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A Guide for Planning & Reporting Community Benefit

2022 Edition

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Chapter Five: Planning and Implementing Community Benefit Programs

5

Chapter Five: Planning and Implementing Community Benefit Programs

The needs assessment and the planning and implementation of community benefit programs should be as rigorous and visible as for any other strategic initiative.

To effectively address the most pressing health needs of your community, your organization will need systematic approaches to work with public health and other community partners to assess and prioritize community health needs and to develop community benefit programs that address those priorities.

The importance of CHNA and planning was reinforced by the Affordable Care Act of 2010 (ACA). The law added requirements for tax-exempt hospitals to conduct CHNAs and to adopt implementation strategies to meet the community health needs identified through the assessments.

The needs assessment and the planning and implementation of community health improvement programs are dependent on effective engagement with community members and groups. This requires building trust over time, understanding the local history and culture, being truly present in the community, and respecting strengths and assets within the community. Community engagement means being in rather than looking at the community. Doing with rather than trying to do for. Asking, learning and listening, not telling.

EQUITY NOTE

- Work with community groups and members to understand the history of discrimination and structural racism in the community.
- Assess current partnerships for diversity and whether they include cross-sector organizations and persons who experience disparities and discrimination.
- Assess and address any barriers to community engagement, such as past negative experiences with the organization and other trust issues.
- Hold meetings and conduct activities at times and places convenient to the community, and provide transportation and childcare if needed.

In Section 5.1, *Assess Needs and Assets*, you will learn how to do the following:

Guideline 1: Plan and prepare for the assessment.
Guideline 2: Define the community.
Guideline 3: Identify data that describes the health needs of the community.
Guideline 4: Understand and interpret the data.
Guideline 5: Define and validate priorities.
Guideline 6: Document and communicate results.

In Section 5.2, *Develop an Implementation Strategy*, you will learn how to do the following:

Guideline 1: Plan and prepare for the implementation strategy (also known as a community benefit plan).
Guideline 2: Develop and prioritize intervention options.
Guideline 3: Select interventions.
Guideline 4: Develop a written implementation strategy.
Guideline 5: Adopt the implementation strategy.
Guideline 6: Update and sustain the implementation strategy.

In Section 5.3, *Develop and Implement Program Plans*, you will learn how to do the following:

Guideline 1: Develop program plans.
Guideline 2: Determine implementation readiness.
Guideline 3: Develop a management plan.
Guideline 4: Promote the program.
Guideline 5: Put plans into action.
Guideline 6: Monitor and evaluate progress.
Guideline 7: Sustain the program.

SECTION 5.1

ASSESS NEEDS AND ASSETS

A CHNA is a systematic *process* involving the community that identifies and analyzes community health needs and assets to plan and act upon priority community health needs. This process results in a *product:* a report used to plan community benefit activities.

This section will cover the basic steps of conducting a CHNA, including how to prepare for the assessment, how to collect and analyze data, how to prioritize identified health needs, and how to document and share the results of the assessment.

CHA RESOURCE ON ASSESSMENT AND PLANNING

While this chapter provides an overview of the CHNA and community benefit planning, please refer to the CHA's resource *Assessing and Addressing Community Health Needs* for a comprehensive look at these processes. This resource can be accessed on the CHA website at https://www.chausa.org/communitybenefit.

Federal law and laws in many states require tax-exempt hospitals to conduct periodic CHNAs and adopt plans to meet assessed needs, so be sure to review all federal and state requirements.

To comply with federal tax-exemption requirements in the ACA, a tax-exempt hospital facility must:

- Conduct a CHNA at least every three years. The assessment must do the following:
  - Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
  - Be made widely available to the public.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA and describe needs that are not being addressed with the reasons why such needs are not being addressed.

Check the Compliance/Public Policy section of CHA's community benefit website (https://www.chausa.org/communitybenefit) for federal regulations and instructions and a description of state requirements.

EQUITY NOTE

- Gather data using culturally appropriate tools and methodologies that consider factors such as the population's language needs, literacy levels and trust of institutions.
- Collect and analyze data on health outcomes and risk behaviors and other factors impacting health by income, disability status, geography, and race and ethnicity.
- Involve community members in collecting and analyzing assessment information.
- Make assessment findings available to community members and groups who experience disparities and request their feedback. Make sure to report back on actions taken and outcomes.

Guideline 1
Plan and prepare for the assessment

The success of your organization's assessment will depend upon proper planning, which includes securing the right resources and engaging key stakeholders.

The following actions will lay the foundation for the assessment.

Form an assessment team. Select a hospital staff person to lead the assessment effort or to be the hospital's lead in a community-led process. Ideally, the individual chosen to lead this process should have knowledge of state and federal hospital assessment requirements as well as the hospital's current community benefit portfolio. They should also be aware of any health system-level assessment requirements that must be met as part of their local process. The duties of the staff leader can include forming an internal team, working with community groups and public health experts, developing a plan and a budget for the assessment, and communicating progress and results to internal and external stakeholders.

The internal team should be staffed with people from departments across the organization, including strategic planning, communications, admissions, finance, emergency, community relations, social services, population health management and clinical areas. To be responsive to the diversity of your community, also include the diversity and inclusion officer, translation services, and community health workers or *promotoras*.

Also invite community members, public health department representatives and other community partners to join the team. These team members will bring key skills (planning, analysis, communications) and knowledge of the community to the assessment process. A community-inclusive process can foster alignment with external stakeholders, promote common goals and objectives, encourage data sharing, and elevate opportunities for joint investment during the implementation phase.

Plan for community engagement. If the assessment will not be a community partnership effort (which is preferred), involve members of the community and representatives from public health at the beginning of the CHNA process. Many hospitals that have an internal assessment team also use an external advisory committee that includes community stakeholders and representatives of organizations knowledgeable about community health issues to provide guidance on the process. Make sure to include persons from vulnerable or minority populations to ensure that the assessment is sensitive to cultural and other issues of importance to these groups.

CONSIDERATIONS FOR RURAL AND CRITICAL ACCESS HOSPITALS

Critical Access Hospitals can face additional challenges when engaging community members as participants or soliciting input for their CHNAs. The geographic isolation of residents being served, as well as limited hospital capacity to reach and engage people, can present a significant barrier to the process.

Given these challenges, local nonprofits, communities of faith, Federally Qualified Health Centers, Community Action Agencies and government entities serving rural populations can become important partners in the planning process. External partners often have greater access to rural populations and may have locally sourced data that the local hospital does not.

Critical Access Hospitals serve many diverse communities, including Indigenous populations, migrants and communities of faith, some of whom may adhere to traditions of self-reliance. Soliciting input from people for whom tradition or travel barriers restrict engagement may not be possible or, at best, may be limited. Reference any specific efforts undertaken to solicit this input in the CHNA even if these efforts were unsuccessful or limited.

Engage the hospital board and executive leadership. Involve your organization's executive leaders and board members from the beginning of the assessment process. Their advice and approval will be needed in the prioritization process. Their support is needed to integrate assessment findings into the organization's strategic and operational plans as well as to secure sufficient resources for the assessment and community benefit programs.

Determine purpose of the CHNA. Identify all the reasons why you are doing the assessment to help define the scope of the assessment, particularly the community and indicators to be assessed. The primary purpose of doing a CHNA is to improve community health. Central to this purpose is helping the hospital and broader community identify local areas with the greatest need, in which vulnerable populations, including communities of color, marginalized groups and those in rural areas, can face significant barriers to achieving health equity and well-being.

Related purposes include community-based or hospital strategic planning, gathering information for grant applications, or to fulfill tax-exemption requirements and other obligations, such as achieving nurse "magnet" status or receiving the Malcolm Baldrige National Quality Award.

Determine how the CHNA will be conducted. Decide if your organization will conduct the assessment on its own or in collaboration with others and whether outside consultation will be needed. Under ideal circumstances, the assessment will be approached as a partnership with other hospitals, community groups, and public health and other public agencies, but this approach may not be feasible for all hospitals. Choose the approach consistent with your organization's and community's goals, resources and capabilities.

If you contract out the assessment, be careful not to miss important opportunities for building relationships and gaining insights. Many health care organizations discover that community assessment is about developing relationships and partnerships as much as it is about uncovering health needs. The assessment process can be used to develop consensus about problems and priorities and to gain the commitment of organizations to work together. In short, the process can be as important as the product.

IRS NOTE

IRS

IRS regulations allow unrelated hospitals and other organizations (such as state or local public health departments) that identically define their communities to prepare a joint CHNA and a joint implementation strategy. Further, the regulations allow hospitals that have overlapping but not identical communities to jointly prepare parts of their CHNAs, providing guidance that should be followed by such hospitals in such cases. Treas. Reg. §§ 1.501(r)-3(b)(6)(v) and 1.501(r)-3(c)(4).

Begin with a team orientation. When convening the assessment team — whether internal or external — begin the process with a brief orientation so participants understand what a CHNA is, why it is required and how it will be used in the hospital's community benefit function.

This is also a good time to review existing community benefit programming and previous assessment material, along with any community feedback. Both staff and community members should be informed of existing community investments and how these investments continue to fulfill a significant community need.

Identify and obtain available resources. Explore what resources are needed and available for the assessment. Make sure to look at both organizational and community resources. Organizational resources may include previous CHNAs or other information on the community collected by the strategic planning office. Also, seek out staff with degrees in public health who are interested in population health and who can help with various aspects of the assessment.

Community resources may include existing assessments or coalitions concerned with community health improvement. Reach out to organizations already conducting or planning an assessment that would be willing to partner with your hospital or share results.

Develop a preliminary timeline. Develop a reasonable timeline to conduct the assessment. The timeline will be dependent on the approach selected, the size of your hospital and its community, the number of partners involved, and the availability of required resources.

Identify the internal hospital board or committee that will have responsibility for review and approval of the CHNA as well as the group's projected meeting schedule. Not all internal boards or committees meet on a monthly basis. When possible, the timeline should specify a date when the CHNA will be available for review. That date should align with the approving entity's meeting schedule.

Note: For hospitals operating on a calendar year basis, it it is very important to remember that, often, meeting dates, times and sometimes agendas can be subject to change during the end-of-year holidays.

Guideline 2
Define the community

The community is the geographic area, priority populations and the range of issues that will be examined by the needs assessment. You may use the previous needs assessment as a guide in defining the community of the current assessment, or you may decide to change the definition. For example, you may expand the geographic area covered or focus on a smaller at-risk area or vulnerable populations.

AGREE ON THE DEFINITION OF COMMUNITY

If the assessment is being conducted with other organizations, it is important to agree on the definition of the community to be assessed or to agree on how to proceed if there are differences.

In defining your community, you should consider your hospital's:

- Primary service area.
- Secondary service area.
- Patient categories (e.g., general population, children only or rehabilitation only).

For all non-specialty hospitals, the assessment should begin by looking at the overall community. After the broad view, the assessment can focus on priority geographic areas or populations. In the case of specialty hospitals, the community may be a subset of the population (e.g., children or those with a specific disease or condition). A specialty hospital's CHNA may focus exclusively on these populations.

Priority areas and populations may extend beyond your hospital's traditional service boundaries:

- Areas and populations served by your hospital's community benefit programs.
- Neighborhoods and other geographic areas that:
  - Have at-risk populations.
  - Have limited access to health care resources or professionals.
  - Have been impacted by adverse social, economic or environmental factors, such as high unemployment, unsafe housing, failing schools or the presence of high levels of toxic materials.

- Populations that are commonly considered to be at risk, such as:
  - Homeless individuals and families.
  - Low-income seniors.
  - Children and pregnant women.
  - Immigrants and migrant workers.
  - Members of ethnic or minority groups.
  - Uninsured and underinsured persons.
  - Persons with certain disabilities or medical conditions.
  - Members of the LGBTQIA+ community.
  - Veterans.

Your organization's CHNA should examine both health issues and risk factors for the geographic areas and populations covered by the assessment. It should also consider social, economic and environmental conditions that influence health (such as high unemployment rates, low graduation rates, the accessibility of healthy food, unsafe housing, and the presence of persistent toxic materials). These are commonly known as the social determinants of health.

IRS

IRS NOTE

IRS regulations state that in defining the community, the hospital may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital, the target population(s) served and principal function. However, a hospital may not define its community to exclude medically underserved, low-income or minority populations who live in the geographic areas from which the hospital draws its patients (unless such populations are not part of the hospital's target patient population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital uses to define its community. In addition, in determining its patient populations for purposes of defining its community, a hospital must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital financial assistance policy. Treas. Reg. § 1.501(r)-3(b)(3).

Guideline 3
Identify data that describes the health needs of the community

Your CHNA process will use data to describe the health needs of your community. Needs can vary from specific adverse health outcomes (e.g., high incidence of asthma) to poor quality-of-life indicators (e.g., high poverty rates).

A significant amount of data can be found using existing public health data (secondary data), while other types of information require new data collection (primary data). Data are often classified as either quantitative or qualitative. Quantitative data are expressed in numbers and help answer the "what" question (what is the problem), while qualitative data are expressed in words and help understand or explain quantitative data by answering the "why" question (contributing factors).

Source: Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). Evidence-Based Public Health: A Fundamental Concept for Public Health Practice. (p. 106).

Many CHNA processes incorporate community surveys, focus groups and stakeholder sector meetings to solicit resident input. This data can be incorporated into the text of the CHNA and used to highlight resident opinions or perceptions about health or social determinant factors.

USE RELIABLE AND CURRENT DATA

To accurately understand and quantify the health and quality of life of your community, it is necessary to use data that is both reliable and current. Outdated data or data not collected properly may inaccurately describe your community.

Review and Evaluate Prior Assessments and Reports

Identify existing needs assessments and any reports focused on the general population and special populations, such as children, seniors and minorities in your community. In addition to internal documents, resources may be available from public health departments, nonprofit organizations such as your local United Way, universities or community organizations.

Even though existing needs assessments and reports may have been published by respected organizations, it is necessary to review and evaluate all data and conclusions for timeliness, validity and relevance to the scope of your CHNA.

Consider the following questions in your review:

- Who conducted the assessment or report, and which community organizations were involved?
- When was the report published? What time period does the data cover?
- What populations and subpopulations do the data describe?
- What data sources were used?
- What were the findings?
- How was the assessment or report used?
- Were any priority areas or populations excluded?

These questions will help you determine whether the information from previous assessments will be useful.

Each subsequent assessment should build upon the last one by tracking and trending indicators related to priority issues that your hospital is addressing, either alone or in partnership with others. This will help your hospital understand what impact its community benefit and collaborative efforts are having on the health needs that it has chosen to address.

While subsequent assessments should track current priorities, they should also take a step back and ensure that new needs are not missed.

Describe Community Demographics

To conduct a CHNA, it is necessary to understand the population characteristics of your community. Examples of demographic information include population size, age structure, racial and ethnic composition, population growth, and density.

The U.S. census is an important source of demographic information. Census QuickFacts (https://www.census.gov/quickfacts/fact/table/US/PST045221) provides county-level demographic information for all U.S. counties and compares county values to state values. Visit the website of the U.S. Census Bureau (https://www.census.gov/) to view a complete list of online data access tools that can be used to access census data. On that site, you can also sign up to receive recurring census updates as new demographic information is released.

Other census resources include Household Pulse Surveys. The Pulse Survey is a point-in-time survey tool that tracks community impact measures, such as employment, food access, housing instability, etc., that are key to understanding national and regional social determinants of health trends. The Census Bureau now sponsors free online tutorials to help individuals and organizations access and use the vast amounts of the Bureau's demographic data and charting.

Also check with your hospital administration or strategic planning office to see if it has purchased demographic files for market research or business planning purposes. It may be able to share this data with you for use in your needs assessment. The benefit of using demographic data from a third-party vendor is that it may be available at the zip code or census-tract level.

Select Indicators

Indicators are measurements that summarize the state of health and quality of life in your community. A broad set of health and quality-of-life indicators should be included in the CHNA.

Because each community is different, the indicator list you select for your community may differ from the indicator lists from other communities; however, there are certain categories of indicators that should be included in all assessments:

- Demographics and socioeconomic status.
- Access to health care, including access to behavioral health and dental service.
- Health status of the overall population and priority populations.
- Risk factor behaviors, including the social determinants of health.
- Maternal and child health.
- Infectious diseases.
- Social environment.
- Natural environment.
- Resources and assets.

See Appendix E for suggested indicators for each of these categories.

Consider the following when selecting indicators for your assessment:

- ***Standards and benchmarks*** – The Department of Health and Human Service's Healthy People initiative provides national disease prevention and health promotion targets spanning many topic areas. Many states and county health departments also have set specific community health improvement goals for their jurisdictions. Also consider how your community compares to traditional standards, such as federal poverty standards and alternate standards, such as benchmarks for a livable wage.

- ***Community and organizational needs and priorities*** – Perceived needs of the community should be a factor in the selection of indicators. Hospital needs or priorities may also influence which indicators you will select for the assessment. For example, a hospital with a large oncology program may want to look at the risk factors and incidence of cancer and access issues related to screening and treatment. A health care system might ask each of its hospitals to address a specific issue, such as violence, aging or homelessness, in addition to broader health needs.
- ***Quality and usability of data indicators*** – Indicator data should be valid and reliable for both the target population and for subgroups of interest. The indicator data should be easily accessible and updated regularly since multiple data points are necessary for analysis of trends and evaluation of interventions.

Identify Relevant Secondary Data

You will need to identify existing quantitative data that support the indicators you have selected. This data will help you better understand the size and seriousness of issues, as well as the trends, and summarize the health and quality of life of your community.

Begin your data-gathering efforts by reviewing trusted sources of secondary data. Information about the health status of the U.S. population at the state, county and zip code level is routinely collected by governmental and nongovernmental agencies through surveys and surveillance systems. Most of these secondary data sources will be accessible online. Hospital data is another important source of information about community health.

A note on data limitations: Population health and demographic data are often delayed in their release, so be sure to let readers know the exact time period for any given data source. Additionally, gaps and limitations persist in data systems for certain community health issues, such as mental health and substance use disorders, crime reporting, environmental health, and education outcomes.

You will need to revisit your indicator list after the available data sources have been identified and may need to add or remove indicators based on data availability.

National-Level Data

There are many national data sources that provide community health information. Examples of these sources include: the U.S. Census Bureau's American Community Survey; the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and the National Health and Nutrition Examination Survey; and the County Health Rankings model (https://www.countyhealthrankings.org).

State-Level data

State Health Data

Nearly every state public health department operates surveillance systems, disease reporting systems and behavioral health surveys. Additionally, almost all states have population-based cancer reporting systems. These sources often provide county- and, at times, municipal-level data. Contact your state health department to determine what survey and surveillance data are available.

State Vital Records

Vital records include birth certificates and death, marriage and divorce records. Because state law dictates vital records reporting, this information varies by state. Vital records can provide valuable information, including birth and death rates, causes of death, birth outcomes, and socioeconomic risk factors. Data is often available at the county level. Many state health departments provide vital record databases, which can be a valuable data source for your CHNA. If your state health department does not regularly release vital statistics data, you can use the CDC's Wonder dataset to explore rates for different causes of mortality at the state and county levels.

County and Other Local Data Sources

County and local public health departments collect data in varying degrees. Check your local public health agency websites to see what information is available.

There are many web-based data platforms that do a very good job of reporting county and sometimes local data that can highlight areas in which health disparities are significant. Community Commons is an excellent example, which can be accessed at https://www.communitycommons.org, as is the County Health Rankings and Roadmaps site, which can be accessed at https://www.countyhealthrankings.org.

Examples of local organizations and services that also conduct assessments and implement action plans:

- Head Start Agencies.
- Housing Assistance Programs, like the Coordinated Entry System.
- Federally Qualified Health Centers.
- City and county Public Health Departments.
- Area Agencies on Aging.
- Certified Community Behavioral Health Clinics.
- Food Access Organizations.

Local philanthropies, including the United Way, rely heavily on community data when directing investments or making grants. They can also be important strategic partners during the implementation phase following the assessment period. By aligning the use of common

data elements, these investment partners can work with the hospital to foster opportunities for shared measurement, evaluation and tracking impact.

United Way as a Data Source

- United Way publishes a state- and county-based index of financial insecurity data that targets low-wage, employed individuals. The index uses the acronym ALICE, which stands for Asset Limited, Income Constrained, Employed. State and local United Ways publish this community-based cost-of-living data on a biannual basis. For more information, check out state or local United Way websites or the United Way national website: https://unitedforalice.org/national-comparison.
- United Way also supports Call 211. Call 211 agencies are locally based resource and referral call centers located in communities throughout the United States. These call centers help individuals access local human service support and other resources. Call 211 centers aggregate and often publish their data. Besides being a good source for the CHNA, this data can help the assessment and implementation teams pinpoint problems in local resource capacity, including seasonal trends, when prioritizing local need.

Hospital Information

Whenever possible, hospital utilization data should be included in your CHNA. Your state hospital association or health department typically collects statewide data on hospital and emergency department utilization.

Within the hospital, quality assurance, medical records, strategic planning, marketing and business intelligence (decision support) departments are likely to have access to hospitalization and emergency visit utilization data for your facility.

This health care utilization data can highlight health problems in the community, particularly information about preventable hospitalizations and the need for increased primary or preventive health services and interventions.

Also review your organization's current community benefit and community health improvement activities. What needs are they addressing, and do the needs persist? Information about these needs should be factored into your CHNA as long as they reflect true community needs, regardless of whether they have been identified as issues by other data sources collected during the assessment.

PREVENTION QUALITY INDICATORS (PQIs)

The Agency for Healthcare Research and Quality (AHRQ) has set the standard for defining preventable causes of hospital admission. PQIs can be used to identify quality of care for ambulatory care sensitive conditions, which are defined by AHRQ as "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease." For more information on PQIs, visit https://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx.

Primary Care Data

Many primary care offices and networks use social determinants of health assessment screening tools as part of patient entry. Social needs screening helps ascertain if individual patients may be at higher medical risk because of income inequality, education, racial and ethnic disparities and other factors.

Tools that screen for social needs typically list between eight and 12 areas of need. This data can be de-identified, aggregated and stratified to help target specific areas of community need, such as food access, housing insecurity and lack of transportation, to inform the CHNA.

Collect Primary Data Through Community and Public Health Input and Feedback

Input obtained directly from community members, community groups and public health experts can be used to collect information about geographic areas or populations when such information is not available from secondary sources or to help explain findings from those sources. It also helps to determine the perceived needs of the community and the community assets available to address these needs. Collecting community input also allows you to directly connect with specific populations in your community, such as disadvantaged or minority populations, and to establish or strengthen relationships with partners. Data gathered directly by you or your assessment partners is considered primary data.

Here are a few examples of information you can collect:

- What health problems are most troubling to community members?
- What are issues of concern to public officials — school principals, emergency responders and the health department?
- Are any community-based organizations or community coalitions already addressing these issues?
- What factors may be contributing to health problems? These factors could be safety concerns, systemic racism, environmental or housing issues, and others.
- What do you think defines a healthy community?

Soliciting Input from Key Demographic Groups

Determine how and where you will capture the voice of low-income and marginalized populations. Ask faith and other leaders from these communities for suggestions as well as opportunities to solicit feedback. Avoid using input from nonprofit service providers or government agencies as a proxy for resident input.

Consider gathering resident input through a short neighbor-to-neighbor survey. Using this approach, the CHNA team can partner with a local church or trusted neighborhood entity to engage, train and deploy local volunteers to implement the survey with their friends and neighbors. This outreach approach can help the assessment team identify or affirm opportunities to impact issues. Remember to build any costs associated with this approach into the CHNA budget.

The needs of senior citizens and disabled populations should always be included in the CHNA process. Meet seniors and those with disabilities where they already congregate to solicit their input. Consider Programs of All-Inclusive Care for the Elderly (PACE), retiree groups, veterans' groups, faith communities or senior meal sites to ensure that the concerns and priorities of elders are solicited and heard. Consider community-based organizations serving the needs of the disabled community, again focusing on existing programs, job training and rehabilitation programs, along with services supporting disabled veterans and their families.

IRS

IRS NOTE

Provisions in the ACA require CHNAs conducted by tax-exempt hospitals to take into account "input from persons who represent the broad interest of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health."

IRS regulations indicate that to meet this requirement, the CHNA must, at a minimum, solicit and take into account input from all of the following sources:

1. At least one state, local, tribal or regional governmental public health department (or equivalent departments or agencies) with knowledge, information or expertise relevant to the health needs of that community.
2. Members of medically underserved, low-income and minority populations in the community served by the hospital facility or individuals or organizations serving or representing the interests of such populations. Medically underserved populations include populations experiencing health disparities or who are at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial or other barriers.
3. Written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.

In addition to the sources described above, the IRS regulations note that hospitals may solicit and take into account input received from a broad range of persons located in or serving its community, including health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

STATE AND LOCAL HEALTH DEPARTMENT PARTNERSHIPS

Many state and local health departments also conduct CHNAs to meet voluntary accreditation requirements. These agencies can be valuable resources and partners in all aspects of the hospital's or community coalition's CHNA, such as helping to design the assessment, collecting and analyzing data, and planning for collaborative action to improve community health.

There are a number of methods to collect community input and feedback. You will want to select at least one approach for collecting this information. Also select at least one method for collecting input from those with special knowledge or expertise in public health. Public health expertise may be available from your local or state health department, a university school of public health, or public health consulting groups, such as a public health institute. This will ensure you have not overlooked any community priorities and have met legislative requirements.

Surveys

Surveys are generally targeted to a larger population than interviews or focus groups. They can be used to collect information from community members, stakeholders, providers and public health experts for the purpose of understanding community perception of needs. Surveys can be administered in person, over the telephone or using a web-based program. Surveys can consist of both forced-choice and open-ended questions. Be aware that many under-resourced populations don't have access to computers, so tailor the type of survey to those in the community you want to hear from.

When using surveys or questionnaires, test the tool first with community members prior to posting or implementation. Is the tool easy to understand, and are unfamiliar terms clearly described? Are there questions that lead a reader to respond in a certain way? Will translation of the survey tool be necessary, and who will do this?

Once posted or implemented, continuously check incoming survey data to affirm that communities of color, ethnic groups and rural populations are responding in a manner that will result in a valid survey sample size. If not, identify ways to conduct the survey differently to improve the level of response.

Questionnaires

Questionnaires can be devised for the general community and for specific groups, such as those in homeless shelters or in clinics. Some hospitals and CHNA partnerships sample attendees at major events, such as health fairs and county fairs. Keep in mind, however, that results from these approaches may not be generalizable to the broader community.

Interviews

Key informant interviews are a method of obtaining one-on-one input from community members, leaders and public health experts. Interviews can be conducted in person or over the telephone.

In structured interviews, questions are prepared and standardized prior to the interview to ensure that consistent information is solicited on specific topics. In less-structured interviews, open-ended questions are asked to elicit a full range of responses.

Key informants may include leaders of community organizations, service providers and elected officials. Individuals with special knowledge or expertise in public health may include representatives from your state or local health department, faculty from schools of public health, and providers with a background in public health. Emergency responders can also identify unmet needs of vulnerable populations.

Also, consider interviews with staff from the hospital's emergency department and social services and discharge planning offices.

Community Forums

Community forums are meetings that provide opportunities for community members to provide their thoughts on community problems and service needs. Community forums can be targeted toward priority populations or involve the broader community. Community forums may require a skilled facilitator. It is recommended to hold these forums in the community and not at the hospital.

Focus Groups

Community focus groups are small-group discussions with selected individuals. A skilled moderator is needed to lead focus group discussions. Members of a focus group can include internal staff, the staff of human service and other community organizations, users of health services, and members of minority or disadvantaged populations.

TIPS FOR HOLDING FOCUS GROUPS AND FORUMS

- Be creative in reaching out to priority populations, and consider holding multiple events to attract these groups.
- Hold focus groups and forums at convenient times (after traditional work hours).
- Record the discussion. Ideally, take notes and use a voice recorder.
- Explore multiple points of view. Try not to let a single issue dominate the discussion.
- Clearly define the hospital's role. Set expectations about what the hospital or partnership conducting the assessment can and cannot do.
- Monitor the time, and use time efficiently.
- Use a skilled facilitator to moderate focus groups and forums. Look among your advisory group and hospital staff for a person with this skill set. If not available, you will find it is a good investment to hire someone with this skill set.
- Hold multiple sessions to ensure you are getting a broad set of viewpoints.
- Pay attention to the demographic profile of individuals participating. Consider gender, race, ethnicity, zip code and age, at a minimum. Do participants reflect community makeup?
- Budget for refreshments and, possibly, travel vouchers for focus groups if feasible. It can also be helpful to provide a stipend for participation.

Identify Community Assets

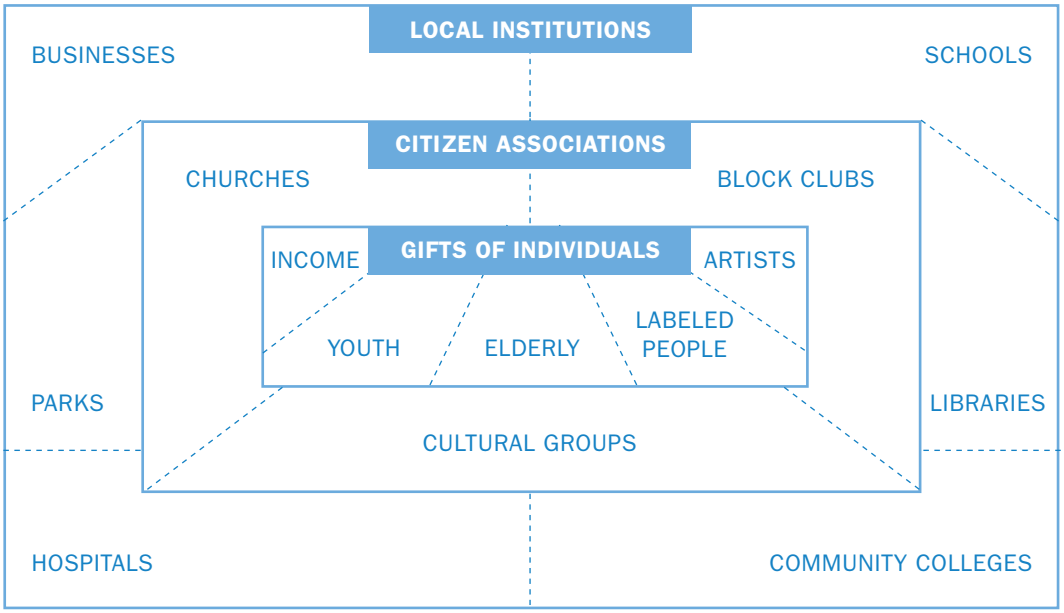
It is also important to receive input about community resources or assets that may be available to respond to the health needs of the community. Your community's assets include other providers, individual community members, local agencies, religious congregations, neighborhood associations and coalitions as well as public agencies. Assessing assets allows you to focus on the strengths of your community, including capacity, skills and the resources available to address identified needs.

IRS

IRS NOTE

IRS regulations indicate that hospitals should include in their CHNA documentation a description of the resources potentially available to address the significant health needs identified through the assessment. The IRS regulations also note that hospitals should solicit and take into account from persons representing the broad interests of the community in identifying these resources. See above for more details on IRS regulations related to what hospitals must do to meet the requirement to solicit and take into account this input.

The asset map below provides a framework from which to consider your community's assets. Consider including questions about community assets in your efforts to collect community input.



Source: Kretzman, J.P., & McKnight, J. (2004). Building communities from the inside out: A path toward finding a mobilizing a community's assets. Langara College.

Once you have collected asset information, it's often helpful to put it on a map. Asset mapping is a process intended to identify and then physically locate a community's strengths and resources. The process involves conducting an inventory that targets a community's human, cultural, economic and other infrastructure resources. This is typically done in a geographically defined area, such as a census tract, zip code, local neighborhood, school district or other geographical subset. Information is then mapped to both inform and support community decision-making.

Guideline 4
Understand and interpret the data

After you have gathered the indicator data and community input necessary to meet the scope of your assessment, you will analyze the information to identify health needs.

Analyze and Interpret the Indicator Data

There are several ways to consider and interpret the indicator data you have identified. Three methods for data analysis and interpretation are discussed below: comparisons, trends and benchmarks.

As you analyze the data, keep in mind that primary (original) and secondary (from other sources) data are reported in a variety of formats (counts, proportions and other types of measurements). It is critical to fully understand the measures reported to accurately interpret the data. Consider seeking someone with experience in epidemiology to assist you in analyzing and interpreting the data.

Comparisons

How does your community compare to other communities, your state, and the U.S.?

To monitor the health and well-being of a community, it is often desirable to compare an indicator from your community to that of another community. Moreover, it may be informative to compare a measure of disease from your community to the number of cases or rate of disease at the national level or state level.

Comparisons showing areas which your community is doing worse than other communities, the state value or the national value, may point to needs in your community that should be addressed. However, there are some conditions and risk factors present in all or most communities that may deserve attention, even if your community does not seem to be doing worse than others. These conditions include heart disease, stroke, obesity, diabetes and cancer. These conditions are often noted in national health improvement initiatives, such as Healthy People 2030, or are among the leading causes of death at the national level.

Trends

Is the indicator data increasing, decreasing or remaining the same over time?

To consider trends, you will need to have values for more than one time point. Often, secondary data sources publish data annually, which allows for the determination of trends.

Indicators that become more unfavorable over time may demonstrate priority needs in your community. Indicators showing no improvement despite efforts to address associated needs may also warrant attention, such as modifying interventions.

Benchmarks

Does the community meet benchmarks?

National benchmarks are standards against which something can be measured or judged. Examples of national benchmarks include Healthy People and the Environmental Protection Agency Air Quality Standards. If available, collect information about any state and local benchmarks. Consider how your community compares to these benchmarks for a variety of indicators.

Data platforms, such as the County Health Rankings and Road Maps (https://www.countyhealthrankings.org), integrate federal and state benchmark data into their reporting. County Health Rankings also include measures of health equity when verifiable data from government sources is available.

Indicators for which your community fails to meet benchmarks may demonstrate needs in your community.

Identify Disparities

When possible, data grouped by demographic factors such as race, ethnicity, language, gender, economic status and age should be evaluated to identify disparities. You will find that some areas or populations experience a greater burden of disease. Consider possible disparities among both geographic areas and subpopulations.

An issue may not appear to be a significant problem until you examine the incidence among groups. For example, maternal and infant mortality rates may not seem significant until you find there are much higher rates among African American mothers and babies when compared to other racial groups.

Identify and Understand Causal Factors

To understand why observed problems exist, consider social, environmental and physical factors that may be influencing the observed needs.

For example, the data may show that your community has a higher rate of obesity than neighboring communities. You can better understand the problem by looking at potential causal factors. For example:

- The density, availability or number of parks and community gardens.
- The availability of healthy food.
- Access to a built environment (sidewalks, bike or walking paths, pools, playgrounds and sports clubs) that increases physical activity.

Some neighborhoods have experienced years of environmental burdens due to racist zoning and land use policies that permitted factories, industrial plants, major transportation arteries and dumping sites to be located close by. As a result, many residents may have respiratory problems and cancers.

Understanding causal factors will allow you to better understand the problem and will enable you to identify opportunities for improvement.

Identify Major Community Health Needs

After analyzing your indicator data and taking into account community input, hospital information related to community need (including needs being met by existing community benefit programs and hospital utilization data) and other information, you will be able to identify and summarize the most important needs facing your community. These needs should be documented in a data summary.

Every indicator included in your assessment should not be included in this summary. Instead, the assessment team should select a manageable number of the most important needs. You may further refine this data summary during the CHNA priority-setting process.

Be as specific to your community as possible. While nationally we see heart disease, cancer, diabetes and behavioral health problems as top health issues, try to dig deeper into your assessment to the issues that might be specific to your community and the factors that contribute to these problems.

IRS

IRS NOTE

IRS regulations state that health needs include the requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as neighborhoods or populations experiencing health disparities). The regulations also note that these needs may include the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral and environmental factors that influence health in the community. Treas. Reg. § 1.501(r)-3(b)(4).

Guideline 5
Define and validate priorities

Your hospital and its partners probably will not have the resources to address all the community needs identified in the assessment. Therefore, it will be necessary to identify and prioritize the needs the hospital will address itself, the needs the hospital will address with others and the needs the hospital will refer to others.

The data summary developed during the data analysis process should help guide the prioritization process.

You may be part of two priority-setting processes: one that is led by a community coalition that sets community-wide priorities and another that is conducted by the hospital to identify priorities for the organization.

Alternatively, there may be one community-wide priority-setting process, and the hospital will select priorities from that process to address — either on its own or with partners.

It is important for the community's voice to be included in setting priorities. Include persons who represent the diversity of your community in terms of race, age, language and other factors to be sure the community being served has a say in the priorities selected.

IRS NOTE

IRS regulations state that input from persons representing the broad interests of the community should be taken into account in prioritizing significant health needs and identifying resources potentially available to address those health needs.

IRS

Determine Who Will be Involved in the Setting of Priorities

For most hospitals, an internal assessment team, the assessment advisory committee and key partners will conduct an initial review of data and identify preliminary priorities. Key partners might include public health officials, other service providers, and community members and leaders.

Priorities should be shared with the hospital board, executive leadership and others in the community for validation and consensus.

Establish Criteria for Priority Setting

Establish criteria for prioritizing the needs identified in the CHNA. You may wish to revisit the original purpose of the assessment and ensure that the criteria selected reflect your original purpose.

Examples of criteria that can be used include the following:

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

EXAMPLE OF CRITERIA FOR PRIORITY SETTING

One coalition considers six criteria when examining the county's leading health problems. Each criterion is ranked on a scale ranging from "completely disagree" to "completely agree":

1. The problem is greater in the county compared to the state or region.
2. We can reduce long-term cost to the community by addressing this problem.
3. We can create a major improvement in the quality of life by addressing this problem.
4. We can solve this problem.
5. We can do something about this problem with existing leadership and resources.
6. We can make progress on the problem in the short term.

Identify Priorities

There is not one generally accepted method for priority identification; instead, there are several processes that can be used to apply the criteria you established to determine priorities for action. You should choose the approach best suited to your organization.

Two commonly used prioritization methods are:

1. ***Ranking***: The priority-setting group is asked to rank identified needs with a numerical score based on the criteria established earlier.
2. ***Discussion and debate***: The needs identified in the data summary are discussed, and criteria (which can be weighted to assign greater importance to certain factors) are applied to these needs to identify priorities.

IRS NOTE

IRS regulations state that documentation of the CHNA should include a prioritized description of the significant health needs of the community along with a description of the process and criteria used in identifying those needs.

IRS

Validate Priorities

Once your priority-setting group has decided on initial priorities, it is necessary to validate the prioritized needs with community members and interested persons and organizations.

Describe the process used for setting priorities, and present conclusions to community groups, hospital executives and board leaders, key stakeholders, and individuals with expertise in public health to confirm that prioritization decisions are understood and supported by the community.

Also identify opportunities to share priorities with marginalized populations to solicit their input. Neighborhood associations, block clubs, senior citizen meal sites, social clubs, school and parent associations, and communities of faith can be important partners in this effort to obtain feedback on priorities.

VALIDATE PRIORITIES

"Validate means to confirm that the need that was identified is the need that should be addressed...Validation amounts to 'double checking,' or making sure that an identified need is the real need."

Source: McKenzie, J.F., Neiger, B.L., & Smeltzer, J.L. (2004). Planning, Implementing, and Evaluating Health Promotion Programs: A Primer. (4th Edition). (p. 95)

Reconciling Priorities

Needs identified as priorities in the priority-setting process may differ from the views of community members. For example, high rates of diabetes leading to poor health and death may be evident from a review of mortality and morbidity data, but community members may cite gang violence as the most pressing health problem, despite statistical evidence to the contrary.

This can be addressed using the following strategies:

- Addressing the community's concern first, building trust and buy-in from community members.
- Embarking on an educational campaign to raise awareness of the priority needs identified by the data.
- Addressing the problem clearly identified by public health data and the problem identified by community members.

The final list of validated priorities will serve as input for the implementation strategy development process described in the next section.

Guideline 6
Document and communicate results

The CHNA should be presented in a manner easily understandable and accessible to your community.

At a minimum, your hospital should develop an assessment report that includes the following as required by the IRS:

- **A definition of the community served by the hospital** and a description of how it was determined.
- **A description of the process and methods used to conduct the assessment.** The description must include the following:
    - A description of the data and other information used in the assessment, including citations on data sourcing and, if possible, the exact time period for any given data source.

- The methods of collecting and analyzing this data and information. In the case of data obtained from external source material, the report may cite the source material rather than describe the method of collecting the data.
- Any parties the hospital collaborated with to conduct the CHNA.
- All third parties the hospital contracted with to assist it in conducting the CHNA.

- **A description of how the hospital took into account input from persons who represent the broad interests of the community it serves.** The description must include:
  - A general summary of any input provided by such persons, including how and over what time such input was provided (e.g., whether through meetings, focus groups, interviews, surveys and written comments and between what approximate dates).
  - The names of any organizations providing input and a summary of the nature and extent of their input.
  - A description of the medically underserved, low-income and minority populations being represented by organizations or individuals that provide input. The regulations note that the report does not need to name or otherwise identify any specific individual providing input on the CHNA.
  - In the event a hospital solicits, but cannot obtain, input from a required source, the hospital's CHNA report must describe the hospital's efforts to solicit input from such source.
- **A prioritized description of the significant health needs of the community along with a description of the process and criteria used in identifying those needs.**
- **A description of resources potentially available to address the significant health needs identified through the CHNA.**
- **An evaluation of the impact of any actions that were taken since the hospital's previous CHNA to address the significant health needs identified in that previous CHNA.**

See a template of an assessment summary report on the CHA website at https://www.chausa.org/guideresources.

Share CHNA Results Widely

After you have summarized the assessment findings, you need to disseminate the information to appropriate groups and individuals. This would include the hospital's board and executive leadership, the assessment team, assessment partners, the local public health department, and others who contributed to the assessment or could use this information. As you share the CHNA information with your community members, be sure to use methods and language accessible to them.

See the list of community partners in Chapter 3, Guideline 5, for possible groups or people to include in the assessment distribution.

Most health care organizations have a communications department that coordinates all of the organization's communications efforts. A staff member from this department can be a valuable asset in helping to prepare assessment findings that are clearly understood and, when appropriate, tailored for specific key audiences. Often, your communications department will have worked with these user groups and will know the most effective ways to share the findings of your CHNA. Before releasing your assessment report, ask the communications department to check it for readability and identify any possible ideas that may need to be clarified or expanded upon.

As you share results with your local community:

- Consider developing an executive summary for community distribution.
- Identify opportunities to talk about the CHNA.
- Share copies of the CHNA at local libraries, as many people may not have access to the internet.
- Take advantage of the community's regular schedule of monthly meetings and events.
- Ask members of the CHNA committee for suggestions, and solicit their help.

IRS

IRS NOTE

Federal law states that a CHNA must be made "widely available to the public." IRS regulations state that this requirement is met when the hospital:

- Makes the report widely available on a website at least until the date the hospital has made widely available on a website its two subsequent CHNA reports.
- Makes a paper copy of the report available for public inspection upon request and without charge at the hospital at least until the date the hospital has made available for public inspection a paper copy of its two subsequent CHNA reports.

Refer to regulations for the definition of "widely available on a website."

DEVELOP AN IMPLEMENTATION STRATEGY

SECTION 5.2

An implementation strategy is the hospital's plan for addressing community health needs, including health needs prioritized in the CHNA and through other means.

IRS

IRS NOTE

Ways to demonstrate community need:

The instructions for IRS Form 990, Schedule H, state that community need may be demonstrated through the following:

- A CHNA developed or accessed by the organization.
- Documentation that demonstrates community need or a request from a public agency or community group as the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or programs.

This section focuses on how to develop your hospital's implementation strategy. Your hospital may also work with others in the community to develop community-wide strategies to address health needs. There are many public health texts and other references that provide excellent guidance for such community health planning.

See the CHA website for more information and references at https://www.chausa.org/guideresources.

The implementation strategy, like the CHNA, is a ***process*** that will result in a ***product***.

The process for developing an implementation strategy starts with assessing readiness to begin planning and securing the right resources. It then moves to developing goals and objectives and identifying indicators for addressing prioritized needs, evaluating and selecting approaches to meet those goals, and documenting the strategy. For the implementation strategy to be most effective, it should be integrated with community-wide health improvement plans and other hospital plans, such as the strategic and operations plans.

EQUITY NOTE

- Build on community strengths and assets, and value community expertise.
- Look at your existing programs: Are they addressing racial and ethnic disparities identified in the community?
- Develop implementation strategies collaboratively with community members who experience disparities, and get feedback from them to ensure services meet their stated needs.
- Consider factors that contribute to diverse populations' higher health risks and poorer outcomes, and revise implementation strategies if community demographics and circumstances change dramatically prior to the next assessment or planning cycle.

Guideline 1
Plan and prepare for the implementation strategy

Before you begin the process of developing or updating the implementation strategy, you should first assess your readiness to begin the process and form an implementation team to carry out the development of the strategy and oversee its implementation.

Assess Your Readiness to Develop the Implementation Strategy

Here are some questions to ask about your readiness to develop an implementation strategy:

- Does the organization have a sustainable community benefit infrastructure — adequate staffing, budget, policies and leadership commitment — to support the implementation strategy?

  See Chapter 3 for more information on key elements of a sustainable infrastructure.

- Has the CHNA been completed and priority issues identified and validated?
- Does the organization have relationships with community members and groups that include persons knowledgeable about the community and public health? This should include public health experts and persons or groups that represent priority populations.
- Has the organization reviewed all federal and state requirements for implementation strategies and community benefit planning?

Form the Implementation Strategy Team

Form a team (internal, external or combination) to oversee the development and implementation of the strategy.

Team Leader

As with the internal assessment team, one person should be selected to lead the effort to develop and oversee the execution of the implementation strategy.

Hospital staff who may be assigned responsibility to lead the implementation strategy team include:

- A senior leader responsible for community benefit.
- A community benefit or outreach program director or staff member.
- A mission director or staff member.
- Someone from the organization's strategic planning office.

Team Members

Consider including the following people on the implementation strategy team.

Hospital representatives:

- Staff responsible for overseeing and coordinating the hospital's community benefit efforts.
- Strategic planning staff.
- Population health management staff.
- Staff from finance to help with budget or resource issues.
- Staff from the diversity and inclusion office.

Others:

- People knowledgeable about the community, including representatives from community groups and representatives of the priority populations identified in the assessment.
- People with public health expertise, including public health officials and staff, faculty from schools of public health, or others with knowledge of public health.

If your hospital formed an assessment team to conduct the assessment, evaluate the team membership to determine who from that group should be asked to be part of the implementation strategy team and who should be added. If your hospital has an existing community benefit team that oversees the planning and implementation of the community benefit program, this team should be used as the basis to develop and update the implementation strategy.

Team Responsibilities

The implementation strategy team is responsible for carrying out key aspects of the strategy development, including:

- Reviewing and advising on budgets, timelines and other implementation details.
- Collecting information about existing assets and programs that the implementation strategy can build upon.
- Establishing and maintaining community partnerships and relationships.
- Identifying measurable outcomes when selecting interventions.
- Being a champion for the implementation strategy inside and outside the hospital.
- Ensuring there is community need data to support all interventions, avoiding any "pet projects."

Guideline 2
Develop and prioritize intervention options

Next, gather information on various interventions (also known as strategies or approaches) to address selected community health needs identified in the CHNA and through other means (noted at the start of this section).

EQUITY NOTE

Without an intentional focus on health equity in the strategy development process, strategies may unintentionally widen health inequities. Well-designed strategies can include supportive activities to address barriers or unintended consequences underserved populations may face during implementation. Such efforts can help ensure maximum impacts across communities experiencing health inequities. Consider these ideas to enhance strategy development efforts.

Balance community input and the best available evidence. Without community input, there can be challenges with strategy design, implementation and evaluation. Build in community ownership at the very beginning of this process to increase the effectiveness and sustainability of strategies.

Establish a process to ensure strategies are linked to identified inequities. Given the multiple factors involved in developing and implementing strategies, efforts can sometimes unintentionally shift away from identified population groups. Ensure strategies are aligned with desired outcomes by writing goals that incorporate identified inequities.

Select a comprehensive set of strategies. Consider selecting a comprehensive set of strategies that work together, as one strategy in isolation has limited reach and impact.

Account for the diversity within the community. Understand the diversity within your community (e.g., age, disability status, geographic area, race and ethnicity, sexual orientation, socioeconomic status). Subpopulations may have different needs that should be considered and accounted for in strategy selection, design and implementation.

Understand Selected Health Needs and Their Causes

The implementation strategy team should review the selected community health needs identified during the assessment process to better understand their root causes.

To identify root causes linked to need, ask what the contributing factors are to the problem:

- Is the problem related to access to needed health services or resources? Are services available but not when and where they can be accessed by priority populations?
- Are public policies exacerbating the problem, such as a lack of environmental safeguards?
- Are there long-standing community norms, mindsets or attitudes that, while not policy based, represent barriers to change?
- What social, economic or environmental factors are at play, such as poverty, low-performing schools, racism, inadequate housing or other social determinants of health?

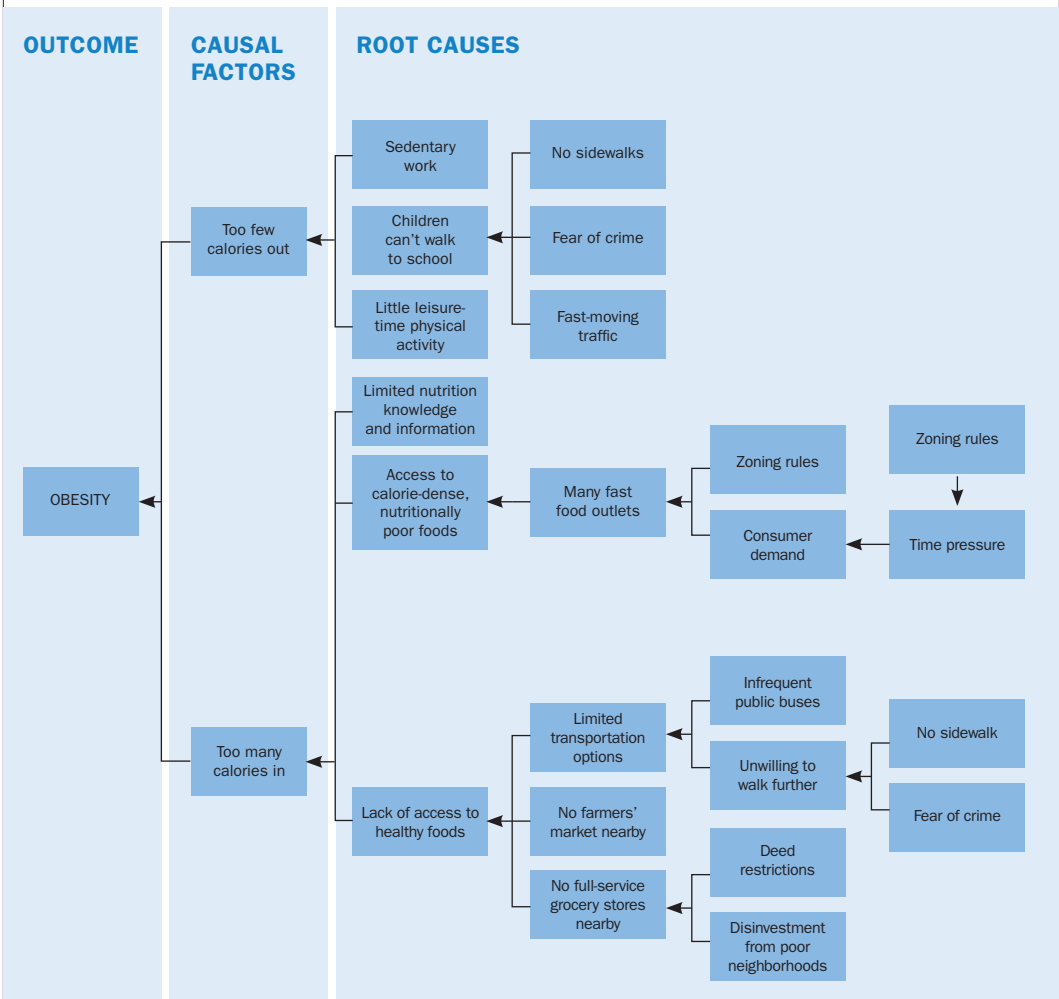
If sufficient data is not available from the assessment process to fully understand the problem, the implementation strategy team may need to collect additional information.

HEALTHY PEOPLE, IRS REGULATIONS AND THE SOCIAL DETERMINANTS OF HEALTH

The U.S. Department of Health and Human Services recognizes that individual and population health is influenced by the relationships between policymaking, social factors, health services, individual behavior, and biology and genetics. For this reason, it has chosen social determinants of health as one of its topics for Healthy People. To learn more, visit https://www.healthypeople.gov. IRS regulations also note that health needs identified in the CHNA may include ensuring adequate nutrition or addressing social, behavioral and environmental factors that influence health in the community.

ROOT CAUSE MAPPING

Health in All Policies: A Guide for State and Local Governments defines root cause mapping as "a structured process for identifying key factors contributing to community health problems, and can help identify methods for addressing these underlying factors and promoting improved outcomes. This method involves repeatedly asking 'Why?' to help people identify the 'causes of causes,' or the social determinants of the issues they seek to address." The process is helpful in identifying possible solutions that can affect the root causes of identified needs and the roles that various community partners can play. This can be useful in the beginning of a collaborative process because it can help people see the mutual benefits that could arise from working together. Below is an example of a root cause map for obesity.



Source: Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in All Policies: A Guide for State and Local Governments.* Washington, D.C., and Oakland, CA: American Public Health Association and Public Health Institute.

Consider Using a Collective Impact Framework

The complex economic, environmental and social problems that often underlie health needs in a community cannot be solved by one organization. As you develop a better understanding of the factors that are at the root of your community's health needs, consider how your organization might lead or be part of a collective impact approach to addressing those factors.

The collective impact framework is a structured form of collaboration that brings together different sectors to solve specific social problems. As defined by the Collective Impact Forum website, the framework has five elements:

1. **Common agenda** – A common understanding of the problem to be solved, agreed-upon goals for the initiative as a whole and a joint approach for taking agreed-upon action.
2. **Shared measurement** – Agreed-upon way to measure and report progress of the initiative. Shared measurement ensures that all efforts are aligned and supports accountability and continuous improvement.
3. **Mutually reinforcing activities** – Participants focus on activities that are in their areas of expertise, and those activities to support and coordinate with the action of others.
4. **Continuous communication** – Regular meetings to build up trust and relationships among participants.
5. **Backbone organization** – An organization, separate from participating groups, with the staff and skills to plan, manage and support the initiative. Activities performed by the backbone organization could include facilitation and mediation, technology and communication support, data collection and reporting, and logistical and administrative activities.

Visit the Collective Impact Forum website at https://collectiveimpactforum.org/ for more information about collective impact and for tools to help implement the collective impact approach. To learn about changes that have been made to the model since its inception, please visit https://ssir.org/collective_impact_10_years_later#.

Identify a Range of Possible Interventions

After studying the possible causes of health needs, identify potential interventions. It will be helpful for the implementation strategy team to have a discussion of the full range of interventions and to consult with public health experts to select the most appropriate approach.

Address the Levels of Prevention

The three levels of prevention are primary, secondary and tertiary. Your intervention approach may focus on one, two or all three levels of prevention.

- **Primary prevention** aims at preventing a particular disease from occurring. Examples include risk assessments for specific diseases, health education about preventing illness and immunizations against specific illnesses. *Will you try to prevent the health problem or risk related to the need?*
- **Secondary prevention** focuses on finding and treating the disease early. Examples include screening for specific illness, such as cancer or high blood pressure, and rapid initiation of treatment to stop the progression of identified illnesses. *Will you work toward early detection and treatment of the problem, with an emphasis on reducing progression?*
- **Tertiary prevention** targets persons who already have symptoms of a particular disease and attempts to make them healthy again. Examples include teaching someone who has asthma how to manage their disease and prevent attacks. *Will you concentrate on managing the health problem?*

CONSIDER THE LEVELS OF PREVENTION

If lead poisoning of children from lead-based paint in low-income housing has been identified as a priority problem, possible approaches include:

- Working to prevent the risk (primary prevention). In the case of lead paint, collaborate with community partners to test paint in apartments and repaint when needed.
- Working for early identification of the problem (secondary prevention). This could include testing children and treating them as early as possible after exposure.
- Treating acute illness related to the problem (tertiary prevention). This could include providing clinics to treat lead poisoning or conducting research on new treatment approaches.

Address the Multiple Factors that Impact Health

Public health experts believe that complex health needs are most effectively addressed with a multi-strategy approach, factoring in individual behavior, social supports and community and health policies. Keep this in mind as you consider your intervention approach for selected problems.

Source: Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). *Evidence-Based Public Health: A Fundamental Concept for Public Health Practice.* (p. 210)

For example, if childhood obesity is identified as a priority problem in your community, your intervention approach may include the following strategies: offering a weight management class that targets individual behaviors, working with a community youth group to form a sports camp that provides social support and an opportunity for exercise, and providing education for local schools on ways to increase student activity and advocating for policies that increase neighborhood safety so children can play outdoors and that increase access to fresh, healthy foods.

A BALANCED PORTFOLIO OF INTERVENTIONS

The Centers for Disease Control and Prevention's (CDC) Community Health Improvement Navigator (CHI Navigator) recommends a "balanced portfolio of interventions" across four actions areas: 1) socioeconomic factors, 2) physical environment, 3) health behaviors and 4) clinical care. The CDC recommends that as you identify and select interventions for your community's health needs, you consider using interventions that work across all four action areas and, over time, increase investments in socioeconomic factors since these factors have the greatest impact on health and well-being. For more information, visit https://www.cdc.gov/chinav/index.html.

Investigate Evidence-Based Interventions

To effectively use hospital and community resources, select approaches that are tested and likely to successfully address targeted needs. These are known as evidence-based interventions.

Public health resources are available for finding evidence-based approaches. Examples of web-based sources for evidence-based approaches include:

- Evidence-Based Practice Centers, Agency for Healthcare Research and Quality (AHRQ) https://www.ahrq.gov/prevention/guidelines/index.html.
- The Community Guide, CDC https://www.thecommunityguide.org/.
- The Cochrane Collaboration https://www.cochrane.org/.
- County Health Rankings and Roadmaps, University of Wisconsin Population Health Institute https://www.countyhealthrankings.org/.
- Healthy People interventions and resources, U.S. Department of Health and Human Services https://health.gov/healthypeople.
- Community Health Improvement Navigator, CDC https://www.cdc.gov/chinav/.
- 6|18 Initiative – Accelerating Evidence into Action, CDC https://www.cdc.gov/sixeighteen/docs/6-18-factsheet.pdf.

- Legacy Guidelines and Measures Clearinghouse, AHRQ https://www.ahrq.gov/prevention/guidelines/index.html.
- Evidence-Based Practices Resource Center, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services https://www.samhsa.gov/resource-search/ebp.

When looking at evidence-based practices that have been successful elsewhere, consider the following questions:

- Do the characteristics of the population where the program was used match your community?
- Is the evidence based on credible public health research?
- Has the approach been proven to be very effective? Somewhat effective? Are results still pending?
- Has the program been effectively replicated elsewhere?
- Is it a cultural fit in your community?
- Do you have or can you obtain resources needed to use the approach?

CONSIDER ALL INFORMATION WHEN SELECTING INTERVENTIONS

"While 'evidence' can be essential in evaluating effectiveness of healthcare interventions, well-informed decisions also require information, and judgments about needs, resources and values, as well as judgments about the quality and applicability of evidence. Relying only on evidence about the effects of health care alone can be inappropriate. Care and compassion are vital, and understanding the nature and basis of disease and the way that interventions work remains important." (Evidence-based health care and systematic reviews, *The Cochrane Collaboration)*

Review Community Assets and Existing Hospital Programs

As you determine what approach to take to address a community health need, consider building upon community assets or refocusing existing programs to meet prioritized health needs.

Asset mapping is a process intended to identify and then physically locate a community's strengths and resources. The process involves conducting an inventory that targets a community's human, cultural, economic and other infrastructure resources. This is typically done in a geographically defined area, such as a census tract, zip code, local neighborhood, school district or other geographical subset. Information is then mapped to both inform and support community decision-making.

Here are some examples of possible expansions to existing assets or programs:

- Parish nurses are taking blood pressures and doing hypertension education after Sunday services adding diabetes testing and education.
- A hospital pediatric dentistry program expands to serve adults.
- Local schools with self-esteem classes for girls from low-income families incorporate diet and exercise education into the classes.

Determine the Feasibility of Proposed Approaches

The implementation team should discuss key aspects of implementing each proposed approach. There may be situations when the discussion of implementation details reveals that the approach is unfeasible because the organization cannot easily obtain certain key elements (such as skilled staff, time frames, required organizational or policy changes, community support).

Here are some factors to consider when determining the feasibility and appropriateness of an approach:

- Community support.
- Actions that will need to be taken.
- Time frames.
- Staff, including who will lead and implement the approaches selected.
- Infrastructure, including the need for steering committees, policies and leadership support.
- Budget, including sources of funding.
- Knowledge and expertise needed to carry out the strategy.
- Partnerships that will be needed to implement the strategy.
- Any possible need for outside experts and consultants.
- Sustainability of the program or service.
- Availability of indicator data to evaluate and report on program outcomes.

If there is a gap between what you think you will need and what is available, consider how the approach could be modified to fit your resources without diminishing effectiveness or how to augment available resources through community collaborations, partnering with a school of public health or securing outside funding. Also consider how the organization can reallocate internal resources for these approaches. For example, the organization could redistribute funds that were previously earmarked for financial assistance but that may no longer be needed because of decreasing requests for charity care, or it could redirect community donations that

were previously not targeted to groups or efforts aligned with the community health needs the hospital is addressing.

Guideline 3
Select interventions

Considerations in selecting interventions to be used to address community health needs include:

- Is there a current community benefit program in place that could be continued or built upon?
- Is the intervention an appropriate fit for the priority population?
- Which approach or intervention will provide short-term results? While some approaches may be geared to the longer term, seeing early success will be important, especially for hospitals and coalitions new to community health improvement.
- Does the approach lend itself to partnerships, and can it generate community support? Can it build on an existing community program?
- Is the approach consistent with your hospital's organizational strengths and community capabilities?
- Are there adequate hospital or community resources to carry out the approach or intervention? If not, can additional resources be obtained?
- What barriers might exist? Are there sufficient resources, or is there a lack of community support? Are there legal, cultural or policy impediments or technological difficulties?
- Does the approach include an equity lens?

Solicit community input to validate possible interventions and to assess the community's capacity to support those interventions. When seeking input on the proposed strategy, the hospital should clarify expectations with the community about what approaches the hospital can and cannot implement due to limitations (e.g., resource constraints, lack of expertise).

The hospital should also plan to come back to the community to share the final strategy and to involve community groups and members in implementing and evaluating the strategy. This can be one way to maintain and strengthen community involvement throughout the assessment and planning cycle.

Guideline 4
Develop a written implementation strategy

A written implementation strategy is a summary describing what your hospital plans to do to address community health needs. The IRS requires hospitals to formally adopt the implementation strategy and to attach it to the Schedule H.

The written summary will be used by the organization's leaders to understand and communicate the goals, objectives and approaches its hospital will undertake to address community needs, and will be used by community members to understand the health care organization's role in addressing community health problems.

The written summary will also serve as a resource for community organizations that want to work with the health care organization on community-based approaches. A written plan is also required by some state laws.

Written hospital implementation strategies can include:

- ***The organization's mission*** – Describe the organization's mission, including its commitment to access, community health improvement and the needs of those living in poverty.
- ***The organization's commitment*** – Describe the organization's commitment to addressing structural racism and other systemic issues, such as a lack of good jobs, schools, health care access and safety, that contribute to health disparities.
- ***The community served*** – Specify the geographic areas and populations that will be addressed.
- ***A description of how the implementation strategy was developed and adopted*** – Explain how the implementation strategy was developed, including who advised or participated in the process. Also, describe how the implementation strategy was adopted by the governing body of the hospital.
- ***The significant health needs and how priorities were determined*** – Summarize the significant community health needs identified through the CHNA or through other means. Describe the assessment process and criteria used to identify priorities.

- ***What the organization will do to address community health needs*** – Describe the actions that will be undertaken to address selected community health needs and the anticipated impact of these actions. This description should include any planned collaboration between the hospital and other facilities or organizations. Also describe the resources the hospital plans to commit to address community health needs.
- ***Community health needs not addressed in the implementation strategy and any reason(s) they are not being addressed*** – Describe which community health needs identified in the CHNA are not being addressed in the implementation strategy but which are expected to be a continuing concern in the community. Explain the reasons the hospital will not address these issues.

See a template of an implementation strategy summary report on the CHA website at https://www.chausa.org/guideresources.

DOCUMENT NEEDS THAT WON'T BE ADDRESSED

Federal law requires hospitals to report needs not being addressed and the reasons why those needs are not being addressed. Comprehensive assessments of community need will inevitably identify more needs than the hospital and community partners can or should address. It would not be prudent to spread hospital and community resources across too many initiatives; instead, focus attention on priority areas to ensure that sufficient resources are available.

Some reasons the hospital might decide not to address certain needs include the following;

- The need being addressed by others.
- Insufficient resources (financial and personnel) exist to address the need.
- The issue is not a priority for community members, and therefore, the approach is unlikely to succeed.
- An evidence-based approach for addressing the problem is lacking or does not exist.
- The need is not as pressing as other problems.
- The need is not as likely to be resolved as other problems.
- The hospital does not have expertise to effectively address the need.

Most hospitals will produce the CHNA and implementation strategy as separate documents, although there may be overlap of some information. This allows for the assessment information to be available as soon as possible.

Guideline 5
Adopt the implementation strategy

To be considered adopted, the implementation strategy must be approved by the hospital's governing board or by a committee or group authorized by the board. In addition to being required by the IRS, board approval demonstrates that the board is aware of the findings from the CHNA, endorses the priorities identified and supports the strategy that has been developed to address prioritized needs.

Hospital policies should specify how the implementation strategy will be adopted, and hospitals should document in the implementation strategy how the strategy was formally adopted.

IRS

IRS NOTE

IRS regulations indicate that the implementation strategy:

- Is considered adopted on the date the implementation strategy is approved by an authorized governing body of the hospital organization.
- Should be approved on or before the 15th day of the fifth month after the end of the taxable year in which the hospital completes the final step for the CHNA.
- Should be a separate document for each individual hospital unless a joint CHNA is conducted.

Guideline 6
Update and sustain the implementation strategy

The CHNA and the implementation strategy development process are usually conducted on a three-year cycle. (Federal law requires CHNAs to be conducted at least every three tax years.)

However, implementation strategies may need to be updated more frequently based on:

- ***Changing community needs and priorities***. Community health needs are not static and can change in the time between assessment cycles. New, high-priority needs can arise, existing needs can become significantly less pressing, or new community resources or programs can become available that help address health needs already being addressed by the hospital.

  Some ways the hospital may become aware of these changes include:

  - Work with community groups and partners.
  - Significant changes in patient populations served or demand for services provided by the hospital.
  - Information gathered by the hospital's strategic planning department.
  - An environmental or unanticipated event, including acts of nature that directly impact the health and physical safety of the entire community or a subset of the community.
  - Information provided by public health agencies relating to enhanced risk of illness or disease based upon emergent pathogens or other risk factors.

- ***Changes in hospital resources***. Reviews and updates of the implementation strategy should be part of the organization's overall planning and budget cycles. This will ensure that changes in hospital resources that may impact the implementation strategy are identified and addressed in a timely manner.

  If all needed resources cannot be obtained (e.g., if hospital financial status has changed or if grant funds are not renewed), the implementation strategy will need to be revised to reflect how available resources will be redistributed among the different approaches in the implementation strategy.

Subsequently, if new resources are made available by the hospital, if community partners are able to contribute funds or personnel, or if new grant funds are obtained, the implementation strategy may need to be updated to reflect new or expanded programs.

- ***Evaluation results.*** Evaluate individual community benefit programs within the implementation strategy to see if they are being carried out as planned and achieving desired results.

  Refer to Chapter 6 in this Guide *and CHA's resource* Evaluating Community Benefit Programs *for more information on how to evaluate community benefit programs. For more information about this resource, visit https://www.chausa.org/communitybenefit.*

  As the programs are evaluated, the implementation strategy team may make recommendations to:

  - Change a program to improve its quality or effectiveness.
  - Expand a program to other geographic areas or populations.
  - Eliminate or replace a program with an alternative approach.

DEVELOP AND IMPLEMENT PROGRAM PLANS

SECTION 5.3

Once you have developed your implementation strategy, your organization (alone or with your partners) will develop and implement program plans for selected interventions. The program plans described in this section most often will be for community health improvement programs or community-building activities.

Program plans (also known as action plans) describe the interventions and what they are intended to accomplish. Implementation includes promoting the program to priority populations, delivering the program to those groups, evaluating and refining the program, and sustaining it into the future.

Guideline 1
Develop program plans

There are numerous program planning frameworks in the public health literature. This guideline summarizes the steps and terms common across various planning models.

KEY PROGRAM PLANNING PRINCIPLES

- ***Use data to guide program development***. Ensure that information about the community's health status, needs and assets are considered in program development.
- ***Encourage community participation***. Involve community members — including representation from individuals for whom the service is intended — in all aspects of program planning, from assessment and priority setting to intervention development and implementation, to enhance the success and sustainability of programs.
- ***Address a range of factors that impact health***. Develop programs that address individual behavior, interpersonal interactions (social support networks), organizational programs and policies, community (structures or processes), and health policy.
- ***Increase community capacity to address community needs***. Promote a systematic planning process within the community that can be repeated for various health priorities.
- ***Evaluate programs.*** Evaluation should emphasize feedback and program improvement.

Source: Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). *Evidence-Based Public Health: A Fundamental Concept for Public Health Practice.* (p. 218)

Developing a Program Plan Can Include These Steps:

1. Define the Problem Being Addressed

Defining the problem accomplishes two purposes: It establishes that the community benefit program is indeed addressing a community need and articulates the problem so that everyone involved in the program knows its purpose. The problem's definition should also identify root causes or related issues impacting the problem.

Root cause analysis is a good way to engage community members in program decision-making. Asking residents why they feel a particular problem exists can elicit a variety of disparity drivers, including multiple social factors that need to be addressed.

2. Determine the Target Population

Who will the program serve? Include geographic area, demographics and other important characteristics of intended program participants and the estimated number of persons who would be served.

3. Develop the Program Theory

The program theory is a simple, direct statement that lays out both desired outcomes and the strategies needed to achieve them. In other words, what is your program aiming to change and how? It is easiest to think of program theory in terms of "if-then" statements: *If* something is offered to program participants, *then* participants will change in a certain way.

Program theories can be developed out of:

- Existing evidence-based programs.
- Research findings.
- Your program staff's experience and ideas.

When developing the program theory, ask:

- *If* a program is provided, *then* what changes are anticipated for participants?
- Why do you believe the program will cause the expected change in participants?
- What evidence do you have that this activity will lead to this result (e.g., data from published literature or experience)?

4. Develop Goals and Objectives

A program goal is the overall broad intent of the program, focusing on who will be affected and what will change as a result of the program. Goals provide direction for the program and are the foundation for the specific objectives and activities that will define the program.

Here are some sample goals:

- Increase safety awareness among children at an elementary school.
- Improve quality of life among chronically ill, low-income persons in an identified neighborhood.
- Prevent falls among the residents of a senior housing complex.
- Increase birth weight, and reduce premature births of infants born to teen mothers in the school district.

Objectives are more precise than goals; they illustrate the steps the program will take to reach goals and therefore should be logically linked to supporting the attainment of the goal. Objectives are the program's intended outcomes (or results), usually expressed in terms of who and what will change. They are also expressed in terms of short, intermediate and long term. Objectives are often related to changes in knowledge, attitudes, skills or behaviors.

Objectives should be written in a "SMART" format: specific, measurable, achievable, realistic and time-bound. SMART objectives can be crafted by answering the following questions:

- What will be done (by program staff) to achieve this change?
- What will change?
- Who will change as a result of the program?
- By how much?
- When will the change occur?

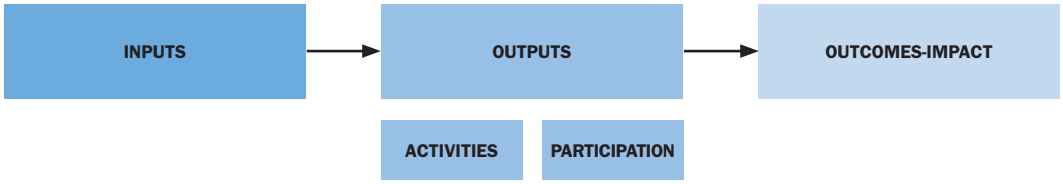
Objectives may relate to the implementation of a program or its outcomes. An implementation (or process) objective may address the number of participants from a targeted population or whether the program replicated an evidence-based program in certain ways. It may also consider participant satisfaction with the program or services. An impact or outcome objective can be short, intermediate and long term.

While most community benefit programs focus on short-term and intermediate objectives, it is critical to align program objectives with long-term, state and national objectives (such as Healthy People) to ensure that the program's strategies are focused, targeted and relevant — and, ultimately, contributing to the collective efforts for improving population health.

5. Develop a Logic Model, and Identify Indicators

A logic model is a graphic description of a program, describing what the program does and what is expected to result from it. In other words, it illustrates the program's theory, showing how planned activities connect to the results or outcomes the program is trying to achieve.

Developing a logic model has many benefits. A logic model can reveal gaps and challenges in a program (e.g., missing resources or activities). It can be used to ensure that all stakeholders have a common understanding of the program. Finally, it can serve as a basic framework for the program's evaluation.



The logic model includes:

- ***Inputs*** – Financial, human and other resources needed to operate the program, sometimes called resources.
- ***Outputs*** – What is done (activities) and who is reached (participants) through the program.
- ***Outcomes*** (also known as impact or results) – Intended changes or benefits resulting from the program. Outcomes can be broken down into short, intermediate and long term.

Indicators are measures that show progress toward meeting intended objectives and outcomes. An indicator answers this question: How will I know it?

Indicators can measure inputs, outputs and outcomes. Indicators for implementation (or process) questions can include the level of participant satisfaction, the number of people reached by the program, the number of materials distributed, etc. Indicators for outcomes questions can include changes in participant knowledge, changes in behavior, and changes in health status or clinical findings.

Here are some questions to consider as you choose your indicators:

- Will the indicator allow you to know the expected result or outcomes (valid)?
- Is the indicator defined and data collected in the same way over time (reliable)?
- Will data be available for the indicator?
- Is data for the indicator currently being collected, or can it be collected with reasonable cost and effort?
- Will the indicator provide information about outcomes to effectively inform program stakeholders?

6. Develop a Work Plan and Timetables

Develop a schedule based on when resources will be available and when activities will take place.

7. Determine What Resources Will Be Needed

Resources to consider:

- ***Staffing*** – Including paid staff, volunteers and consultants.
- ***Supplies and materials*** – Such as educational resources, in appropriate languages.
- ***Equipment*** – Such as audiovisual equipment for educational programs or exercise equipment for fitness classes.
- ***Facilities*** – Such as clinics, hospitals or mobile vans.
- ***Financial*** – Based on a budget, including total expected costs, expected sources of revenue, total expected reimbursements or payments, and expected shortfall or surplus in revenues over costs.

STAFFING CONSIDERATIONS

Program staff – Determine the skills and knowledge needed to implement the program, such as clinical skills, facilitation skills, or language or other communications skills. Discover whether there are persons with these skills available in your organization or partner organizations. If none are available, you will have to recruit new people. Staffing should reflect the diversity of the community being served.

Volunteers – Volunteers can bring needed skills, energy and time to the program. As community members, volunteers can also foster community ownership. Keep in mind that successful volunteer experiences — success for the program and for the volunteers — will require the same rigor used for the implementation team in hiring, orienting, training, supervising and recognizing performance.

Consultants – Consultants may be used to provide specific skills needed for program implementation, such as program design, financial management, facilitation, problem resolution or evaluation. Before engaging a consultant, be sure you identify what you need to have done, the skills needed and how much you can afford.

Community health workers – Many hospitals and primary care networks now employ community health workers (CHWs) and promotoras. These front-line public health workers are trusted members of the community who have deep understanding of the community's needs and challenges. This trusted relationship allows CHWs to serve as a link between health care and the community to facilitate access and improve the quality and cultural competence of service delivery.

8. Design the Evaluation Before Program Implementation

As you plan a program, begin thinking about how you will evaluate it. Evaluation should be considered an extension of program planning because evaluation results are critical to making effective decisions about program improvement, the use of program resources and future community benefit programming.

Designing the evaluation before program implementation will allow you to choose among several evaluation approaches and select the one that best fits your needs. Determine what you will want to know about the program's implementation and impact. This will give you greater flexibility in specifying the information you want to collect and will ensure that it is collected at the appropriate times during program implementation.

See Chapter 6 for more information about program evaluation.

IRS

IRS NOTE

Planning for evaluation will also help the organization prepare to meet the following IRS requirements:

- Implementation strategies must include anticipated impact of planned actions.
- CHNA reports must include an evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital's prior CHNAs.

See Appendix F for a sample Community Benefit Planning Form.

Guideline 2
Determine implementation readiness

Review some of the key steps in the planning process to ensure that you have done all the necessary background work required for successful program implementation.

Have You Selected a Program Likely to Meet Your Goals?

Before implementing a program or activity, ask the following questions to determine if the program has a good chance of meeting its intended goals and objectives:

- Is the program a response to a community health need?
- Is the program likely to achieve the desired result because there is sufficient evidence it will be successful in your situation, with the population the program will serve?
- Will you use a single strategy or multiple strategies to achieve the goal?
- Are necessary resources available, or can you obtain them to implement the program as planned?

Have You Engaged Program Users?

A successful initiative has buy-in from program users from the start. This comes from involving people who will use the program in the CHNA process and during the early planning stage.

During the planning stage, make sure you have asked potential users how the program should be designed (location, hours of service, cost, perceived benefit) to encourage their participation.

Be respectful of program users' situations. Are they taking time off from hourly wage jobs? Can they attend meetings during the day? Night? Do they need childcare? Ask them what they need to be able to be involved and participate.

Have You Engaged Community Leaders and Partners?

During the assessment and planning stages, you should have established and strengthened relationships with community leaders and program partners. They can help you connect with the population you want to reach and promote the program.

To determine if you have sufficiently engaged the community, the program implementation team should determine whether community leaders and partners were engaged in the assessment, prioritization of needs or planning for the program.

Is the Program Adequately Planned?

The planning stage should have established anticipated impact of the program, including program goals, objectives (at least short term and midterm) and identified indicators of program success.

The planning stage should also have identified the major activities that will be involved, estimated the resources that will be needed to carry them out, and determined whether the resources are available or can be obtained.

Guideline 3
Develop a management plan

EQUITY NOTE

- Focus the implementation strategy on health disparities in the community, and ensure that programs and activities address health inequities.
- Collaborate with diverse community organizations on managing implementation of programs and identifying and addressing issues that might prevent programs from achieving desired impacts.
- Maximize the use of community health workers in assessment, planning, implementation and evaluation.
- Use advocacy to address laws and regulations that enable structural racism in the community.

Develop a plan for how you will set up and manage the program. This will involve determining a structure for the program, developing a recordkeeping system, firming up the timetable and setting up a management system.

Determine the Structure of the Program

The program structure will define:

- ***The sponsorship or ownership of the program*** – Decide whether your organization will be the sole sponsor or owner of the program or whether the program will be a joint effort with others. If sponsorship will be shared with other organizations, make sure the roles and responsibilities of each sponsor, including financial commitments and reporting, are documented and clearly communicated to all.
- ***The oversight of the program*** – Determine whether the program will have its own organizational governing body or an advisory group or if an existing group will have oversight over the program. The purpose of an oversight structure is to ensure that the program is meeting its goals and objectives and, when needed, to provide guidance to program managers in resolving implementation issues.
- ***The program leader*** – Staffing will be dependent on the nature of the program. However, all programs should have an administrative champion — the person on staff responsible for all aspects of the implementation (monitoring, budgeting and evaluation).

Develop a Recordkeeping System

You will need to put in place a recordkeeping system for when the program is launched, Consider the following: What information should be collected at registration? Will medical information about participants be needed? How will you track participants' progress? Who do you need to keep informed, and what do they want to know?

Update the Planning Timetable

In the earlier planning phase, a rough timeline may have been developed to identify when key milestones would be completed. In the implementation stage, the timetable should be updated to include the tasks required to implement the program and who will be responsible for carrying them out. These tasks, often referred to as logistics, include the following:

- ***Program administration*** – Hiring and training staff and volunteers, including interpreters if needed; securing resources; setting up the recordkeeping system; convening staff; meeting with partners and advisors; and overseeing and managing of the budget.
- ***Program development and rollout*** – Pilot testing, updating the program and program delivery.
- ***Program evaluation*** – Implementation and impact evaluation.
- ***Program sustainability*** – How sustainability is being planned and addressed.
- ***Communication*** – Ongoing messaging to the broader community, nearby residents and the individuals receiving services.

Lay out all the tasks in a timeline, making sure to sequence activities in the right order. This will help in prioritizing tasks that need to be completed before others can begin. The timeline will also be helpful in monitoring the program progress so that timely corrections can be made, if needed.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Step 1											
	Step 2										
		Step 3									
			Step 4	Step 4							
					Step 5						
						Launch					
							Step 7	Step 8			
									Step 9	Step 9	
											Plan Next Steps

Develop a Management System

A system of management will describe how you will organize the program's human, financial and technical resources.

Determine the following:

- How will the program hire, orient and train staff, volunteers and consultants? Be sure your system of management includes the time and resources needed to train, supervise and monitor performance.
- How will the performance of staff, volunteers, consultants and the director be reviewed?
- Who will be responsible for or supervise day-to-day activities?
- Who will be responsible for each of the steps in the timeline?
- Who can make program changes? Approve spending?
- What policies and procedures will guide the program?
- What recordkeeping and documentation will be needed?
- How will the program be evaluated in terms of quality and impact?

Guideline 4
Promote the program

The goal of program promotion is to attract participants from the priority population and keep them engaged until desired outcomes are achieved. As you promote the program among the people you want to reach, consider addressing these factors.

Your Message

Make sure your message is related to what the intended population wants and needs and is culturally appropriate. Focus on how the program will impact the community and those served by the program.

Select the Right Communications Vehicles

Various media can be used to promote interest and deliver your message: electronic, print, posters, displays and ads. Know the media habits of those you want to reach, as well as the

cost and benefit of various tools. Remember that not all intended audiences have computers. Be sure the communications vehicles are right for intended users and will reach a significant portion of the population you want to reach.

Use of Direct Contact

Depending on the need you are addressing, and the program being promoted, you may want to contact intended users directly. For example, a childhood asthma program could contact families who have visited the emergency department for asthma over the past year. You can also contact physicians and other clinicians who know and are trusted by the people you want to reach and ask them to promote the program.

Community health workers (CHWs) and promotoras can also help with program promotion. CHWs and *promotoras* are often recruited from the same communities they will serve. As such, they are viewed by members of the community as trusted sources of information and support, whereas others from outside the community may not be.

Engage Participants and Other Community Members

As you promote the program, be sure to listen carefully to the reaction of potential users and others. Ask if they have suggestions for how to attract and motivate participation. Keep community members informed about the program, and invite them to endorse as well as participate. Talk to community members about what success of the program would look like.

Guideline 5
Put plans into action

1. Determine How the Program Will Be Implemented

Some programs begin with a pilot program; others are phased in or implemented all at once.

Pilots

Pilots are small-scale or field-test versions of your program. Pilots allow you and your team to work out any of the bugs in the program before it is offered to the larger population. Pilots will let you know if the program is accepted by intended program users, has the needed resources, seems to run smoothly and is ready for wider implementation.

When piloting a program:

- Use a similar setting and similar population to that of the full program. Look for whether the strategies are implemented and work as planned.
- Assess resources to determine if you have the right materials, space, staffing and skills.
- Involve participants in critiquing all aspects of the program: content, approach, facilitator and staff effectiveness, space and timing.

If you make major changes in the program as a result of the pilot, you may want to pilot again.

Phasing In

Phasing in means partially implementing the program. There are several ways to phase in a program: by limiting the number of participants, adding more locations as implementation proceeds and identifying participants' abilities (for example, a beginner or advanced exercise program) or level of need (for example, creating a dental clinic program that starts with treatment of major problems and then phases into prevention and maintenance services).

Total Implementation

Total implementation involves implementing the entire program at the same time. Public health experts advise against this approach because it is often difficult to quickly and efficiently identify and resolve issues across a whole program, particularly a complex program with many components.

CAUTION ABOUT TOTAL IMPLEMENTATION

"Implementing the total program all at once would be a mistake. Rather, planners should work toward total implementation through the piloting and phasing-in processes. The only exceptions to this might be "one-shot programs, such as programs designed around a single lecture, and possible screening programs, but even then piloting would probably help."

Source: McKenzie, Neiger, Smeltzer 279

2. Launch the Program

As you prepare to launch the program, here are some decisions to be made:

- Consider launching the program so it coincides with another special event that can help promote the program (e.g. starting a weight loss program at the beginning of the year or offering an immunization clinic prior to the start of the school year).
- How will you publicize the program with the media? Materials should focus on who the program is for and what it is expected to accomplish. Make it timely by connecting the program with recent studies, introduced legislation or a local policy issue.

3. Anticipate Implementation Issues

A number of issues may arise that you will want to be sure to anticipate. These include:

- ***Legality*** – Reduce the risk of liability by meeting with your legal staff to understand potential legal issues (such as negligence, informed consent, confidentiality and privacy) and put in place policies and procedures to address these issues.
- ***Program safety*** – Make sure the space and location is safe and free of hazards.
- ***Program quality*** – Make sure staff and facilitators are knowledgeable and skilled at what you are asking them to do.
- ***Ethics*** – Be sure that all participants, staff and partners are treated with respect. Make sure the program does no harm and has a reasonable chance of improving health. Maintain confidentiality.
- ***Problem-solving*** – Be ready for problems, and know who will be responsible for addressing the unexpected. Identify and review problems on a regular basis, especially early in program implementation (e.g., after the first session, first week or first month).
- ***Diversity*** – Staffing diversity is very important to the success of the program, particularly when serving an ethnic or racially diverse community.

Guideline 6
Monitor progress

Monitor the program as it is implemented, especially in the beginning. After the first session, first month or other designated time frame, identify what is going right and what could be improved.

Some things to ask as you monitor your program:

- Are we following our plan?
- What can we do better?
- What is going right with the implementation?
- Are we getting the participation we expected in terms of number of participants and attendance?
- Are we getting the results we expected?
- Are there unanticipated results or side effects?

See Chapter 6 for guidelines on assessing the quality and effectiveness of a community benefit program.

Guideline 7
Sustain the program

The decision as to whether to sustain, change or end the program involves asking:

- Have participants' goals been met? If yes, the program may no longer be needed, unless there are other potential participants who could benefit from the program. If goals have not been met, why not? Does this mean that the program should continue or be changed or that another approach should be tried?
- If the need for the program continues, do we have the funds and other needed resources to continue the program? Can they be obtained?

To sustain the program:

- ***Institutionalize it.*** If the program will be long term, make it a permanent part of your organization or partnership. Give it ongoing attention in the organization's planning, governance and communications processes.

- ***Obtain stable funding***. Funding can become a permanent line item of your organization's (or partnership's) budget or could be incorporated into the budget of another organization. You may also apply for grants or public funding. Other funding sources are philanthropy or charging fees for the service.
- ***Nurture relationships and partnerships.*** Programs are built on relationships with participants, partners, community members, staff and volunteers. Communicate regularly, and take time to meet with and listen to what each of these stakeholders has to say about the program.
- ***Utilize feedback and evaluation findings.*** Strengthen programs through continuous improvement. What are participants and staff members saying about how the programs could be improved? Is the program getting desired outcomes?
- ***Ensure community buy-in and partnership support.*** Sustainability will depend on whether the community finds value in the program and whether partners agree it is worth the time and other investments needed. On an ongoing basis, take the pulse of your participants and partners to guage their support.
- ***Build community capacity.*** Community engagement requires doing with, not for, our communities and building on their strengths and assets. Be sure your program is not duplicating or competing with community efforts. Work with the leaders recognized and trusted by their communities, and use CHWs to ensure program success.

Definitions in This Chapter

Ambulatory care sensitive conditions
Illnesses for which timely primary care services would reduce the need for hospitalization.

Morbidity
The incidence rate or the prevalence rate of a disease.

Mortality
A measure of the number of deaths in a given population.

Primary data
Information you have collected yourself.

Priority area
Geographic area experiencing significant socioeconomic, health or other needs.

Priority population
Population most impacted by priority health issues.

Qualitative data
Types of information that are described in terms of words rather than numbers.

Quantitative data
Types of information using numerical measurement.

Reliability
Reliability refers to consistency of measurements. A reliable measure will give identical or nearly identical values when measuring the same thing over time.

Secondary data
Existing information, collected by someone else.

Validity
Validity refers to the accuracy of measurements. A valid measure accurately measures what it is intended to measure.

Sources: Brownson et al. (2010); McKenzie et al. (2004).

Notes: