base for obesity screening and counseling. In its coverage determination, CMS noted that the Centers for Disease Control (CDC) had reported that “obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States.” To be eligible for coverage, CMS requires that patients must have a body mass index (BMI) greater than or equal to 30. According to CMS, Obesity IBT must be provided by a primary care practitioner in a primary care setting. CMS requires patients to lose at least 3 kilograms of weight during the first six months of services. Patients who do not achieve this minimum weight loss must wait six more months before resuming services. CMS defines Obesity IBT as: 1) Screening for obesity; 2) Completing a dietary assessment; and 3) “Intensive” counseling that should follow the “5 A’s” framework. In

2002, the Agency for Healthcare Research and Quality (AHRQ) began promoting the 5 A's framework based on the recommendation of the USPSTF Counseling and Behavioral Interventions Work Group, whose purpose was to adapt "existing USPSTF methods to issues and challenges raised by behavioral counseling intervention topical reviews." The work group concluded that the 5 A's framework was useful for organizing research findings on behavioral counseling interventions for many types of risky behaviors. The 5 A's are also taught to primary care practitioners in regular and continuing medical education as a framework for providing behavioral interventions. The 5 A's Framework: Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods; Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits; Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior; Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance and support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment. The 5 A's framework was originally proposed by the Canadian Task Force on Preventive Health Care as a variation on the National Cancer Institute's 4 A's tobacco cessation intervention model. On January 1, 2014, the Accountable Care Act began to mandate that commercial insurance plans also cover evidence-based preventive services, including preventive counseling for obesity, with no out-of-pocket costs for patients. Under the Affordable Care Act, all medical plans that do not hold "grandfathered" status must offer preventive care services. States accepting federal funds to expand Medicaid coverage must also offer such services to patients who didn't qualify previously for Medicaid. While it became law in 2010, the Affordable Care Act was not fully implemented until January 1, 2014. **Objectives:** Objective #1: Identify the obstacles to implementing Obesity IBT, including those that are specific to practices with certain characteristics, such as specialty type or location. Objective #2: Determine areas of future exploration that might be of interest to providers who are attempting to overcome the obstacles to providing Obesity IBT in their primary care clinics. **Methods:** Searched publicly available information to determine the current number of patients receiving Obesity IBT relative to the number of patients eligible for Obesity IBT; compiled a list of obstacles based on previously conducted one-on-one interviews with 17 primary care practitioners and 7 clinic office managers. The primary care practitioners were based in Brooklyn, NY; Manhattan, NY; Dallas, TX (3), Austin, TX (2), El Paso, TX (2), Albuquerque, NM; Monterey, CA (2), Chicago, IL; Cleveland, OH; Yuma, AZ; Hayward, CA; and Stockton, CA. The managers were based in Dallas (2), Austin, El Paso, Albuquerque, and Monterey (2). Conducted a literature search to acquire insight into the prevalence and characteristics of each type of obstacle as well as to identify additional obstacles that were not mentioned during the one-on-one interviews. The practitioners were selected based on their willingness to be interviewed at either a medical conference or during a visit to their clinic. Depending on the amount of time each practitioner could make available, the length of the interviews varied from less than five minutes to over one hour. The focal point of the interviews was to assess the

practitioner's attitude toward offering Obesity IBT and clarify what obstacles they saw to offering services in their clinic. When an obstacle was mentioned that had not been mentioned in a previous interview, it was noted. **Participation in Obesity IBT:** According to the Congressional Budget Office, 52 million Americans were enrolled in Medicare in 2013 and 85% were seniors over 65 years of age. CMS estimates that approximately 30% of those seniors are obese—over 13 million people. In 2013, approximately 50,000 of those 13 million Medicare patients received at least one session of Obesity IBT. Furthermore, according to the CodeMap® database, the Medicare billing code for Obesity IBT was only billed 159,493 times in 2013. This represents a small fraction of the services that theoretically could have been rendered. The National Center for Health Statistics estimated 36.4% of American men between 65 and 74 years of age were obese between 2009 and 2012 and 44.2% of American women between 65 and 74 years of age were obese between 2009 and 2012. Data on the number of obese private insurance patients who are receiving preventive counseling for obesity was not available. Medicare Patients Receiving Obesity IBT Services in 2013: 50,000. Eligible for Obesity IBT Services: 13,000,000. **Results and Reflections:** Obstacles to Obesity IBT: Facility constraints, including cost of space, waiting times and limited hours of operation; services are primarily provided in primary care offices, and the cost of clinic space varies widely by city. In 2014, the cost per square foot for medical office space was only \$13.75 in Boise, Idaho. In Manhattan, it was \$59.30. The use of space in a primary care clinic can also have a high opportunity cost. Rental rates are much lower than physician office visit rates. Retail clinics may offer less travel time and more convenient hours to some patients, but waiting times can still be long. Physician time constraints and pressure to focus on urgent medical concerns: “Estimates suggest that a primary care physician would spend 21.7 hours per day to provide all recommended acute, chronic, and preventive care for a panel of 2,500 patients.” “Doctors have too many other competing priorities, and Medicare beneficiaries have so many other medical problems that obesity tracks down to last on the priority list.” Low patient compliance and a lack of patient awareness of eligibility: “Patients with higher BMIs self-report less willingness to adhere to general healthcare requests/recommendations than patients with lower BMIs.” CMS does not publicize the availability of Obesity IBT services other than a listing in the handbook that is mailed to Medicare beneficiaries each year. **Possible Areas of Future Exploration:** The development of protocols for physicians seeking to maximize patient participation in Obesity IBT is a possible area of future exploration. A physician who has established primary care clinics in areas where medical office lease rates are relatively high suggested providing Obesity IBT on nights and weekends. This idea could be explored as an option for clinics that lack the space to provide services during regular hours. CMS specifically allows the use of auxiliary staff to provide Obesity IBT; the use of auxiliary staff to support time-constrained practitioners is a possible area of future exploration. CMS allows for the “general supervision” of auxiliary staff under its new Chronic Care Management for primary care providers. A similar approach (which does not require space in the clinic because the provider does not need to be in the same location as auxiliary staff) might also be an interesting area of future exploration.

18. “Julian Street Inn: Smoke-Free Facility Needs Assessment, First-Person Timelines, and Adverse Childhood Experiences”

Saya Yusa, H4A Fellow, 2015; Patricia Dolan, Program Director, Julian Street Inn

Background: Homelessness in the Bay Area: Around 26,000 individuals become homeless every year in the South Bay. Silicon Valley’s latest tech boom has caused rents to soar. According to the latest Silicon Valley Index, the area now has the fifth-largest homeless population in the country. InnVision Shelter Network - Julian Street Inn (JSI): JSI provides interim shelter and services for 71 homeless adults seeking mental health stability. JSI provides case management, housing and job assistance, and other “Beyond the Bed” services to enable clients to become self sufficient in the long term. Literature Review: Conducted literature review for Plans 1 through 3, especially on Adverse Childhood Experiences (ACE). **Objectives:** Plan 1 (January-March 2015): Assist transitioning of JSI into a smoke-free facility by assessing attitudes about this transition, as well as understanding the services that may benefit a smooth transition. Plan 2 (April 2015): Address the stereotypes of homeless individuals by having clients tell their own story. Plan 3 (May 2015): Test the hypothesis that JSI clients have a high prevalence of childhood trauma by administering the Adverse Childhood Experiences (ACE) test. **Methods:** Plan 1 (January-March): Create and distribute a needs assessment survey to the JSI clients (n=43). The survey asked clients questions about past smoking behaviors and possible resources that may be beneficial for smoking cessation. Plan 2 (April): Have clients (n = 10) create timelines of the events that were important in their lives. Plan 3 (May): Administer the ACE test to clients (n=2). The ACE study, which was first conducted in 1985 by Dr. Vincent Felitti, found a strong relationship between childhood experiences and multiple risk factors for adult health. **Results + Reflections: Key Learnings:** Smoking Cessation: When asked “What resources would you need to quit smoking for good?” some clients responded that they would need a change in environment (e.g., a “stress free” environment). Childhood Trauma: Some clients identified a childhood trauma to be a “significant event” in their lives. This was observed in the first-person timelines and the ACE tests of JSI clients. Compassion: When administering the ACE test to two clients, it was evident that this test could possibly trigger clients to remember past traumatic events. Even though a research project may have positive benefits in the long run, it is important to realize the direct impact that a study may have on its participants. **Next Steps + Future Directions:** Smoking Cessation: Some JSI residents may benefit from smoking cessation interventions that focus on environmental stress relief. Resilience: A useful follow-up for clients with high ACE scores may be to work on resilience and positive thinking. ACE in Medicine: The prevention and treatment of ACE factors may have the potential to play a huge role in preventive medicine in the near future.