

Community Health Improvement Data Sharing System

**User's Guide
June 2014**



Instructions for Template Use

The three CHIDSS templates are designed to provide forms intended to facilitate local or regional efforts to capture and identify data/information that can inform dialogue amongst various community stakeholders.

The basic design of each template is intended to point a user towards looking for specific elements in a public report. Reports should be reviewed for specific data/information elements that are listed in the rows of each template. The columns of the templates are broken out by sections that are designated to each local entity that a user assesses.

A user is expected to review a public report using guidance provided in the following sections of this User's Guide. While reviewing the public reports, users can then use the templates to indicate whether the elements being reviewed are present. For future reference, a user should document/flag where each element is present in a report.

Specific instructions are provided on each of the individual templates. Data entry typically consists of simple Y (yes) or N (no) responses to if the data/information element is reflected in the report. It should be noted that the Community Engagement template provides additional instructions for data entry as it pertains to the "Sources of Input" and "Partner on Individual Project(s)" sections.

The templates can be accessed with the links provided below. You can click on the links below or copy and paste the link onto an internet browser. Each link will allow you to download each of the templates directly.

Community Definition Template:

Community Engagement Template:

Priority Setting Template:

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I. Overview

A. Purpose

The central purpose of the Community Health Improvement Data Sharing System (CHIDSS) is to support the advancement of practices among hospitals, local public health agencies, and other community organizations and groups with a stake in community health improvement. The basic proposition is that the increased transparency made possible by the required electronic posting of hospital Community Health Needs Assessments (CHNAs) and the voluntary posting of Implementation Strategies by nonprofit hospitals creates both a precedent for similar postings by other organizations engaged in similar activities AND an opportunity for comparative review of specific elements of community health improvement activities. The data and information available through these documents is most relevant and useful for review at the local and regional level. At this scale, there is considerable potential to consider relative alignment and focus where needs are concentrated and how best to mobilize and leverage available assets.

The core of the CHIDSS are three online templates to document key elements of the community health improvement process; both to assess the practices of individual organizations and to assess relative alignment with the practices of other organizations in the region. The three templates focus on the following elements:

- Defining Community
- Engaging Community Stakeholders
- Priority Setting and Implementation Strategies

The structure of the templates is informed by reporting requirements for tax exempt hospitals as outlined in the Patient Protection and Affordable Care Act (PPACA) and reinforced in the IRS Form 990, Schedule H. They also reflect an interest in moving beyond minimum compliance and support an approach that reflects a commitment to the optimal use of limited resources.

B. Potential Users

The online templates and the instructions in this CHIDSS User's Guide are intended for use by staff and leadership from the following types of entities:

- Hospitals
- Local public health agencies
- Section 330 community health clinics
- United Ways
- Community-based organizations
- Community/consumer advocacy organizations
- City and county public sector oversight bodies
- Higher education and private research institutions

II. Defining Community

A. Geographic Parameters

Stakeholder organizations identify the geographic parameters of their assessments to provide a basis for determining the focus of investments and interventions. In some cases, they may identify a particular population and/or content focus based upon the mission and scope of expertise of their organization. For hospitals in particular, the geographic parameters of the community they serve is determined by that hospital's service area. This is typically defined by areas where some proportion of that hospital's patients resides.

What to Look For, and Where

Stakeholder organizations often define their community in the executive summary and/or introduction of their CHA/CHNA reports. Common headings/sections in the assessments where this information can be found include, but are not limited to: *Community Served, Definition of Community, Our Community, Community Definition, Service Area, Description of Community, and Description of Community Served.*

Community Definition Template

Community Definition			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
<i>Y if Yes, N if No</i>			
Hospital or other institutional service Area			
Specific method to calculate service area			
County			
Region (e.g., multiple counties)			
Municipal/City			
Zip Code(s)			
State			
ID health disparities in community definition			
In other section of assessment			
ID geo concentration(s) of health disparities at sub-county level			

Instructions for Use

Enter Y (Yes) if the entity defined its community as its service area or N (No) if it did not. For all other categories in this template, data entry consists of simple Y (yes) or N (no) responses to if the data/information element is reflected in the report.

Specific Methodology/ No Methodology to Define Service Areas

Use of a specific methodology to determine a service area provided by the hospital provides the basis for determining the specific reasoning used in establishing the parameters of the assessment. Typically, a specific methodology will include data/records (e.g. hospital records, inpatient discharges, ER visits) to determine the geographic parameters of communities. The examples below illustrate the language used where specific methodologies were applied and where they were absent.

Sample Language

1. Specific Methodology for defining service area:

"The community benefit service area of [hospital facility] is depicted in Figure 4 and is comprised of where our patients originate, based on discharge data; 27 zip codes in 6 geocoded regions".

"[Hospital X] defines its service area for this Community Health Needs Assessment looking at where the majority of its inpatients reside. In CY 2011, over eighty percent of [Hospital X's] inpatients came from the eastern half of [5] Counties... While [hospital X] does serve some residents of the western portion of [X] County, it has relatively few resources in that part of the county. It is also telling that [hospital X] has a 34.4% market share of inpatients in eastern [X] County vs. only 5.7% in the western zip codes.

2. No specific methodology for defining service area:

"The [X] Medical Center community was identified through a facilitated meeting with senior staff as a geographic area determined to be the current primary hospital service area, which includes all or portions of the zip code service areas surrounding [7 municipal areas]..."

"Although [X] Medical Center serves patients from a wide range of counties in central and southern [state], the majority of our community outreach efforts and health improvement projects are focused on [X] County, where the medical center is located".

Geographic Categories

The geographic parameters that hospitals defined their communities include: city/municipality, county, regional (e.g. multiple counties), and state. Hospitals also used zip codes to define the geographic boundaries of their service areas and CHNA communities. Examples include:

Sample Language

1. Community defined as a **county**:

"Though [Hospital facility X] has a nominal presence in other counties such as [County X] and [County Y]), we consider County[X] to be our primary service area and the CHNA Community".

"Definition of the Community Served: [Hospital X] facility is an inpatient tertiary hospital serving the needs of East [state], beginning with [X] County (population 209,714)".

2. Community defined as a **region** (e.g. multiple counties):

"[Hospital X's] service area is generally defined as east central [state X], including all or parts of more than 25 counties in east central [state X] and western [state Y]. For the 2011-2013 plan, research and remedies are directed towards community health issues identified in [X], [Y] and [Z] counties".

"The service area of [X] Hospital... is comprised of six counties...with a population of 1.4 million".

3. Community defined as **municipality/city**:

"Although [X] Medical Center serves the entire [city X] metro area and beyond, for the purpose of the community health needs assessment the community served is defined as the city of [X]".

"The greater [city] community includes the communities of [six municipal areas]. This area encompasses a population of nearly 840,000 ..."

4. Community defined by **zip codes**:

"Service Area: [X] Medical Center is comprised of three separately licensed hospitals... and is part of the [X] Health System... The three [system] hospitals together serve the greater [city] area and the zip codes related to the primary and secondary service areas are delineated in Table 2 below".

[Hospital system], in conjunction with QHR, defines its service area as [X] County, which includes the following zip codes..."

5. Community defined as a **state**:

"While the community health needs assessment considers other types of health care providers, the [X] Center is the single largest provider of specialized rehabilitative services for children under the age of 18 in the state... For this reason the Center's community or service area encompasses the entire state..."

B. Identification of Health Disparities

There are countless opportunities, given persistent concentrations of health disparities in our society, to focus and align community health improvement activities amongst stakeholders that serve shared communities. Within any given region, select geographic areas and populations demonstrate the greatest needs and most significant potential to produce measurable outcomes. Many stakeholder institutions already identify and target these areas with various institutional resources. There are numerous opportunities to align investments, assessments, planning processes, and interventions and give primary focus of these efforts in geographic communities where health disparities are concentrated.

What to Look For, and Where

Hospitals most commonly identified disparities in the demographics section of their respective CHNA reports. Health disparities identified in a CHNA may be reported in geographic or non-geographic (population-based) terms. Common headings include, but are not limited to: *Community Demographics, Health status of the community, and Community Population*. Other sections of the assessments where hospitals identified disparities include introduction, community definition (may also be included in the introduction), as health priorities (e.g. health disparities, access to care for the uninsured) and implementation plans (e.g. target populations for programs/activities). The samples below illustrate where hospitals identified disparities in geographic terms (i.e. zip codes, cities, sub-county, and communities) and non-geographic terms (i.e. general population).

Sample Language

1. Identified disparities in **community definition**:

The Greater X areas CHNA ... have identified the areas of north and central X along with the Westside of X and X. These areas also have the greatest health needs and the most limited access to health services. The X Medical Center Implementation Strategy focuses on populations with greatest need so will continue to focus on these areas and the immediately surrounding neighborhoods in the greater X area".

"Although X Medical Center serves the entire X metro area and beyond, for the purpose of the community health needs assessment the community served is defined as the city of X. There is a special emphasis on serving low-income neighborhoods in X's central city".

2. Identified health disparities **in other section of assessment:**

"Generally, targeted populations include the uninsured and underinsured, and children at risk—from conception through childhood. A greater proportion of our resources will be spent in [X] County, where the largest population in our service area resides and where our community benefit program has long been established".

"Persons who turn 18 are considered by many of the key informants to be an underserved population. The X Center cares for children under the age of 18 and once these children turn 18 their options of long-term care are very limited. Also, children with complex pulmonary issues that require ventilators are a population who were identified as being underserved due to the limited number of...specialists in the area".

"Even though there is this area of higher population, the entire county is considered rural and is determined to an "underserved" area for healthcare. The needs in the county vary greatly in the southern end from the northern end. Because the largest concentration of the population is in the north that is where the majority of the services are located and public transportation throughout the county is less than adequate."

3. Identified **geographic concentrations of health disparities at the **sub-county level:****

"Using the X Index... a tool that indicates a communities needs and access to care, using several variables associated with health disparities (including income, education), identified the areas with greatest need in their service area. The CHNA surveys for the X area included representation from these areas... A large number of survey respondents (490) live in 'Highest need' areas in X. The other half of the survey sample was drawn from the moderate to low need zip codes. The data sample properly represented the vulnerable neighborhoods of X."

"The highest proportion of Medicaid and self-pay is in the immediate vicinity of the hospital and the [X] area. This would also identify those in most need of assistance from community benefit programs in the [X] area. The highest Medicaid emergency room visits reside in the zip codes [X]. Access to care will be a priority focus for this identified area of need".

III. Engaging Community Stakeholders

A. Sources of Input

An important consideration in the community health improvement process is the degree and manner in which hospitals and other institutions engage diverse community stakeholders as partners with shared ownership for health¹. It is important for hospital staff and leadership to establish more direct and ongoing working relationships with diverse community stakeholders to determine how best to leverage limited internal resources. Nonprofit hospitals are required by Treasury/IRS to “consider input” from community stakeholders in their CHNA processes.

What to Look For, and Where

Engagement of community stakeholders is commonly identified in the CHNA reports as input in the identification of health needs (e.g. surveys, focus groups, key informant interviews), prioritization process and/or as members of an advisory group/oversight committee. Headings for sections in the reports that include this information include, but are not limited to: *Methodology, Process and Methods, Primary Data, Identification of Community Needs, Prioritization of Needs, Input from the Community, and Survey/Interview Findings*. The names of individuals and stakeholder organizations are also often listed in the appendix section of needs assessments.

Community Engagement Template:

Community Engagement					
Categories of Input/Engagement	Entity: Hospital X				
	Form of Input in Assessment				
Insert Y if yes, N if no	Survey	Focus Groups	Public Forum	Key Informant Interviews	CHNA Advisory Committee
Identified in CHNA					
Source of Input					
No specification					
Lay community members					
Community-Based Organizations					
Govt Public Health Local					
Govt PH State					
Other Public Sector officials					
Insert P for person, R for representative					
People experiencing disparities					
Medically underserved people					
Racial/ethnic minorities					

¹ Shared ownership reflects a model of partnership where a broad spectrum of stakeholders holds themselves accountable as a group for improving the health and conditions of the community they mutually serve.

Instructions for Use

The user will identify the different sources of input in the respective sections of the needs assessment mentioned above and will fill the template accordingly. The user will enter Y for Yes and N for No in the row “identified in CHNA” for each of the forms of input documented in respect to each stakeholder type. If the identities of the individuals or organizations are not provided or are indiscernible then the user will enter N for No Specification in the respective row. If the entities provide sufficient information of the organizations and individuals solicited for input regarding the specific populations they belong to or serve, then the user will enter P if there are persons identified belonging to the following groups: *people experiencing disparities, medically underserved people and racial/ethnic minorities*. The user will enter R for representative if the organizations or individuals identified in the needs assessment were cited because they serve or represent these populations.

Sample Language

The examples below illustrate the participation of stakeholders in the needs assessment process.

Example 1:

“First was a health survey which consisted of questions to the broader community through a telephone interview. Through a third-party organization, a telephone interview was conducted to a random sample of community members.”

“The third piece of the assessment process was conducting interviews and focus groups with key stakeholders in the community in the spring and summer of 2012. A total of 34 key informants, 10 of who were public health officers, as well as 6 group interviews were conducted in X County and key themes that emerged from the participants related to rising health concerns were poverty, race, chronic diseases, social marketing, schools, health literacy and health insurance coverage and access to care”. [Participants listed in the Appendix].”

Example 2:

“More than 1,800 residents provided input via community forums conducted in all four quadrants of [X] County and through an on-line survey (available in both English and Spanish). Another 40 community leaders, physicians, and other health professionals shared their expertise at a special community forum. In addition, secondary data was compiled from demographic and socioeconomic sources as well as national, state and local sources of information on disease prevalence, health indicators, health equity and mortality. This was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community as a whole”.

The template below illustrates how to appropriately enter information for Example 1 into the template:

Community Engagement		Entity: Hospital X				
Categories of Input/Engagement	Form of Input in Assessment					
	Survey	Focus Groups	Public Forum	Key Informant Interviews	CHNA Advisory Committee	
Insert Y if yes, N if no						
Identified in CHNA	Y	Y	N	Y	N	
Source of Input						
No specification					N	
Lay community members	Y	N		N		
Community-Based Organizations	N	Y		Y		
Govt Public Health Local	N	Y		Y		
Govt PH State	N	Y		Y		
Other Public Sector officials	N	N		N		
Insert P for person, R for representative						
People experiencing disparities	N	R		R		
Medically underserved people	N	R		R		
Racial/ethnic minorities	N	R		R		

B. Forms of Input in Assessment

Another important consideration in the community health improvement process is how community stakeholders were engaged in providing input into the assessment process. The most common forms of input identified in the CHNA reports include surveys, focus groups, public forums, key informant interviews, and as members serving on a CHNA advisory committee. Forms of input reflect a hospital's effort to gain multiple perspectives and feedback on identifying the needs that are present in its community. Attention should be paid to whether a hospital clearly documents the extent to which stakeholders were engaged through these forms of input.

What to Look For, and Where

Engagement of community stakeholders was most commonly identified in the CHNA reports under the same headings as sources of input mentioned above. Stakeholders participating with an advisory role may also be referred to as members of the following but are not limited to: *external community benefit committee, external oversight committee, community benefit subcommittee, external advisory group, and steering committee.*

Community Engagement		Entity: Hospital X				
		Form of Input in Assessment				
Insert Y if yes, N if no		Survey	Focus Groups	Public Forum	Key Informant Interviews	CHNA Advisory Committee
Identified in CHNA						
Source of Input						
No specification						
Lay community members						
Community-Based Organizations						
Govt Public Health Local						
Govt PH State						
Other Public Sector officials						
Insert P for person, R for representative						
People experiencing disparities						
Medically underserved people						
Racial/ethnic minorities						

Instructions for Use

See Instructions for Use under *Sources of Input*.

Sample Language

Below are samples examples that illustrate the various forms in which input was solicited/collected from local stakeholders and the extent to which they were involved in the CHNA process.

1. Input collected in the form of a **survey, focus group, and public forum**:

"Community Input Information and opinions were gathered directly from persons who represented the broad interests of the community served by the Hospital. Twenty telephone interviews with community stakeholders and four focus groups with 64 area residents were completed from September through October, 2012. For the interviews, community stakeholders were identified by the [hospital] Community Benefit department staff. The stakeholders were known to the Medical Center staff as those with special knowledge or expertise in public health; individuals who are leaders and representatives of medically underserved, low-income, minority and chronic disease populations; or regional, State or local health or other departments or agencies that have current data or other information relevant to the health needs of the community served by the hospital facility."

2. Input collected in the form of **key informant interviews**:

"Key informant interviews were conducted with six individuals with specialized knowledge regarding health needs of individuals served by the X Center during April 2013".

"Forty-one individual key informant interviews were conducted between August and December 2012. Among the key informants were the health officers for the twelve local health departments, as well as leaders of academic centers, health coalitions, foundations and community organizations focused on a range of public health issues and/or health disparities. These key informants represent the broad interest of the community served, including medically underserved, low income and minority populations".

3. Stakeholders participating in **CHNA advisory committee**:

"X Medical Center convened an External Advisory Group made up of public health social services and those offering care to the underserved. The External Community Health Need Assessment Advisory Group exists to help X Health System evaluate the initial priorities selected by the MHS Community Health Need Assessment Advisory Team. These groups, convened by each X hospital, will review existing data and offer insights into community issues affecting that data. They will help identify local community assets and gaps in the priority areas, and will offer advice on which issues are the highest priority".

"At each step of the process, members of the Internal Community Benefit Committee and Community Benefit Sub Committee were asked to review the data, tools and results of the research, and their input was included to maximize the relevance and effectiveness of the research. The Community Benefit Sub Committee also represented the community in this needs assessment process. This group includes local health care providers; hospital representatives; public health officials ; community stakeholders including nonprofit employees working with underserved communities; nonprofit employees working with underserved communities; school board and district representatives; and leaders and representatives of underserved, low-income and minority populations. Public health officials serving on the Committee were also able to represent the needs of persons with chronic diseases."

"A Steering Committee was convened to assist [X] hospital in conducting the [CHNA]. A diverse group of community members, representing various organizations and populations within the community came together in May 2012. For a list of all Steering Committee members and their affiliations, please see Appendix A."

- We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources to exist in their portion of the county.
- In addition, we deployed a CHNA “Round 1” survey to our local expert advisors to gain local input as to local health needs and the needs of priority populations. Local expert advisors were local individuals selected to conform to the input required by the Federal guidelines and regulations [1].
- We received community input from 19 local expert advisors”.

“The Community Benefit Sub Committee also represented the community in this needs assessment process. This group includes local health care providers; hospital representatives; public health officials ; community stakeholders including nonprofit employees working with underserved communities; school board and district representatives; and leaders and representatives of underserved, low-income and minority populations. Public health officials serving on the Committee were also able to represent the needs of persons with chronic diseases. The Community Benefit Sub Committee was chartered according to the document in Appendix C”.

4. **Broad language in which level/form of participation** among community stakeholders in assessment process is unspecified:

“Our needs assessment involved the following five steps to attain the full scope of our community’s needs... (Step 2) Community individuals as well as experts in the public health arena were invited to attend community roundtables for input on the needs of the community”.

“In [regional area] there are a number of businesses, nonprofits, government agencies and citizens that are committed to our community well-being. As such, the steering committee worked to ensure the development of this document linked in with a number of community planning processes underway including XX and Healthy [county] 2020. The recognition that much work had already been done in these areas was critical in the development of the information contained in this document. It is also important that as the implementation phase gets underway, these processes work together to not duplicate efforts. The process through which each of the county Health Improvement Plans were developed engaged a cross section of community members. Through initial gathering of community data, to data analysis and workgroup, residents have had opportunities to engage in the process and be active members to drive community change”.

“Each person interviewed was asked a series of standard questions, with further discussion on areas and populations specific to their community role and perspective. From their responses – as well as substantial data from state and local resources – the following health needs were identified:”

C. Community Involvement in Priority Setting

While the IRS does not address whether community stakeholders should participate in the priority setting process, it is broadly understood that a quality approach to this process involves the participation of stakeholders with a broad spectrum of expertise and experience. In fact, the entire process of developing explicit criteria and processes for priority setting is intended to support the development of consensus among diverse perspectives. This section of the CHIDSS User's Guide helps to identify the level of collaboration among hospitals with other hospitals and stakeholder organizations (i.e. local health departments, United Way) in regards to the selection of priorities.

What to Look For, and Where

Headings for the prioritization of needs include, but are not limited to: *Prioritization of Needs, Prioritization Process, Significant Needs Identified, Identifying Community Priorities, and Prioritized Description of Needs.*

Community Engagement		
Categories of Input/Engagement	Entity :	
	Priority Setting	
Insert Y if yes, N if no	Priorities set for hospital only	Priorities set for group of hospitals, PH, etc.
Identified in CHNA		
Source of Input		
No specification		
Community-Based Organizations		
Govt Public Health Local		
Govt PH State		
Other Public Sector officials		
Lay community members		
Insert P for person, R for representative		
People experiencing disparities		
Medically underserved people		
Racial/ethnic minorities		

Instructions for Use

If a hospital does not provide any information indicating selecting priorities in alignment with other hospitals and/or stakeholders, the user will enter N for No under Priorities set for group of hospitals, PH, etc., and a Y for Yes under Priorities set for hospital only. If a hospital selects priorities in alignment with other hospitals and/or stakeholders, then the user will enter a Y for Yes under Priorities set for group of hospitals, PH, etc., and a N for No under Priorities set for hospital only.

If a hospital has indicated selecting priorities set for hospital only and indicates sources of input that were included in the priority setting process, the user will enter a Y for Yes and a N for No for each source of input documented as participating in the priority setting process. If a hospital has indicated selecting priorities set for a group of hospitals, public health departments, etc. and indicates sources of input that were included in the priority setting process, the user will enter a Y for Yes and a N for No for each source of input documented as participating in the priority setting process.

Sample Language

Below are examples that illustrate alignment in the selection of priorities among hospitals and other stakeholder entities (i.e. other hospitals, local health departments, United Ways, community based organizations).

1. Priorities set for **hospital only:**

"Hospital X's internal work group further refined this list to determine which of the top ten identified needs would develop into strategic action plans".

"Using findings obtained through the Key Informant Interview Process and collection of primary and secondary data, the Center completed an analysis of these inputs to identify community health needs. Once the health needs were identified management of the Center responded to the needs with their explanation/plan for implementing change".

2. Priorities set for **group of hospitals, public health departments, etc.:**

"[Hospital XX] will continue to partner with [State Y] CHIP and Z County Health Department to create strategies and tactics around SHIP objectives...By adopting the same health improvement objectives we hope to create alignment, synergy, and efficient resource allocation for establishing and promoting these community healthcare improvement objectives."

"Based on the documented needs from each of the County Health Improvement Plans and shared conversation amongst the group, there were two priorities the team felt could be collectively addressed: Healthy Weight and Access to Health Insurance/Care"

D. Participation in Implementation/Oversight

As is the case with priority setting, Treasury/IRS is silent on the issue of community stakeholder participation in the planning and implementation of programs and activities described in hospital Implementation Strategies. Hospitals with substantive experience, however, recognize the importance of in depth and ongoing engagement of diverse stakeholders as a statement of shared ownership for health and in order to make optimal use of limited resources. There is a need for dialogue with diverse community stakeholders that includes, but moves beyond a focus on “personal responsibility” to address the immense array of obstacles to health behaviors in the community context. This dialogue will not occur if it remains within the purview of internal medical care providers and hospital administrators. In order to stimulate more inclusive dialogue, it is appropriate for local stakeholders to review Implementation Strategies and identify areas where the engagement of community stakeholders offers the potential to strengthen and expand the potential impact of community health improvement activities.

What to Look For, and Where

Participation of community stakeholders in the process of project planning are most commonly found in the description of the programs/ activities within the provided implementation strategy/plan (hospitals are not required to post their implementation strategy plan). These descriptions are commonly entitled: *Action plan/steps, Community Partners, Community Partner Role, Implementation activities, and Goals.*

Community Engagement			
Categories of Input/Engagement			
	Implementation / Oversight		
	Participation in Project Planning	Partner on Individual Project(s)	Members of CB Function Oversight Body
<i>Insert Y if yes, N if no</i>			
Identified in CHNA			
Source of Input		<i>Enter A if project advisor, F if receiving funding, I if providing in-kind support</i>	
No specification			
Community-Based Organizations			
Govt Public Health Local			
Govt PH State			
Other Public Sector officials			
Lay community members			
<i>Insert P for person, R for representative</i>			
People experiencing disparities			
Medically underserved people			
Racial/ethnic minorities			

Instructions for Use:

Enter N for No Specification if the information documented in the implementation strategy did not provide sufficient information to determine the role or participation of stakeholders in the planning processes and involvement in programs/ initiatives. Enter Y for Yes or N for No in the column Participation in Planning in Project Planning if a hospital provides sufficient information in identifying the respective stakeholders in planning/ design of activities to address the priority needs. If the stakeholders identified belong to or serve the following populations enter P for Person or R for Representative respectively in the rows provided.

In the Partner on Individual Project(s) column, the user will then enter A if a stakeholder participates in an advisory role, F if they will receive Funding or I if they receive In-kind support for a project/program/ initiative. Enter Y for Yes or N for No in the column Members of CB (Community Benefit) Oversight Body column if the respective stakeholders were a part of any governance body responsible for oversight of the implementation of programs.

Sample Language

Below are examples of language in hospital Implementation Strategies in the national study cohort describing community stakeholder participation in planning process or implementation process:

1. Participation in Project Planning:

Example 1:

"A highly-targeted, innovative and integrated care delivery and coordination model to decrease adverse birth outcomes among low-income African-American mothers. The program addresses two City X program Y's goals: 1) improving and maximizing existing services that help at-risk African-American mothers develop self-care skills during the inter-conception period; 2) and strengthening father involvement in African American families. This grant is based on a previous work of Program X, which is funded by the United Way. Partners: Program Z and the University of X' Center for Urban Population Health. Additional partners include: The X state Partnership Program (funding partner) City X Collaborative (Hospital X caregivers, including Program Y, have been actively engaged in the Program X from its inception).

Example 2:

"Through its well-coordinated network of healthcare facilities, providers and service sites within X County, X Health Care has a system strategy for leveraging resources and expertise to strengthen community capacity to address significant health needs. For example, teen pregnancy is being addressed on a system level... X Health Care continues to be a community partner and works with other organizations to reduce the teen pregnancy rate in the city of X, including a long-standing partnership with the United Way Collaborative and the City of X Health Department for this purpose".

2. Partner on Individual Project(s):

Tobacco Use Prevention: "The [X] County report on cigarette smoking in 2010 found over 15% of [city] residents report smoking. To combat the start of use of tobacco products, the "Tar Wars" tobacco education will be conducted by the [X] Program targeting 5th grade students in the [local] Unified School District.

Overweight/Obesity: "[Hospital X] will work in partnership with the City of [X] to promote the Healthy Active [city] initiative to battle overweight and obesity in our community. In addition, we will provide nutrition communication in multiple languages. As well [hospital] staff is active participants on the City Department of Health board".

Healthy Eating and Active Living – “Goal 1: Increase knowledge of the importance of healthy eating in vulnerable neighborhoods. Strategies: A. Partner with the [local CBO] to support new grocery store ‘First Choice’ and Walgreens Fresh Food store located in West [X] by offering a cooking fair to educate the population about the benefits of healthy eating habits”.

“Action Steps: X Medical Center is committed to keeping this shelter open and will recommit to pay utilities, maintenance, food and linens totaling approximately \$40,000/yr”.

3. Participation in Oversight Body:

“The Steering Committee, which was convened at the beginning of the CHSD process and again when results from the report were first presented, will also be informed of the implementation plan to see the value of their input and time in the CHSD process as well as how X HealthCare is utilizing their input. Furthermore, Board members reviewed the CHSD report and implementation plan on May 8, 2013 so they can act as advocates in X County as X HealthCare seeks to address the healthcare needs of their community”.

“The Community Benefit Sub Committee also represented the community in this needs assessment process. This group includes local health care providers; hospital representatives; public health officials ; community stakeholders including nonprofit employees working with underserved communities; school board and district representatives; and leaders and representatives of underserved, low-income and minority populations. Public health officials serving on the Committee were also able to represent the needs of persons with chronic diseases.”

Example:

The example below illustrates how to appropriately enter information into the template using the information provided in this section's examples 1 and 2 of sample language for Participation in Project Planning.

Community Engagement			
Categories of Input/Engagement	Entity: Hospital X		
	Implementation / Oversight		
Insert Y if yes, N if no	Involved in Project Planning	Partner on Individual Project(s)	Members of CB Function Oversight Body
Identified in CHNA		A if project advisor, F if receive funding, I if provide in-kind support	
Source of Input			
No specification			N
Lay community members			
Community-Based Organizations	Y	FAI	
Govt Public Health Local	Y	A	
Govt PH State			
Other Public Sector officials			
Insert P for person, R for representative			
People experiencing disparities			
Medically underserved people			
Racial/ethnic minorities		R	

IV. Priority Setting and Implementation Strategies

A. Priority Setting Process and Criteria

Stakeholders often apply decision making processes that allow them to select a subset of priorities from a larger set of identified needs. These processes may consider available resources to effectively address all needs in all communities (all at the same time). They also facilitate the participation of people with a broad spectrum of expertise and experience with a stake in improved community health, and criteria with sufficient specificity to inform a selection among alternative options. A clear priority setting process provides specific methods (e.g. ranking) of group decision making and indicates whether priorities were set by an individual institution and/or among a group of stakeholders.

Nonprofit hospitals are required by IRS/Treasury to identify the criteria used to select health priorities. The criteria are intended to assist in the selection among a larger number of options as a focus for community health improvement activities. The criteria should point hospitals and community stakeholder partners towards the largest and most costly health-related issues, and towards activities that offer the greatest potential to produce measurable outcomes. The criteria used in priority setting must have sufficient specificity to inform a selection among different options for the focus of investments and /or interventions.

What to Look For, and Where

Headings for the prioritization of needs include, but are not limited to: *Prioritization of Needs, Prioritization Process, Significant Needs Identified, Identifying Community Priorities, and Prioritized Description of Needs. The prioritization process may also be found in the implementation plan.*

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Priority Setting Process and Criteria			
<i>Y if Yes, N if No</i>			
Process described			
Specific methodology (ranking, weighting)			
Criteria Described			
Provided Specific Criteria			
Institution-relevant criteria			
Community-population health criteria			

Instructions for Use

For all categories in the Priority Setting and Criteria section of this template, data entry consists of simple Y (yes) or N (no) responses to if the data/information element is reflected in the report.

Priority Setting Process Described

Below are examples that illustrate descriptions of the priority setting process, including identification of a) participants, b) steps in the process, c) methods used, and d) the reasoning behind the design of the process.

Sample Language

5. Priority setting process described:

"Before prioritizing needs, the Internal Community Benefit Committee was provided a list of the top 20 needs derived from our primary and secondary data collection. The needs were presented above. Our Internal Community Benefit Committee is comprised of leaders and physician experts from [X] Hospital. Members gave input that combined various issues according to common factors, yielding a list of ten priorities. These were Metabolic Syndrome, Cardiovascular Disease, Lifestyle, Asthma, Mental Health, Health Environment, Substance Abuse, Teen Pregnancy, Bicycle Helmets, and Sexually Transmitted Infections. This new grouping of ten needs was then submitted to the external Community Benefit Sub Committee and prioritized for a final group of three top needs".

"[Hospital X] hosted a community forum on January 9, 2013 in XX and another in XX on January 10, 2013 to prioritize the identified health needs. The forums engaged 22 community leaders in public health, government agencies, schools, and non-profit organizations that serve the medically underserved, low-income, minority and chronic disease populations in the community. These individuals have current data or other information relevant to the health needs of the community served by the hospital facility. A review of the Community Health Needs Assessment findings with the identified health needs was presented at the community forums. The forum attendees were engaged in a process to prioritize the health needs using the Relative Worth method. The Relative Worth method is a ranking strategy where each participant received a fixed number of points; in this case 100 points (5 dots equaled 100 points, where each dot was worth 20 points). Instructions were given, and the criteria for assigning points were explained. The points were assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels). This iterative methodology built on the identification of health needs based on the criteria of size and seriousness."

6. Priority setting process not described:

"During the Community Health Needs Assessment Committee meeting, members expressed their thoughts about several health concerns in the area and where [hospital] should concentrate its resources over the next three years. The

committee included Board members, physicians, senior hospital leadership, and some department directors. The committee then turned to identifying and prioritizing the health issues in the service area.”

Specific Methodology/No Methodology to Describe Priority Setting Process

Use of a specific methodology to describe a priority setting process provides the basis for determining the specific reasoning for selecting a subset of priorities from among a group of identified needs. Typically, a specific methodology will reflect the use of ranking or weighing different needs based on some combination of factors. For example, the relative incidence or severity of needs in a given community; and/or the available capacities and resources of stakeholders involved in the priority setting process

Sample Language

1. Use of Specific Methodology in priority setting:

“The health needs were identified from issues supported by the primary and secondary data sources gathered for the X Health Needs Assessment. The needs were indicated by community survey responses, key informants and secondary data sources. The needs were given a value based on the size and seriousness of the problem (as indicated by survey respondents, key informants and prevalence and incidence within the community) and are displayed in the tables below: Those needs with a score of 4 or higher were identified as a priority”.

“The forum attendees were engaged in a process to prioritize the health needs using the Relative Worth method. The Relative Worth method is a ranking strategy where each participant received a fixed number of points; in this case 100 points (5 dots equaled 100 points, where each dot was worth 20 points). Instructions were given, and the criteria for assigning points were explained. The points were assigned to health needs based on the size of the problem (relative portion of population afflicted by the problem); or seriousness of the problem (impact at individual, family, and community levels). This iterative methodology built on the identification of health needs based on the criteria of size and seriousness”.

2. No Specific Methodology described in priority setting:

“After reviewing the FY12 Community Needs Assessment, five issues were identified as priorities:

- 1. Diabetes*
- 2. Access to health care uninsured and underinsured as well as insured*
- 3. School Health*
- 4. Respiratory diseases*
- 5. Wellness*

Description of Criteria

Nonprofit hospitals are required by IRS/Treasury to identify the criteria used to select health priorities. The basic premise in priority setting in community health improvement is that there are not enough resources to address each and every need that has been identified in the assessment process. The criteria are intended to assist in the selection among a larger number of options as a focus for community health improvement activities. The criteria should point hospitals and community stakeholder partners towards the largest and most costly health-related issues, and towards activities that offer the greatest potential to produce measurable outcomes.

What to Look For, and Where

Criteria used to determine health priorities is typically listed following the process and methodology section of the assessments and associated with the prioritization process under the headings mentioned in the description of the prioritization process.

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Priority Setting Process and Criteria			
<i>Y if Yes, N if No</i>			
Criteria Described			
Provided Specific Criteria			

Instructions for Use

For all categories in this template, data entry consists of simple Y (yes) or N (no) responses to if the data/information element is reflected in the report. For the row labeled *Criteria Described*, enter a Y for Yes into the template for detailed descriptions of criteria and N for No for inadequate/ general descriptions of criteria.

Sample Language

Below are examples that illustrate detailed versus generalized, inadequate descriptions of the criteria and how they were used in the priority setting process.

1. Criteria Described:

"To facilitate prioritization of identified health needs, a ranking and prioritization process was used. Health needs were ranked based on the following seven factors. Each factor received a score between 0 and 4.

- 1) *How many people are affected by the issue or size of the issue? For this factor ratings were based on the percentage of the community who are*

impacted by the identified need. The following scale was utilized for health outcomes and factors: >20% of the community population=4; >10% and <20%=3; >5% and <10%=2 and <5%=1.

- 2) *Chronic diseases were rated based on state ranking for incidence of the disease. A factor of 1-4 was assigned based on which quartile the state was reported.*
- 3) *What are the consequences of not addressing this problem? Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating for this factor.*
- 4) *The impact of the problem on vulnerable populations. Needs associated with vulnerable populations identified through the community health needs assessment process was rated for this factor.*
- 5) *How important the problem is to the community. Needs identified through community surveys and/or focus groups.*
- 6) *Prevalence of common themes. Determined by how many sources of data (Leading Causes of Death, Primary Causes for Inpatient Hospitalization, Health Outcomes and Factors and Primary Data) identified the need.*
- 7) *How closely does the need align with [health system] strategies?*
- 8) *Does the hospital have existing programs which respond to the identified need?"*

"Prioritization of specific issues within each strategic issue was based on the following reasons/criteria: a) ability to make an impact, b) capacity/ability to do what it takes to make an impact, and c) ability to measure results."

2. Generalized (inadequate) description of criteria:

"The items set forth below are those which found consistent identification and, ultimately, prioritization in the primary information gathering process and which are supported by the secondary information related to demographics and health status."

"[Hospital]-Key Learnings: [X] Healthcare market presidents appointed key leaders in the organization to analyze data that was gathered, determine resource availability of the facility and identify the needs that would be addressed at this time. Several meaningful meetings were held with subcommittees in each of the top areas identified prior to setting the priority needs to address in our initial plan. Through our assessment and review of all of the findings from the research, our summary of the top community needs are."

Criteria Specificity

The criteria used in priority setting must have sufficient specificity to inform a selection among different options for the focus of investments and /or interventions. Specific criteria includes descriptions of a weighting method (i.e. relative worth method), ranking system, identifies participants and a detailed description of the process. Examples of criteria with insufficient specificity to select among alternatives include “alignment with the charitable mission of our hospital,” or whether content options (to be distinguished from specific interventions and the specific roles/contributions of the hospital) were “within the budget of the hospital.”

Sample Language

Below are examples that illustrate the use of criteria with sufficient specificity as well as those that lack specificity.

“The following criteria were used to choose priority issues for [X] County:

- 1. Consider the magnitude of the problem –*
- 2. How widespread is it in the county? How many people are affected?*
- 3. Consider the severity of the problem – how does it impact the health of the community?*
- 4. Are there significant racial or geographic disparities associated with this problem?*
- 5. Has there been previous work done in this problem area?*
- 6. Consider the successes/barriers encountered locally-*
- 7. Is there institutional commitment to address the problem?*
- 8. Are there community organizations that could address the problem?*
- 9. Are there multi-level and/or evidence-based interventions available to address the problem?*

Particular consideration was given to addressing prior work done in these focus areas, the potential for current or new community partners and the availability of evidence-based interventions to address the objectives under each focus area.

Particular consideration was given to addressing prior work done in these focus areas, the potential for current or new community partners and the availability of evidence-based interventions to address the objectives under each focus area.”

“During 2013, XX hospital facility leaders prioritized significant needs based on the following criteria:

- 1. Meets a defined community need (i.e., access for underserved populations);*
- 2. Aligns community benefit to organizational purpose and clinical service commitment to coordinate care across the continuum;*
- 3. Aligns with hospital resources and expertise and the estimated feasibility for the hospital to effectively implement actions to address health issues and potential impact ;*

4. Reduces avoidable hospital costs by redirecting people to less costly forms of care and expands the care continuum ;
5. Has evidence-basis in cross-section of the literature for management of chronic diseases in defined populations
6. Leverages existing partnerships with free and community clinics and Federally Qualified Health Centers (FQHC) ;
7. Resonates with key stakeholders as a meaningful priority for the [X] hospital to address Potential exists to leverage additional resources to extend impact Increases collaborative partnerships with others in the community by expanding the care continuum Improves the health of people in the community by providing high-quality preventive and primary care ; and aligns hospital resources and expertise to support strategies identified in local health department Community Health Improvement Plan (CHIP)."

Type of Criteria

There are two types of criteria considered in the selection of priorities for the development of community health improvement plans. The first type is **population/community criteria** that include, but are not limited to the following:

- **Size of the problem** (i.e., number of people per 1,000, 10,000, or 100,000)
- **Seriousness of the problem** (i.e., impact at individual, family, and community levels)
- **Economic feasibility** (i.e., cost, available resources)
- **Necessary time commitment** (i.e., overall planning, implementation, evaluation)
- **External salience** (i.e., evidence that it is important to diverse community stakeholders)
- **Existing efforts** (i.e., who else is working on this? How best to complement?)

The second type is **institution-relevant criteria** that include, but are not limited to the following:

- **Institutional expertise** (i.e., Can we make an important contribution?)
- **Institutional strategy** (i.e., Is this aligned with our organizational priorities?)
- **Degree of controversy** (i.e., Might action on this issue offend important constituents?)

Examples of criteria that are institution-relevant include “aligned with the strategic direction of the hospital,” or “aligned with core competencies of the hospital.” Examples of population/community health criteria include, but are not limited to the size of the problem (i.e., incidence or prevalence), the severity/cost of the problem to the community, or importance of the problem to the community.

What to Look For, and Where

Criteria used to prioritized needs often is described in the prioritization process and can be found under headings including, but not limited to: *Prioritization of Needs, Prioritization*

Process, Significant Needs Identified, Identifying Community Priorities, and Prioritized Description of Needs. The prioritization process may also be found in the Implementation Plan.

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Priority Setting Process and Criteria			
Y if Yes, N if No			
Institution-relevant criteria			
Community-population health criteria			

Instructions for Use

For all categories in this template, data entry consists of simple Y (yes) or N (no) responses to if the data/information element is reflected in the report.

Sample Language

Below are examples of descriptions of criteria that a) include institution-relevant criteria only, b) include institution-relevant criteria and population/community criteria, and c) population/community criteria only.

1. Examples of descriptions of criteria that include **institution-relevant criteria:**

“[X] Medical Center Implementation Strategy was developed based on the findings and priorities established by the 2012 Greater [X] CHNA and a review of the hospital’s existing community benefits activities”.

“[X] Healthcare has assessed the resources available at the [hospital] facility when choosing the following priorities to address at this time:”

2. Included **institution-relevant criteria and population/community health criteria:**

“Leadership ranked the health needs based on three factors:

- Size and Prevalence of Issue*
- Effectiveness of Interventions*
- Hospital’s Capacity”*

“Health needs were prioritized utilizing a method that weighs:

- 1) The impact on vulnerable populations;*
- 2) The importance to the community;*
- 3) The size of the problem;*

- 4) The seriousness of the problem;
- 5) Prevalence of common themes;
- 6) How closely the need aligns with the strategies and strengths of the hospital and [X] Health; and
- 7) An evaluation of existing hospital programs responding to the identified need".

3. Included **population/community health criteria only**:

"To set priorities, criteria focused on identifying disproportionate unmet needs, primary prevention strategies, advancements toward a continuum of care and a program that is collaborative and involves the community. This is reflective of the heritage of [hospital]".

"The health needs were identified from issues supported by the primary and secondary data sources gathered for the ...Community Health Needs Assessment. The needs were indicated by community survey responses, key informants and secondary data sources. The needs were given a value based on the size and seriousness of the problem (as indicated by survey respondents, key informants and prevalence and incidence within the community) and are displayed in the tables below".

B. Priorities Identified

Identification of priorities provides insights into the focus and entry point of stakeholder organization investments and interventions, and thus ways in which alignment across organizations may enhance the effectiveness and sustainability of efforts.

What to Look For, and Where

Descriptions of priorities are found in the prioritization process or in the description of respective programs/ activities in the Implementation Plan.

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Priority Setting Process and Criteria			
<i>Y if Yes, N if No</i>			
Priorities Identified			
Number of Priorities			
Priority #1			
Priority #2			
Priority #3			
Priority #4			
Priority #5			
Priority #6			

Instructions for Use

For all categories this template, data entry consists of the user entering in all of the priorities reported by an institution into the cells provided in the Identified Priorities section of the Priority Setting and Implementation Template. The information recorded in this section of the template should serve as a starting point of a conversation with respective institutions in a given community about their existing program activities, partners, and the geographic/population focus of their programs. Suggested questions to ask stakeholder institution representatives include, but are not limited to:

- a) "Can you tell me more about this Priority?"
- b) "What existing or proposed activities does your organization plan to implement to address this priority?"
- c) "Which other local stakeholders is your organization partnering with to address this priority or to implement these programs?"
- d) "Which specific populations or neighborhoods is your organization focusing on to address this priority?"

Sample Language

Below are examples of descriptions of priorities that have been grouped into the following categories: access to services, chronic disease management, health behaviors, determinants of health, and insufficient specificity.

Examples:

- *Access to Services*
 - “Fragmented continuum of care”
 - “ED: nurse for sexual assault victims”
- *Chronic Disease Management*
 - Diabetes
 - “Provide services to improve chronic disease outcomes”
- *Health Behaviors*
 - Obesity/Overweight
 - Physical activity and nutrition
- *Determinants of Health*
 - “Limited access to healthy foods”
 - “Poverty”
 - “Transportation barriers”
- *Insufficient Specificity*
 - “The Aging Population”
 - “Outreach, communication and collaboration—among and between individuals, agencies and organizations, healthcare providers”

C. Population/Geographic Focus of Interventions

Just as it is essential to identify geographic concentrations of health disparities at the regional level as part of the community health assessment process, it is of course equally important to develop an implementation strategy that gives focus to these areas. For some time, hospitals have been encouraged to both focus where needs are concentrated and serve the “community at large.” The latter framing is an important *part* of a larger population health improvement strategy, but does not in any way preclude a major focus in physical *places* where health disparities are concentrated.

What to Look For, and Where

Hospitals often provide descriptions of target populations and activities/ programs aimed at serving these populations in the descriptions of programs in the implementation plan or within in the CHNA (often within the description of the community).

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Priority Setting Process and Criteria			
Pop/Geo Focus for Implementation Strategy			
<i>N if No, SP if for specific program(s), A for All</i>			
ID focus on populations			
Under/uninsured pops			
Medicare pops			
Medicaid pops			
Age groups, gender			
Pops with disparities			
ID focus in geo areas			
HPSAs and/or MUAs			
Disparities			

Instructions for Use

For all categories in this section of the template, data entry consists of entering N for No: if none of the program content listed in the Implementation Strategy address any of the health disparity categories listed; SP for specific program(s): if the Implementation Strategy lists a specific program or programs that target any of the health disparity categories listed; or A for All: if all of the program content listed in the Implementation Strategy address any of the health disparity categories listed. If an entity identified a focus population for in their implementation strategy, proceed to enter Y (Yes) for any of the groups identified (i.e. under/uninsured, Medicare, Medicaid, age groups, gender) in the subsequent rows. If an entity identifies a geographic area of focus in their implementation strategy, the user will enter Y (yes) or N (no) if HPSAs (health professional shortage areas) and MUAs (medically underserved areas) are identified as populations/ areas of focus for programs/ initiatives.

Sample Language

Below are examples of exceptional descriptions of populations and/or geographic areas of focus, and those where the language is too general to know where and/or whether there will be any focus as well as examples where specificity is used for project descriptions, but were not provided in the general implementation plan.

1. Examples of **population targeted** (i.e. Medicare, Medicaid, age groups, gender, under/uninsured) focus of programs/ initiatives:

"Target population: Medicaid-eligible and uninsured patients using the emergency department (ED) for primary care and frequent users of the ED for non-emergent conditions.

1. What We Will Do: To improve access and coverage for uninsured and Medicaid-eligible patients using [hospital] Emergency Department (ED) for primary care and dental care we will implement the following:

- Safe Mom Safe Baby | A case-management service provided specifically to pregnant or recently delivered women experiencing intimate partner violence.

Partners: [Hospital facility X] Women's Health Center and Wellness Center

Target population: Women receiving obstetric services at [hospital] and other [local]-facilities.

2. What we will do: Provide support to abused pregnant women through case management, education and advocacy (including intensive case management when needed) Maintain partnership with [X] Peace Center, which helps the woman pursue protective legal action and connect to other community resources Help women interact successfully with healthcare providers and navigate the complicated criminal justice, legal and social service systems in order to produce the best health outcomes for both moms and babies Develop a collaborative model of care for survivors of IPV that can be replicated in other health care settings to improve outcome.”

“Identified health need: Access to Care

Aim Statement: [Hospital facility X] will target Medicaid and uninsured adult patients who have presented at the ED with dental conditions and identified patients in need from the [hospital dental program] waiting list to help reduce the utilization for dental services.

Community Need: Access to Care

Aim Statement: The aim of the program is to assist seniors in maintaining their independence in the community and improve their quality of life.”

“Goal 3: Support collaborative initiatives to address [X] food deserts, to raise the “food IQ” of residents, and promote access to nutrition education/counseling and exercise

Strategies: A. Continue the Transitions of Care Program to provide support to patients with Medicaid or no insurance who live in neighborhoods within zip codes ... who are discharged from [X] Hospital in an effort to improve their ability to self-manage their condition at home. This free program includes the coaching support of a nurse navigator by phone, home visits from peer advisors (aka community health workers) trained to link residents with community resources, and a visit from a dietitian when nutritional counseling is needed.”

2. Identified focus in **geographic areas**:

"The Problem (identified need): In [County X] from 2005-2008, there were 499 infant deaths in [city]. The area where [hospital campus] is located has one of the highest rates of infant mortality in [city].

How we'll respond to the need:

- Promote early, high-quality prenatal care for all residents in [X] with a specific focus in the zip codes near [hospital campus] that have a high infant mortality rate.
- Ensure that pregnant women with a history of preterm birth are offered and receive the highest quality of care.
- Create culturally sensitive, comprehensive safe sleep programs that are shared with the women and families in our sites and within our communities.
- Assure that women of childbearing age have resources to get the care they need before conception to reduce the risks of medical conditions that affect pregnancy outcomes in our community.
- Utilize the [hospital] Women's Outpatient Center to:
 - Provide care to women regardless of their ability to pay.
 - Collaborate with partners on reducing disparities in birth outcomes.
 - Offer more scheduling options for appointments to improve access to care.
 - Offer Progesterone."

2. Examples where **language is too general** to determine the population or geographic focus:

"PRIORITY: Healthy Lifestyle with a focus on obesity and diabetes.

How we'll promote a healthy lifestyle:

- Continue to hold National Nutrition Month activities.
- Offer counseling and education on healthy living to adolescents.
- Offer farmers' market produce in cafeteria for patients and community.
- Provide talks on healthy living at health fairs, community events, and employers as requested.
- Educate broader community on effects of diabetes and how to control and reduce side effects of the disease.
- Offer group and individual diabetes self-management training.
- Offer diabetes screenings in the community throughout the year to proactively assess if a person is in need of diabetes health care.

PRIORITY: Alcohol Use

- How we'll respond to the need:
- Improve access to services, screening, intervention, treatment and recovery at our mental health and addiction facilities.

- *Expand services for AODA assessments.*
- *Create collaborative with [X] County Mental Health Redesign Task Force.”*

Example: The example below illustrates how to appropriately enter information provided for the examples listed in *identified focus in geographic areas*.

Priority Setting and Implementation Strategy		
MSA/County/Region:	Entity: Hospital X	
Pop/Geo Focus for Implementation Strategy		
<i>N if No, SP if for specific program (s), A for All</i>		
ID focus on populations		
Under/uninsured pops	SP	
Medicare pops	N	
Medicaid pops	N	
Age groups, gender	SP	
Pops with disparities	SP	
ID focus in geo areas		
HPSAs and/or MUAs	N	
Disparities	SP	

D. Metrics for Implementation Strategy

A review of metrics reported by stakeholders demonstrates the scope and relative rigor of identified programs and monitoring strategies, as well as opportunities for alignment with other current or planned activities in local communities.

4 broad categories can be used to group the types of metrics reported by hospitals, they include:

1. Process (e.g., numbers of people served, numbers of units of services provided)
2. Service utilization (e.g., reduced ED utilization for a particular diagnosis)
3. Community/social metrics (e.g., improved access to healthy foods, improved transportation)
4. Population health (e.g., reduction in prevalence, acuity for specific conditions)

What to Look For, and Where

Focus of metrics in the implementation strategy were most commonly found under headings including, but not limited to: *Evaluation methods, Goals, Evaluation mechanisms, How we will evaluate our impact, Outcomes, Measurable objectives, and Measures of Success*.

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Metrics for Implementation Strategy <i>N if no, A if for all, SP if for specific programs, or C if identified a related category, but not specific metrics (e.g., reduce preventable ED use)</i>			
Process metrics			
Service utilization metrics (individual/cohort)			
Community/social metrics (SROI)			
Population health metrics			

Instructions for Use

For all categories in this section of the template, data entry consists of entering N for No: if none of the program content listed in the Implementation Strategy indicate using measures for any of the metric categories listed; SP for specific program(s): if the Implementation Strategy lists a specific program or programs that indicate using measures for any of the metric categories listed; A for All: if all of the program content listed in the Implementation Strategy indicate using measures for any of the metric categories listed; or C for related Category: if any of the program content listed in the Implementation Strategy identified a measure related to one of the listed metric categories, but not specific metrics (e.g., reduce preventable ED use).

Sample Language

Below are examples that illustrate the various metrics described in the implementation strategies/plans including: process metrics, service utilization metrics, community/social metrics (SROI), and population health metrics. The examples provided shows how the metrics were used (including different combinations) and where (if any) criteria were applied. (*No examples of population health metric were available from initial cohort.*)

1. Examples of Process Metrics and Service Utilization Metrics:

Example 1:

"A. Community Need: Access to Care – Dental

Aim Statement: [Hospital facility] will target Medicaid and uninsured adult patients who have presented at the ED with dental conditions and identified patients in need from the [hospital dental] waiting list to help reduce the utilization for dental services.

Outcome: Provide approximately 200 people with 600 dental treatments to reduce repeat ED visits for dental conditions.

B. Community Need: Access to Care

Aim Statement: Transitions targets individuals and families facing life-limiting illnesses providing assistance, encouragement and support at no charge.

Referrals come from the community at large, physicians, hospitals and local agencies

Outcome: Provide support and advocacy to individuals facing life limiting illness with a goal of increasing admits by 20% over 2012.

Example 2:

A. *"Objective 1: Increase the number of slots available in the clinic for same-day appointments. Measure of Success: Provide 4 same-day appointment slots per primary care provider to be available to community members.*

B. *Objective 4: [X] HealthCare will be in the top 10% in HCAHPS scores by January 1, 2016. Measure of Success: [X] HealthCare ranks in the top 10% in HCAHPS scores, sees decreased numbers of patient calls after they are discharged as well as reduced readmission rates.*

C. *Objective 5: Increase the local availability of specialists. Measure of Success: At least 3 more specialists are available within the local area".*

2. Example of SROI Metric:

“...Long-term objectives are to change the profile of childhood asthma in the most affected areas of the [following] cities...through improved health care delivery and quality, outreach, education, support systems, improved living environments and changes in policy at all levels. The program is committed to improve clinical outcomes including reduction in preventable hospitalizations, emergency room visits, and school absenteeism due to asthma, and enhanced quality of life measures.”

Example: The example below illustrates how to appropriate enter information into the template for the examples listed under *Process and Service Utilization Metrics*.

Priority Setting and Implementation Strategy	
MSA/County/Region:	Entity 1: Hospital X
Metrics for Implementation Strategy	
<i>N if no, A if for all, SP if for specific programs, or C if identified a related category, but not specific metrics (e.g., reduce preventable ED use)</i>	
Process metrics	SP
Service utilization metrics	SP
ROI metrics	N
SROI metrics	N
Pop health metrics	N

Appendix A: Community Definition Template

Community Definition			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
<i>Y if Yes, N if No</i>			
Hospital or other institutional service Area			
Specific method to calculate service area			
County			
Region (e.g., multiple counties)			
Municipal/City			
Zip Code(s)			
State			
ID health disparities in community definition			
In other section of assessment			
ID geo concentration(s) of health disparities at sub-county level			

Appendix B: Community Engagement Template

Community Engagement											
Categories of Input/Engagement	Entity:										
	Form of Input in Assessment					Priority Setting		Implementation / Oversight			
	Survey	Focus Groups	Public Forum	Key Informant Interviews	CHNA Advisory Committee	Priorities set for hospital only	Priorities set for group of hospitals, PH, etc.	Participation in Project Planning	Partner on Individual Project(s)	Members of CB Function Oversight Body	
<i>Insert Y if yes, N if no</i>											
Identified in CHNA											
Source of Input											
No specification											
Community-Based Organizations											
Govt Public Health Local											
Govt PH State											
Other Public Sector officials											
Lay community members											
<i>Insert P for person, R for representative</i>											
People experiencing disparities											
Medically underserved people											
Racial/ethnic minorities											

Appendix C: Priority Setting and Implementation Strategy Template

Priority Setting and Implementation Strategy			
MSA/County/Region:	Entity 1:	Entity 2:	Entity 3:
Priority Setting Process and Criteria			
<i>Y if Yes, N if No</i>			
Process described			
Specific methodology (ranking, weighting)			
Criteria Described			
Provided Specific Criteria			
Institution-relevant criteria			
Community-population health criteria			
Priorities Identified			
<i>Number of Priorities</i>			
Priority #1			
Priority #2			
Priority #3			
Priority #4			
Priority #5			
Priority #6			
Pop/Geo Focus for Implementation Strategy			
<i>N if No, SP if for specific program(s), A for All</i>			
ID focus on populations			
Under/uninsured pops			
Medicare pops			
Medicaid pops			
Age groups, gender			
Pops with disparities			
ID focus in geo areas			
HPSAs and/or MUAs			
Disparities			
Metrics for Implementation Strategy			
<i>N if no, A if for all, SP if for specific programs, or C if identified a related category, but not specific metrics (e.g., reduce preventable ED use)</i>			
Process metrics			
Service utilization metrics (individual/cohort)			
Community/social metrics (SROI)			
Population health metrics			