ADVANCING THE STATE OF THE ART IN COMMUNITY BENEFIT TOOLKIT

INSTRUCTIONAL MATERIALS AND TEMPLATES FOR THE COMPREHENSIVE REVIEW AND ENHANCEMENT OF COMMUNITY BENEFIT PROGRAMS

Acknowledgments

The instructional materials and templates in this document are a collaborative product of institutional partners, staff and consultants engaged in the ASACB demonstration, with periodic input from the ASACB National Advisory Committee and other external stakeholders in the field. There were numerous draft versions of each of the templates, with each successive version informed by active exchange of ideas and on the ground field testing by each of our institutional partners.

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This document and other ASACB related tools, standards, institutional policies, and model programs are available on our website at www.asacb.org, sponsored by the Association for Community Health Improvement (ACHI) of the Health Research and Educational Trust, a nonprofit research affiliate of the American Hospital Association.

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Advancing the State of the Art in Community Benefit
Comprehensive Review and Enhancement of Programs

Introduction

Advancing the State of the Art in Community Benefit (ASACB) is a research demonstration of the Public Health Institute and a diverse group of hospitals[1] to develop and implement uniform standards for community benefit programming. The standards focus on better alignment of institutional governance, management, and operations, and on a more rigorous and strategic allocation of resources at the program level. Experience in the field has demonstrated that both tracks are needed to secure meaningful institutional commitment and facilitate the optimal use of limited charitable resources to address unmet health needs in local communities**.**

The programmatic focus of the ASACB Demonstration is on activities outside of traditional, emergency room and inpatient-based charity care. These activities range from primary care clinical services delivered in community settings to comprehensive approaches to community-based prevention. The approaches involve the engagement of diverse community stakeholders as ongoing partners in efforts to encourage the adoption of health behaviors and to help create social, environmental, and political conditions that support positive health behaviors. A central theme in ASACB is that reliance upon traditional charity care as the central means of fulfilling nonprofit hospital charitable obligations represents poor stewardship, given that a significant proportion, if not a majority of these clinical services involve resource intensive treatment of preventable illnesses. While this problem will not be fully resolved without systemic change at the societal level, hospitals with visionary leadership and commitment can begin to transform the public dialogue about how best to address continuing increases in the cost of medical care. The application of ASACB standards represents a proactive, cost-effective, and sustainable approach to community benefit that will help to reduce the demand for high cost ER and hospital inpatient care to treat preventable health problems.

The institutional focus of the ASACB Demonstration is on increasing the alignment of nonprofit hospital governance, management, and operations with their charitable mission. This is accomplished through the implementation of 14 Institutional Policy (IP) Measures[2] to both clarify and codify roles, responsibilities, and general practices. For example, IP Measure #1 calls for the establishment of a board level committee with diverse community representation to oversee all community benefit-related functions. IP Measures 2, 3, and 4 call for the development of a formal charter that clearly indicates committee roles and responsibilities (#2), criteria and competencies for committee member recruitment (#3), and criteria for priority setting and program selection (#4). Other measures address issues such as senior executive accountability for performance, community benefit manager responsibilities, authority, and

[1] Partners include three health systems, Catholic Healthcare West, St. Joseph Health System, and Texas Health Resources, and two independent hospitals, Lucile Packard Children's Hospital at Stanford and Presbyterian Intercommunity Hospital; a total of 70 hospitals in California, Texas, Arizona, and Nevada.
[2] See ASACB website (www.asacb.org) for a listing and explanation of the 14 IP measures.

competencies, integration with organizational strategic planning, program commitment, and community input. While it is not essential, we strongly encourage hospitals to implement the ASACB IP measures prior to or in concert with the comprehensive review of programs. This will establish an institutional infrastructure of understanding, accountability, and engagement that supports, rather than impedes the comprehensive review and enhancement of programs.

Implementation of ASACB standards is guided by five ASACB Core Principles. These principles facilitate more effective targeting and design of program activities, leveraging internal resources by identifying and building on existing resources within local communities, and developing evidence-based systems to monitor and link clinical service delivery to community-based prevention. To implement the ASACB standards and accomplish these objectives, partners have developed a set of tools and processes to guide the development, implementation, evaluation and documentation of community benefit activities.

This document outlines the five ASACB Core Principles, describes the essential steps in the comprehensive review process, and includes four templates to guide the review and enhancement process. A description of each of the templates and an outline of the stepwise process are provided in this introduction.

Five ASACB Core Principles

A central objective of ASACB is to utilize a more strategic approach to community benefit program planning and implementation. This strategic approach is guided by a commitment to five Core Principles. The overall design, implementation and evaluation of community benefit program activities will be guided by each of the Core Principles.

Preliminary Review Template (PRT)

For hospitals with ten or more community benefit programs, we encourage the use of the Preliminary Review Template (PRT) to conduct an introductory assessment of program alignment with the Core Principles. The PRT provides a basis for prioritizing the CRT process, based on criteria that include the size of the program, the level of net hospital investment, and relative alignment with the Core Principles.

It is important to view this as a very preliminary assessment, to give hospital community benefit managers an overarching sense of the volume of work needed to bring programs into alignment, and to select where to start. Typically, ASACB partners divided programs into tiers, or groups for the comprehensive review process, focusing first on Tier 1 programs (highest priority), then Tier 2 programs, etc.

Comprehensive Review Template (CRT) – Long Form

The purpose of the Comprehensive Review Template (CRT) is to help community benefit staff assess community benefit programs and identify enhancement strategies to increase their alignment with the five ASACB Core Principles. Use the CRT to review all current community benefit programs, beginning with those that are identified as highest priority in the Preliminary Review Template process.

The CRT is divided into two sections. Section one assesses the relative alignment of a program with the five Core Principles. Section two identifies potential enhancements to increase alignment with the five Core Principles. For the CRT enhancement section, you will want to encourage an expansive and creative thought process, without the immediate constraints of current hospital resources. This will allow the full emergence of ideas, at least some of which may be made possible by securing support in the future from unexpected sources. In addition, it will be important to think long term; some enhancements may not be fully implemented for five or more years. The important goal is to establish a vision that is comprehensive, evidence-based, and involves the ongoing engagement of diverse community stakeholders as full partners.

Comprehensive Review Template – Short Form

The CRT Short Form was developed for use once community benefit managers and other program staff have achieved a full understanding of the five ASACB Core Principles and their practical application in the enhancement of current program activities. This is a "stripped down" version of the CRT that does not include most of the supporting information included in the Long Form.

Program Enhancement and Monitoring Template

Upon the completion of the CRT, selected enhancement strategies for a program will be entered into the Program Enhancement and Monitoring Template (PEMT). The Template provides a brief description of program activities, and then outlines the enhancement strategies, measures, and specific steps taken by pilot site hospitals to better align existing programs with the five ASACB Core Principles.

In the comprehensive review process, pilot sites collect baseline information on existing programs to assess relative alignment with ASACB Core Principles, and then develop enhancement strategies to increase alignment. They then use the PEMT to identify measures that provide evidence of the successful implementation of the enhancement strategy, and action steps that will achieve the desired measurable impact. In short, the PEMT serves as a concise, detailed strategic action plan to increase the effectiveness of community benefit programs.

Preparing for Implementation of ASACB Standards: Key Assumptions

It is important to note that implementation of the ASACB standards assumes serious institutional commitment and prior experience working in local communities. All partners in the ASACB demonstration initially participated in a readiness assessment to determine if there was sufficient institutional commitment and experience to proceed. In terms of institutional commitment, at a minimum your hospital should have the following in place:

- Strong support from the hospital CEO; support that is communicated to and validated by other members of the executive management team.
- A minimum of .5 FTE staff time dedicated to community benefit program management
- Basic understanding among staff (and optimally, of at least one member of executive management team) of public health concepts (e.g., community health planning, epidemiology, behavioral sciences, health policy and administration)
- Designated authority to the Community Benefit Manager to engage other departments and managers and to make necessary changes to community benefit programs.

In terms of working in communities, community benefit staff should have some demonstrated experience in the following:

- Engagement of diverse community stakeholders (e.g., community-based organizations, advocacy groups, neighborhood residents, local business) as partners in the design and implementation of programs.
- Conducting and/or participating in community assessments, ideally those that include both an assessment of needs and the identification of community "assets."
- Design of community-based programs and the development of monitoring strategies

The listing of these assumptions is not intended to discourage hospitals from implementing ASACB standards; rather, the intent is to guarantee that the appropriate groundwork is laid to ensure success. While we encourage hospitals to seriously assess their readiness against these assumptions, it is understood that there may be areas where commitment and experience are not optimal. Early identification of these areas will provide a basis for focused improvement as you implement the standards.

As noted previously, we encourage the implementation of the 14 ASACB Institutional Policy Measures prior to or in concert with the comprehensive review and enhancement of programs. Partners in the Phase II implementation process found that the IP Measures implementation process engaged leadership and fostered the level of support needed to transform community benefit programming in their institution.

A Stepwise Process for the Review and Enhancement of Community Benefit Programs

The following approach is recommended to implement the comprehensive review and enhancement of community benefit programs. This assumes

1. **Meet with Executive Management Team (EMT)**
   a. Overview of principles, process, projected outcomes
   b. Overview and relationship to the development and implementation of the 14 Institutional Policy Measures
   c. Solicit advice (key for buy-in)
   d. Establish protocol on how to best address obstacles in the implementation process (e.g., resistance from mid-level managers and directors)

2. **Group meeting with program managers/directors**
   a. Orientation on ASACB concepts, principles
   b. ID steps in process
   c. ID and engage internal leaders (expected supporters)
   d. Establish a non-threatening process (how to make us even better!)

After the initial meeting(s) with the Executive Management Team, we recommend holding orientation sessions to engage all individuals who are involved in the implementation and management of community benefit programs. The group meetings will facilitate shared learning and exchange of ideas among participants. These meetings will also help identify individuals

who quickly understand and support the concepts and practices you are encouraging, and those with whom you may need to spend some extra time to bring on board.

3. Engagement of Community Benefit Committee

(If this is a new committee established as part of the implementation of the 14 Institutional Policy Measures, you will have already addressed ASACB concepts and principles, and the focus will be on their role in the comprehensive review and enhancement of programs.)

a. Orientation on ASACB concepts, principles (If not done previously)
b. Determine committee role in comprehensive review process (In most cases, this may focus on an opportunity to review and review and provide input on proposed enhancements to existing programs)

4. Complete the PRT (for hospitals with 10+ programs)

a. Fill in the PRT spreadsheet with all community benefit programs
b. Identify those programs that are best aligned with Core Principles, have a high volume of activity or have a high financial outlay.
c. Categorize these programs as Tier I and begin the CRT process with them.

5. Individual meetings with program managers/directors

a. Focused orientation with CRT
b. If manager has high level of competence, leave assessment component with them to complete baseline; if not, fill out with them in meeting (could be 2nd meeting)

Schedule individual or small group meetings with the program representatives. For larger and more complex programs, you may want to limit the first meeting to the completion of the program assessment. This will allow some time for you and the program representative(s) to fully digest the results of the assessment and consider possible enhancements. You should provide a copy of the completed program assessment for the program representative(s) to review and supplement with any additional information that was not available in the initial meeting.

6. Individual meetings to ID and review proposed enhancements

a. ID enhancements in first meeting; type up and forward for their review
b. Discuss and revise in second meeting

For the second meeting, consider all possible enhancements for each Core Principle. At this point, you will be asked to make a broad assessment of the hospital, community, and/or foundation resources that may be necessary for implementation. You will conduct a more detailed assessment when you identify specific action steps during the completion of the Program Enhancement and Monitoring Template.

7. Complete program enhancement and monitoring template (PEMT)

a. Plug enhancements into PEMT; ID potential measures and activities
b. Meet with program manager to review measures and activities; leave with them
c. Revise activities and measures as appropriate, complete PEMT

8. Provide monthly progress reports to EMT

The Five ASACB Core Principles

The five ASACB Core Principles provide the framework to guide the comprehensive review of programs. Full application of all five Core Principles is a desirable goal for all community benefit programs and activities. It is important to note, however, that ***only Core Principle #1 must be fully implemented in order for a program or activity to be counted as a community benefit***.

Core Principle #1:
Emphasis on Communities with Disproportionate Unmet Health Needs
Community benefit programs generally fall into one of two categories: programs that focus exclusively on ***vulnerable populations*** or programs that serve the ***community at large***. For ASACB, vulnerable populations are clearly defined as populations that face financial or non-financial barriers to care (legal, transportation, language, culture, etc.) and/or have physical or psychological disabilities. If your targeted population does not meet this criterion (e.g., if it focuses on a general population subcategory such as women, children, or seniors), it should be placed in the community at large category.

Programs that serve the community at large do not target vulnerable populations, but should identify the geographic parameters of the community to be served. Typically, this would be the hospital primary service area, a city, or a county. You will then identify any communities within those parameters with disproportionate unmet health-related needs (DUHN).

Communities with DUHN might be zip codes, census tracts, or neighborhoods where there is a higher prevalence or severity for a particular health concern than the general population within the larger geographic boundaries. In the absence of good data for a particular health concern, proxy measures may be used that provide evidence that community residents within these smaller areas likely face multiple health problems and/or have limited access to health care (e.g., household income, employment, insurance coverage, ethnic/cultural composition).

Alignment with CP #1 requires that the program include outreach mechanisms and program design elements that ensure access to the residents within these DUHN communities.

Core Principle #2:
Emphasis on Primary Prevention
Primary prevention includes three types of activities:
Health promotion: Health messages to encourage healthy lifestyles in the general population.
Disease prevention: Targeted interventions for at-risk populations.
Health protection: Make changes in local environments to support health behaviors

It is important to note that it may not be feasible and/or appropriate to add a primary prevention component to smaller scale and/or short-term programs and activities. For example, if a hospital supports a health fair, while it is essential that the health fair ensures access for communities with disproportionate unmet health needs (CP#1), and strongly encouraged that the hospital

secures follow up care for people who may have positive screenings for illnesses (CP#3), the development of a primary prevention component may not be relevant.

Our primary focus is to encourage the development of a health protection activity to complement the traditional focus on health promotion. In practical terms, we encourage hospitals to move beyond telling people to change their behavior (health promotion) to engage them as partners to remove barriers to behavior change in their communities (health protection). Again, taking this step may be more feasible with larger programs, but it should be considered as an important step toward producing measurable and sustainable impacts for all programs.

In addition, it should be noted that in adding a primary prevention component, the hospital might not be directly responsible for its implementation. Rather, the hospital role may be to coordinate with community partners who are implementing complementary activities, or assist in the development of new components to be taken on by community partners. Documentation should address which community partners are responsible for specific activities within each component.

Core Principle #3
Build a Seamless Continuum of Care

This Core Principle calls for the development of evidence-based links between clinical services and community-based services/activities. For clinical service programs, we encourage links to prevention services/activities to reduce demand and/or to community support services to prevent their recurrence. For community-based prevention programs, we encourage coordination with providers to identify and reduce the demand for relevant clinical services.

As with CP#2, it may not be feasible to build evidence-based links for smaller scale programs or short-term activities. Major projects with an "upstream," public health focus should, however, strive to establish an evidence-based link to the clinical service delivery process.

In some cases, prevention programs may be too far removed from clinical service delivery to establish evidence-based links. For example, a community-based primary prevention program that focuses on educating community members about the importance of good nutrition and physical activity (health promotion), and creating opportunities for increased physical activities and increasing access to good nutrition (health protection) will not be able to identify near term measurable impacts upon clinical service utilization. In these situations, you will identify alternative health-related measures that validate the impact of the program.

Core Principle #4:
Community Capacity Building

Community capacity building involves the strategic allocation of charitable resources (i.e., staffing, equipment, technical assistance, financial support, advocacy) to mobilize and build upon what is already in place in local communities. This approach will reinforce an ethic of shared accountability with community stakeholders, reduce duplication of effort, and increase the effectiveness and viability of community-based organizations (CBOs).

To build community capacity, you must first identify existing community "assets," including CBOs, businesses, physical infrastructure, local coalitions, and the skills of individual

community members. These "assets' can serve as sites for program activities, implement important program components, and provide other sources of support to help achieve program objectives.

In the review and enhancement of current community benefit programs, you should explore new roles for existing community partners and engage new community entities as partners. This may come about, for example, by shifting the role of the hospital from the implementation of a particular component to providing technical assistance and support to a community-based organization (CBO) that carries out the component. The near term goal, in this case, may be for the CBO to acquire the ability to serve a larger and/or different cohort of local residents than previously served, or provide a different type of service. The long-term goal may be to enhance the viability of the CBO through diversification of its skills and funding base. In the documentation of enhancements, you will identify both strategic investments made by the hospital to build capacity, and measures that validate the achievement of identified objectives

Core Principle #5:
Collaborative Governance

The fifth Core Principle emphasizes a collaborative approach to plan, implement, and evaluate community benefit programs and activities. This is accomplished through ongoing coordination, sharing of resources and skills, and enhancing the capacity of other partners to achieve a common purpose. In practical terms, this involves engaging community stakeholders as full partners with shared accountability for community benefit program activities.

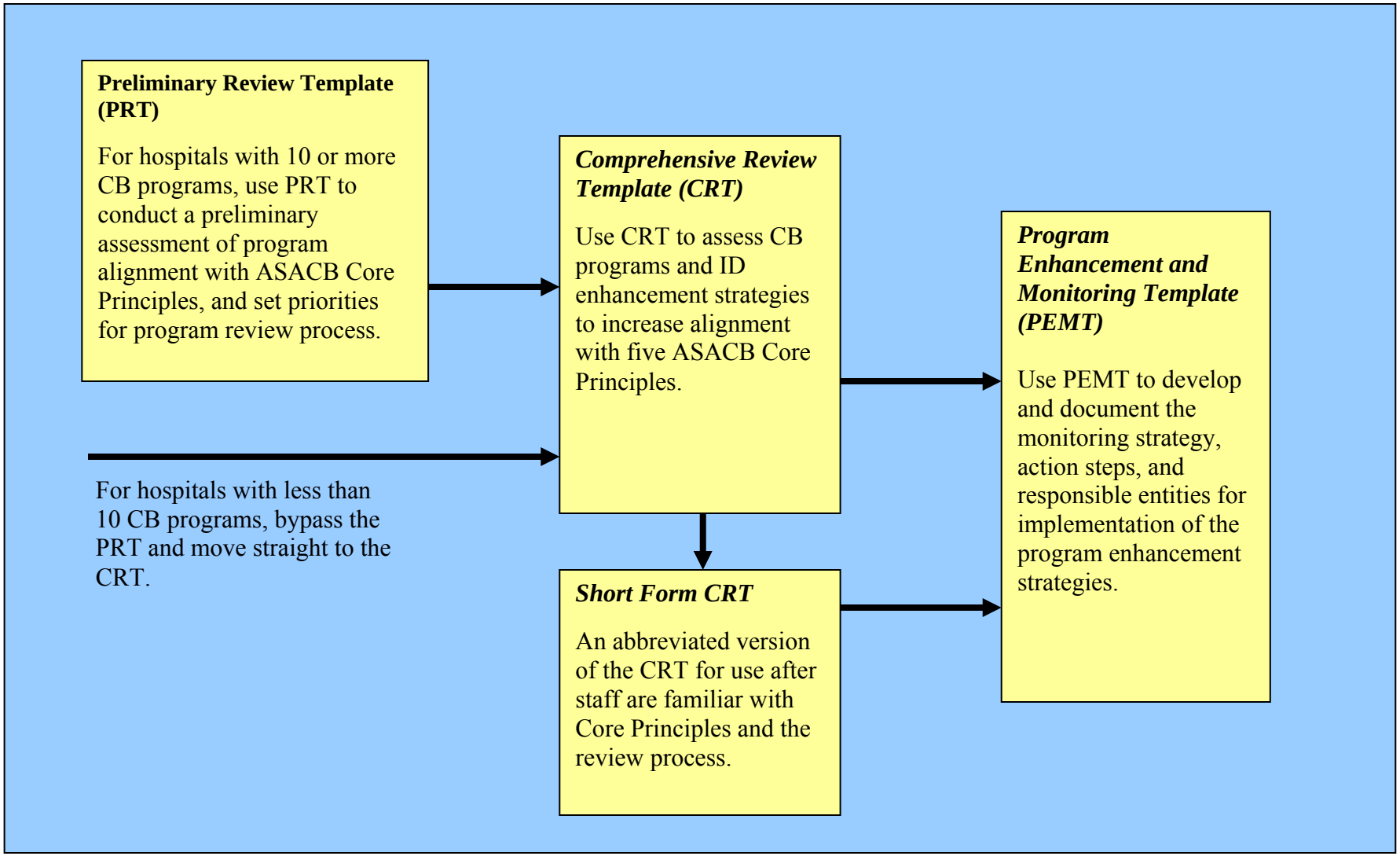
As full partners with shared accountability, community stakeholders have equal standing with their hospital partner to make decisions regarding the design, direction, and focus of a program. As such, they are invested in the success of a program, and equally share the responsibility if the program is not successful.

A clear distinction must be made between collaborative governance at the policy level and collaborative governance at the programmatic level. As part of the Institutional Policy measures, ASACB requires the establishment of a board level community benefit committee to provide oversight and policy guidance for all charitable services and activities supported by the hospital. This committee should include strong representation from diverse community stakeholders. This structure promotes collaborative governance at the policy level by engaging a variety of community stakeholders in community benefit decision making. Allied with this Institutional Policy measure, Core Principle #5 focuses collaborative governance at the programmatic level. ASACB supports the engagement of diverse community stakeholders in all aspects of community benefit programming, including selection, design, implementation and evaluation of program activities. The community stakeholders engaged in community benefit governance at the policy level are chosen for their unique set of competencies and will be different than those stakeholders involved in the planning of community benefit programs. At both the policy level and programmatic level, ASACB promotes a collaborative governance approach.

ASACB Comprehensive Review Template Flow Diagram

ASACB Comprehensive Review and Enhancement of Community Benefit Programs

Template Flow Diagram



Preliminary Review Template (PRT)

ASACB Program Activity Preliminary Review Template

Program Activity (Use ASACB Content Category)	Vuln Pop or Gen Pop (GP or VP)	If Vuln. Pop meets ASACB criteria (Y or N)	IF GP, meets DUHN criteria (Y or N)	Primary Prev. emphasis (Y or N)	Evidence based links to clin. svs (Y or N)	Comm. Capacity Bldg. emphasis (Y or N)	Collab. Gov. with Comm. Ptrs. (Y or N)	Meets ASACB criteria as a priority (Y or N)	Part of CB budget or other dept. (CB or D)	Hospital Net Contrib. (in $$$)	Hospital FDN Contrib. (in $$$)	External FDN Contrib. (in $$$)	Comm. Contrib. (in $$$)	Total Budget (in $$$)	Number of people served	Cost per person (in $$$)
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Comprehensive Review Template (CRT)

Comprehensive Review Template ©

INTRODUCTION

Please use this template for the formal review of all current community benefit programs and activities.

Section I, Baseline Assessment, presents a series of questions to assess your community benefit program based on the five ASACB Core Principles.

Section II, Enhancement Strategies, offers methods to identify appropriate program enhancements that will bring your community benefit program into better alignment with the Core Principles.

Program Title: *(Enter program title in the box.)*

Program description: *Please provide brief description of the program.*

Program goal(s): *Please identify program goal(s) and measurable objectives.*

SECTION I: BASELINE ASSESSMENT

In this section, you're going to complete an assessment of each community benefit program and its relative alignment with the five ASACB Core Principles. This will provide you with a "baseline," or a current status assessment of the program. It will serve as your starting point to complete Section II, where you will identify specific enhancement strategies as needed to increase alignment with the five ASACB Core Principles.

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1. Core Principle #1
Emphasis on Communities with Disproportionate Unmet Health-Related Needs (DUHN)

Does this community benefit program focus exclusively on vulnerable populations or does it serve the community-at-large?

a) This program focuses exclusively on Vulnerable Populations

Yes _____ No _____

*If yes, what **ASACB vulnerable population criteria** does it meet?* (Please check all that apply)

- ☐ Financial barriers to access (e.g., uninsured, underinsured)
- ☐ Language/cultural barriers to access
- ☐ Documentation barriers (e.g., undocumented immigrants)
- ☐ Lack of transportation
- ☐ Physical disability / lack of physical mobility
- ☐ Mental disability
- ☐ Social isolation (e.g., seniors living alone)
- ☐ Other (Enter "Other" information in box below)

If this program meets ASACB vulnerable populations criteria, skip to Core Principle #2; if not, classify the program as "Serves the Community at Large" and respond to community at large questions.

b) This program serves the Community At Large

Yes _____ No _____

If the program serves the community at large, please indicate whether communities with disproportionate unmet health-related needs (DUHN) have been identified.

c) We have identified DUHN community(ies) who may benefit from this program

Yes _____ No _____

If yes, identify the communities with DUHN (Enter names of each community with DUHN in box):

DUHN Community Profile (Enter key characteristics of the DUHN communities in box):

If communities with DUHN have been identified, please indicate what steps, if any have been taken to date to ensure DUHN community member access to the services and activities of this program.

d) Steps taken to date to ensure DUHN community(ies) access to the program

(Please check all that apply)

- ☐ Targeted outreach (e.g., dissemination of flyers, community meetings, PSAs)
- ☐ Include population(s) representatives in planning and decisionmaking
- ☐ Select sites in DUHN communities for services/activities
- ☐ Design program elements that are tailored to community characteristics
- ☐ Other (Enter "Other" information in box)

- ☐ No steps taken

2. Core Principle #2
Emphasis on Primary Prevention

*Please identify any primary prevention activities are **currently** implemented as part of this program. Please note that these could be activities implemented directly by the hospital **or** by community partners with whom the hospital coordinates in the implementation of the program.*

a) Types of Health Promotion

What types of **health promotion** activities does this program offer?

Please identify the health promotion activities and the responsible entity (responsible entities may be hospital staff or community stakeholders with whom the hospital coordinates).

Type of Activity and Description		Responsible Entity
☐	Group education	
☐	Social marketing	
☐	Provider[3] education	
☐	Special activities (e.g., health fair, walk)	
☐	No health promotion activities	

b) Disease/Injury Prevention

What types of **disease/injury prevention** activities does this program offer?

Please identify the types of disease/injury prevention activities and the responsible entity.

Type of Activity and Description		Responsible Entity
☐	Community-based interventions[4]	
☐	Clinical interventions[5]	

[3] Community providers outside of staff and contract physicians with admitting privileges to hospital
[4] Examples include, but are not limited to, in home fall prevention program for seniors, car seat fitting/car safety program, programs focused on defined vulnerable populations.
[5] The provision of primary care and clinical services by licensed practitioners in a variety of non-hospital settings. Examples include, but are not limited to, primary care clinics, dental care, behavioral health services, physical therapy, pharmaceuticals, skilled nursing.

☐	No disease/injury prevention activities	

c) Health Protection

What types of **health protection** activities does this program offer?

Please identify the types of health protection activities and the responsible entity.

	Type of Activity and Description	**Responsible Entity**
☐	Physical infrastructure[6]	
☐	Community support systems[7]	
☐	Economic development	
☐	Public policy advocacy[8]	
☐	No health protection activities	

3. Core Principle #3 Build a Seamless Continuum of Care

If the primary focus of the program is on community-based prevention, please indicate whether there are current evidence-based links to clinical services, and how clinicians are involved.

If the primary focus of the program is on clinical service delivery, please identify any current links to community-based prevention to reduce the demand for the services and/or community support services to prevent recurrences, and whether community stakeholders are involved.

a) Community-Based Prevention Focus or Clinical Service Focus

The **primary** focus of this program is

☐ Community-Based Prevention

☐ Clinical Service Delivery

[6] Examples include, but are not limited to, housing renovation, turning a vacant lot into a playground or community garden, putting in stop lights, speed bumps, or street lights, clearing dilapidated housing, neighborhood cleanups, and graffiti removal.

[7] Examples include, but are not limited to, neighborhood watch groups, interest group associations, establishing barter banks for neighborhood services, after school youth support networks, and childcare cooperatives.

[8] Examples include, but are not limited to, local ordinances to: clear certain kinds of billboards from neighborhoods, prohibit liquor and cigarette sales near school sites, and remove sodas and fast foods from school settings.

If the primary focus of the program is community-based prevention, please answer questions b and c, and skip d and e. If the primary focus of the program is clinical service delivery, please skip questions b and c, and answer questions d and e.

Programs with a Community-Based Prevention Focus

b) Does this program have a link to clinical service delivery?

Yes _____ No_____

If yes, please describe how it links to clinical service delivery.

c) Are clinicians engaged in the design and/or implementation of program activities?

Yes _____ No _____

If yes, please identify type of clinician and the type of activity they support.

Type of Clinician	Type of Activity

Programs with a Clinical Service Delivery Focus

d) Does this program link to community prevention and/or community-based support systems?

Yes ____ No _____

If yes, please describe the link(s)

e) Are community stakeholders engaged in program design and/or implementation?

Yes _____ No _____

If yes, please describe who is involved and the type of activity.

Person or Entity Involved	Type of Activity

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4. Core Principle 4 Community Capacity Building

Please identify a) the hospital's current role in this program, b) any community stakeholders currently engaged as partners and their role(s) in the program, and c) whether the hospital currently provides any form of assistance to build community partner capacity in the program.

a) Current hospital role in program

Identify hospital role/contribution and responsible person or entity in the box.

List specific hospital contributions	Responsible Entity (title or department)

b) Are community stakeholders engaged as partners in this program?

Yes ____ No ____

*If yes, identify the current community partners and their roles in the program (Identify **only** community partners that are making ongoing, substantive contributions to the program; i.e., if a community stakeholders only role is to come to periodic meetings as an advisor, do not include in list.)*

(Enter description in box)

Community Partner	Contribution(s)

Community Partner	Contribution(s)

c) Does the hospital currently provide any form of assistance to build the capacity of community partners in the program?

Yes _____ No_____

If yes, please identify the form of capacity building assistance (e.g., technical assistance, advocacy, equipment or other material donations, in-kind support), and any objectives that have been identified.

Form of Capacity Building Assistance	Capacity Building Objective

5. Core Principle #5 Collaborative Governance

*Please identify the **current** involvement of community stakeholders as decisionmaking partners in this program. Areas for decisionmaking include a) program design, b) program targeting, c) deliver service component, d) ID and secure financial/in-kind support (e.g., space), e) outreach/marketing, f) evaluation, g) advocacy.*

a) Are community stakeholders engaged as decisionmaking partners in this program?

Yes _____ No _____

If yes, please identify stakeholders, their role designation (see letters associated with the role above), and description of role in box.

Current Stakeholders	Current Roles (please list letter [a,b,c,d,e,f,g] and describe)

SECTION II: ENHANCEMENT STRATEGIES

Please identify program components from Section I that are not aligned with each of the five Core Principles. These components will be your focus in the completion of Section II. In this section, you will identify and design program enhancement strategies that will increase alignment with each of the five Core Principles.

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1. Core Principle #1 Emphasis on Communities with Disproportionate Unmet Health-Related Needs (DUHN)

If the program serves the community at large, and communities with DUHN have not been identified previously, please determine whether such communities are located within the geographic parameters established for the program.

a) Are there communities with DUHN within the geographic parameters of this program?

Yes _____ No _____

If yes, please identify each community, and outline key characteristics (e.g., ethnic/cultural composition, socio-economic status, HH income, disease prevalence, economic activity).

Communities with DUHN	Key Characteristics

b) What steps should be taken to ensure that the identified DUHN communities have access to this program?

(Please check all that apply)

- ☐ Targeted outreach (e.g., dissemination of flyers, community meetings, PSAs)
- ☐ Include population(s) representatives in planning and decision making
- ☐ Select proximal sites for services/activities
- ☐ Design elements in program tailored to community characteristics
- ☐ Other (Enter "Other" information in box below)

C) Please describe specific strategies to be implemented.

Enter specific strategies in box.

---

2. Core Principle #2
Emphasis on Primary Prevention

Please identify specific enhancements to be implemented to increase program emphasis on primary prevention. New program components may be implemented by the hospital or by community partners in collaboration with the hospital.

a) A new health promotion component will be added, or an existing health promotion component will be enhanced.

Yes _____ No _____

If yes, please identify potential enhancement strategies.

*Identify ways to strengthen the **existing** health promotion component*

*Identify **new** health promotion component to be implemented by hospital or a community partner*

*Identify **hospital and/or community resources needed** to implement health promotion enhancement*

b) A new disease/injury prevention component will be added, or an existing disease/injury prevention component will be enhanced.

Yes _____ No _____

If yes, please identify potential enhancement strategies.

*Identify ways to strengthen the **existing** disease/injury prevention component*

*Identify **new** disease/injury prevention component to be implemented by hospital or community partner*

*Identify **hospital and/or community resources needed** to implement health promotion enhancement*

c) A new health protection component will be added, or an existing health protection component will be enhanced.

Yes _____ No _____

*Identify ways to strengthen the **existing** health protection component*

*Identify **new** health protection component to be implemented by hospital or a community partner*

*Identify **hospital and/or community resources needed** to implement health promotion enhancement*

---

3. Core Principle #3
Build a Seamless Continuum of Care

Please identify enhancements to establish operational links between community-based prevention programs and clinical services, and to engage clinicians and community stakeholders in the program.

a) For community-based prevention programs, identify links that can be made to clinical services, and in what ways providers can be engaged to help reduce the demand for clinical services

Identify Links from community-based programs to clinical services	Ways to engage providers in program design and implementation

b) For clinical services, identify links to community-based prevention programs, and in what ways community stakeholders can be engaged to reinforce and sustain positive health impacts

Identify links from clinical services to community-based programs	Ways to engage stakeholders in program design and implementation

4. Core Principle #4
Community Capacity Building

*Please identify ways to expand the roles of existing community partners in program activities, ways to engage new community stakeholders as partners, and ways that the hospital may provide assistance to build community capacity. Please keep in mind that you are in the idea phase of this process. As such, you are only identifying **potential** new roles for existing partners and/or new community stakeholders to be engaged. We encourage you to think broadly and consider all options, including the engagement of community stakeholders with whom you may have had difficulty in the past.*

a) New or expanded roles for existing community partners

*Please identify **existing community partner**s and list the **new or expanded role**(s) to consider in the program.*

Community Partners	New or Expanded Roles

b) New community partners and potential role(s) in program

*Please identify potential **new community partners** and list the role(s) they can play in the program.*

New Community Partners	Roles

c) Hospital assistance to build community capacity

Please identify and describe the type of assistance the hospital can provide to increase the capacity of community stakeholders to support and sustain the goals of the program.

Types of Resources	Brief Description
❑ Financial assistance	
❑ Technical assistance/Expertise	
❑ Staff support	
❑ Space and facilities	
❑ Materials and equipment	
❑ Advocacy	
❑ Other	

5. Core Principle #5 Collaborative Governance

Please identify potential enhancements to increase the involvement of community stakeholders as decisionmaking partners in the program.

a) Current Community Stakeholders and Proposed New Roles

*Please identify community stakeholders **currently** involved in program and ways to increase their involvement as decision making partners. Roles include: a) program design, b) program targeting, c) deliver service component, d) ID and secure financial/in-kind support (e.g., space), e) outreach/ marketing, f) evaluation, g) advocacy.*

Enter stakeholders, role designation (letter associated with the role), and description of role in box.

Current Stakeholders	New Roles (please mark letter [a,b,c,d,e,f,g] and describe)						
	A	B	C	D	E	F	G

b) New Community Stakeholders and Roles

*Please identify potential **new** community stakeholders and potential roles as decision making partners.*
Roles include: a) program design, b) program targeting, c) deliver service component, d) ID and secure financial/in-kind support (e.g., space), e) outreach/ marketing, f) evaluation, g) advocacy.

Enter stakeholders, role designation (letter associated with the role), and description of role in box.

New Stakeholders	**Roles (please mark letter [a,b,c,d,e,f,g] and describe)**						
	A	**B**	**C**	**D**	**E**	**F**	**G**

Comprehensive Review Template – Short Form

Advancing the State of the Art in Community Benefit
Comprehensive Review Template
Short Form

Date:

Program Name:

Director/Coordinator:

Program Goal(s):

Program Description:

Part I - ASSESSMENT

Core Principle #1 – Emphasis on DUHN communities

Core Principle #1	Yes/No →	If yes, describe activity →	Means of Verification (How do we know this?)
Does this program target vulnerable[9] populations?			
Does this program target the general population/community at large?			
If the program serves the community at large, is there an emphasis on communities with disproportionate unmet health needs (DUHN)?			

Core Principle #2 – Emphasis on Primary Prevention

Core Principle #2	Yes/No →	If yes, describe activity →	Means of Verification (How do we know this?)
Does this program have a health promotion component?			
Does this program have a disease/injury prevention component?			
Does this program have a health protection component?			

[9] Defined as people with financial or non-financial barriers to care, or physical and/or psychological disabilities.

Core Principle #3 – Build a Seamless Continuum of Care

Core Principle #3	Yes/No →	If yes, describe activity →	Means of Verification (How do we know this?)
If this program focuses on community-based prevention activities, is there a link to clinical service delivery?			
Are clinicians engaged in the design and implementation of program activities?			
If the program focuses on clinical services, is there a link to community prevention and/or support systems?			
Are community stakeholders involved in the design and implementation of activities?			

Core Principle #4 – Build Community Capacity

Core Principle #4	Yes/No →	If yes, describe activity →	Means of Verification (How do we know this?)
Please identify the role of the hospital in supporting this program.			
Do community partners have a role in this program?		Identify partners and associated roles.	

Core Principle #5 – Emphasis on Collaborative Governance

Core Principle #5	Yes/No →	If yes, describe activity →	Means of Verification (How do we know this?)
Are community stakeholders engaged as partners in planning, implementing and/or evaluating this program?		Identify stakeholders and their roles.	

Part II - ENHANCEMENT

1) Emphasis in communities with disproportionate unmet health needs

a) If the program serves the community at large, what enhancement(s) would you make to better reach and address the needs of communities with DUHN?

•	•

b) How will you do this?

•	•

2) Primary Prevention

Health Promotion (encourage behavior/lifestyle change in general population)

a) What are ways to add or strengthen a health promotion component in the program?

•	•

b) What resources do you need to make this happen?

•	•

Disease Prevention (special interventions for populations at particular risk)

a) What are ways to add or strengthen a disease prevention component in the program?

•	•

b) What resources do you need to make this happen?

▪	▪

Health Protection (changes in <u>community</u> environment to support changes in behavior/lifestyle)

a) What are ways to add or strengthen a health protection component in the program?

•	•

b) What resources do you need to make this happen?

▪	▪

3) Build a Seamless Continuum of Care

a) If the program focuses on community-based prevention, in what ways might providers be engaged to help reduce the demand for clinical services?

▪	▪

b) If the program focuses on clinical services, in what ways might community stakeholders be engaged to reinforce and sustain positive health impacts?

•	•

c) How can the program better support other programs in the hospital and how can other hospital programs support this community benefit program?

•	•

4) Community Capacity Building

a) What are potential expanded roles for current community partners?

•	•

b) Which other community stakeholders could help strengthen the program?

•	•

c) What assistance can the hospital provide to increase the capacity of community stakeholders to support and sustain the goals of the program?

•	•

5) Collaborative Governance

a) What are ways to increase the involvement of community stakeholders to help determine the focus and direction of the program?

•	•

Program Enhancement and Monitoring Templates (PEMT)

Program Enhancement and Monitoring Templates

ASACB Program Enhancement and Monitoring Templates (PEMT) present a detailed analysis of a hospital's community benefit program and the steps involved in bringing it into alignment with the ASACB Core Principles. The focus of the Enhancement and Monitoring Templates is to take an existing community benefit program and bring it into better alignment with the five ASACB Core Principles. To this end, program baselines and enhancements have been identified. Action Steps are designed to move the community benefit program from the baseline to the desired enhanced state, with measurements taken at key points to show movement toward the program enhancement. The Program Enhancement and Monitoring Templates serve as a detailed strategic action plan to implement community benefit programs.

Template I

Template 1 provides an overview of a hospital community benefit program, including: program Title, brief Description, program Goal/Aim and Outcome(s) for the program. Baseline and Enhancement Strategies for the program are outlined based on the ASACB five Core Principles[10]. A program may not have Enhancement Strategies for all of the Core Principles; it may be that the program is already in alignment with a Core Principle and does not require a further enhancement. An enhancement may not be relevant for a particular program or is too far "upstream" to be identifiable.

Template 2

Template 2 takes each of the Enhancement Strategies and details the Evidence/Indicators of Success to accomplish the Enhancement Strategies, Data/Information Source, the Action Steps and Timeline, Person or Entity Responsible, and Progress toward Achievement of Action Step. At the bottom of each Enhancement Strategy is an Indicator/Link to Goal statement that provides an explanation for how each Enhancement Strategy contributes to the overall program goal.

The Enhancement Strategies in Template 2 are listed in order from Core Principle 1 through 5. It is important to note that some of the Enhancement Strategies may be duplicative, that is, the same enhancement may be listed as accomplishing more than one Core Principle on Template 1. These Enhancement Strategies will be listed only once on Template 2 in the chronological order where the enhancement is most likely to occur.

Program Components

Descriptions of each of the Program Components follow:

Goal/Aim: Overall goal/aim for the program. Program enhancements should support achievement of the goal while moving the program into alignment with the ASACB Core Principles.

Measurable Outcomes: Outcomes for the program. The standards of measured benefits or changes in individuals' or populations' knowledge, attitudes, values, skills, behavior, condition or status. If these measures are achieved, then the program goal will be achieved.

[10] For a detailed description of the Core Principles, see: Public Health Institute. 2004. Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability. Oakland, CA: Public Health Institute or visit the ASACB website at www.asacb.org.

Each enhancement does not have an outcome. Rather, enhancements support the achievement of the overall program outcomes.

Enhancement Strategies: Strategies for program enhancement are based on the ASACB Core Principles. The enhancements support the program goal/aim and provide a strategy that will aid the progress toward achievement of the program outcomes.

Evidence/Indicators of Success: Measures or evidence that indicate progress toward the achievement of the Enhancement Strategy, and incremental movement toward the measurable outcomes and program goals/aims. A timeframe establishes when/how often the measure should be taken. Some indicators of progress may be one time indicators, while others might be measured on a regular basis (e.g. quarterly, monthly).

Data Source: Sources of data to measure the Evidence/Indicators of Success.

Action Steps and Timeline: Systematic step-by-step activities with associated timelines. Action Steps are detailed activities undertaken to accomplish the Enhancement Strategies as measured by the Evidence/Indicators of Success. Establishing realistic timelines to accomplish the Action Steps will result in a prioritization of activities.

Person or Entity Responsible: The person or group responsible for accomplishing the action step according to the identified timeline.

Progress Toward Achievement of Action Step: Documentation of accomplishment of action steps.

Indicators/Links to Overall Goal: Specifically addresses how each Enhancement Strategy contributes to the achievement of the program goal.

Program Enhancement and Monitoring Template #1

Program Title:

Description:

Program Goal(s)/Aim(s):

Program Measurable Outcomes:

BASELINE	**Core Principle #1** **Emphasis on DUHN**	**Core Principle #2** **Primary Prevention**	**Core Principle #3** **Seamless Continuum of Care**	**Core Principle #4** **Capacity Building**	**Core Principle #5** **Collaborative Governance**
ENHANCEMENT STRATEGIES	**Core Principle #1** **Emphasis on DUHN**	**Core Principle #2** **Primary Prevention**	**Core Principle #3** **Seamless Continuum of Care**	**Core Principle #4** **Capacity Building**	**Core Principle #5** **Collaborative Governance**

Program Enhancement and Monitoring Template #2

ENHANCEMENT STRATEGIES	EVIDENCE/ INDICATORS OF SUCCESS AND DATA SOURCE	ACTION STEPS & TIMELINE	PERSON OR ENTITY RESPONSIBLE	PROGRESS TOWARD ACHIEVEMENT OF ACTION STEP
Enhancement Strategy		Date		
		Date		
		Date		
Indicator(s)/Links to Overall Goal:				
Enhancement Strategy		Date		
		Date		
		Date		
Indicator(s)/Links to Overall Goal:				

ENHANCEMENT STRATEGIES	EVIDENCE/ INDICATORS OF SUCCESS AND DATA SOURCE	ACTION STEPS & TIMELINE	PERSON OR ENTITY RESPONSIBLE	PROGRESS TOWARD ACHIEVEMENT OF ACTION STEP
Enhancement Strategy		Date		
		Date		
		Date		
Indicator(s)/Links to Overall Goal:				
Enhancement Strategy		Date		
		Date		
		Date		
Indicator(s)/Links to Overall Goal:				

ASACB Acronyms and Glossary

Acronyms

The following are acronyms used in documents published as part of the Advancing the State of the Art in Community Benefit demonstration. Most of these acronyms are unique to the demonstration; a few are commonly used in literature, or have been developed for specific tools developed by others in the field.

ACS: Ambulatory Care Sensitive[11] conditions

ASACB: Advancing the State of the Art in Community Benefit

CaL: Community-at-Large

CB: Community Benefit

CBISA: Community Benefit Inventory for Social Accountability

CBO: Community-Based Organization

CNI: Community Needs Index[12]

CP: Core Principles (there are 5)

CRT: Comprehensive Review Template

DUHN: Disproportionate Unmet Health-Related Needs

IP: Institutional Policy Measures (there are 14 IP measures)

PEMT: Program Enhancement and Monitoring Template

PRT: Preliminary Review Template

[11] Ambulatory Care Sensitive conditions include a class of 28 clinical diagnoses developed by Billings, J., et al, 1993 to cover conditions for which a group of physicians agreed that hospitalizations could be reduced or prevented through timely access to primary care and preventive services.

[12] An assessment methodology developed by Catholic Healthcare West that combines five measures (e.g., income, education, culture, insurance coverage, and housing) to identify communities with disproportionate unmet health-related needs as a focus for community benefit programs.

Glossary of Terms

Activity – A single service or activity implemented and/or supported by hospital that may or may not be linked to other services and/or activities.

Ambulatory Care Sensitive Conditions – a class of illnesses for which physicians have determined that timely access to quality primary care services would reduce the need for hospitalizations. There are 28 medical diagnoses in three categories (preventable conditions, acute onset illnesses, chronic conditions) that have been identified as ACS conditions.

Baseline – refers to the initial assessment of a hospital's community benefit program activities as measured against the five Core Principles.

Collaborative Betterment - begins within public, private, or nonprofit institutions outside the community and is brought into the community. Community involvement is invited into a process designed and controlled by larger institutions. This collaborative strategy can produce policy changes and improvements in program delivery and services, but tends not to produce long-term ownership in communities or to significantly increase communities' control over their own destinies[13].

Collaborative Empowerment - begins within the community and is brought to public, private, or nonprofit institutions. An empowerment strategy includes two basic activities: (1) organizing a community in support of a collaborative purpose determined by the community; and (2) facilitating a process for integrating outside institutions in support of this community purpose. The empowerment approach can produce policy changes and improvements in program delivery and services. It is also more likely to produce long-term ownership of the coalition's purpose, processes, and products in communities and to enhance communities' capacity for self-determination[14].

Collaborative Governance - emphasizes a commitment to a collaborative approach to the governance and management of community benefit activities. Meaningful partnerships between hospitals and community stakeholders create a platform for shared action and advocacy to address systematic problems like access to health care.

Community - all persons and organizations within a circumscribed geographic area that have a sense of interdependence and belonging.

Community Assets – a full spectrum of local entities, including community based organizations, businesses, physical infrastructure, formal and informal community groups, and the skills of individual residents (for more on community assets see works by John McKnight).

Community-at-Large – The general population. Programs that serve the community-at-large are not specifically targeted toward vulnerable populations; rather they are designed to engage all members of a community (e.g. health fairs, support groups, community health education).

Community Benefit – A legal term first used in IRS Ruling 69-545 (1969) that defines the charitable

[13] Himmelman, Arthur T. 2002. Communities working collaboratively for a change. Minneapolis, MN: The Himmelman Consulting Group, page 5.

[14] Ibid, page 6.

obligations of tax-exempt hospitals. The ruling defined community benefit as "the promotion of health for a class of persons large enough to constitute benefit for the community at large." In practical terms, community benefit encompasses a full range of services and activities provided by nonprofit hospitals to address the symptoms and causes of health-related concerns.
As implied in the original IRS ruling, the services or activities should produce a measurable impact in the community. The community benefit standard does not explicitly require a focus on the poor, but the language suggests the need for an evidence-based, population health approach. As such, an emphasis in communities with disproportionate unmet health-related needs is both expected and necessary in order to produce a measurable impact.

Community Benefit Manager – an individual at a hospital facility responsible for community benefit or community health management. Community Benefit Mangers possess special competencies that enable them to accomplish the community benefit/community health function.

Community Capacity Building – to mobilize and build the capacity of existing community assets (i.e., community-based organizations, businesses, physical infrastructure, local coalitions, and the skills of individual community members). Involves the strategic allocation of charitable resources (i.e., staffing, equipment, technical assistance, financial support, advocacy) to enhance effectiveness and viability of community-based organizations and informal networks, reduce duplication of effort, and provide a basis for shared advocacy and joint action to address structural problems in the community.

Core Principles – a strategic approach to community benefit program planning and implementation is guided by a commitment to five ASACB Core Principles. Core Principles direct the design, implementation, and evaluation of community benefit program activities. The five Core Principles are: 1) Emphasis on Disproportionate Unmet Health-Related Needs (DUHN); 2) Emphasis on Primary Prevention; 3) Build a Seamless Continuum of Care; 4) Build Community Capacity; and 5) Emphasis on Collaborative Governance.

Empowerment - the capacity to set priorities and control resources that are essential for increasing community self-determination[4].

Enhancement Strategies - Strategies for program enhancement are based on the ASACB Core Principles. The enhancements support the program goal/aim and provide a strategy that will aid the progress from the program baseline toward achievement of the program outcomes.

Indicator - a measure that indicates progress toward the outcome. It is an intermediate measure, a benchmark, a milestone along the way to the outcome.

Influence – power to affect change.

Initiative – the early stages of a large-scale effort to address one or more priority issues, typically including an advocacy component. Note: An initiative can become one or more programs, to the degree that a hospital and/or community stakeholders take on an identified set of coordinated activities for an unspecified period of time. Similarly, an initiative can become a project if a hospital and community stakeholders secure funding for a coordinated set of activities for a specified period of time from external philanthropic entities.

Institutional Capacity Building – to build the capacity of an organization's assets. Enhance existing programs, develop new ones, allocate financial resources, materials, expertise and advocacy to build

on what already exists in the organization. The result should enhance the effectiveness and viability of the institution.

Monitoring Strategy – the process by which data collection is initiated and completed. How will you document progress (by whom, how often, which data)?

Outcome measures – standards of measured benefits or changes in participants' knowledge, attitudes, values, skills, behavior, condition or status. If these measures are achieved, then the program goal will be achieved. The regular, systematic tracking of the extent to which program participants experience the benefits or changes intended.

Primary prevention – an umbrella term to include community health improvement efforts. Primary prevention includes three types of activities:
Health promotion: Health messages to encourage healthy lifestyles in the general population.
Disease prevention: Targeted interventions for at-risk populations.
Health protection: Make changes in local environments to support health behaviors

Process measures – documentation of daily tasks, activities, work plans, or services provided.

Program – a set of coordinated activities with specified measurable objectives and no defined end date. The hospital may lead or be in a contributing role with community partners.

Project – same as a program, but with specified start and end dates and most often funded by external philanthropic entities. Note: A project can become a program if hospital and community partners determine to continue the set of coordinated activities for an unspecified period after the end of the external grant period.

Seamless Continuum of Care – the development of evidence-based linkages between clinical services and community health improvement activities that yield measurable impacts on health status and quality of life.

Secondary Prevention – activities that involve the early detection and prompt treatment of illnesses to slow their progression, reduce complications and minimize disability.

Sustainability – aligning hospital governance, management and operations in a manner that will facilitate broad, effective and continued commitment.

Tertiary Prevention – rehabilitation services to limit disability and support self-sufficiency among community members who have experienced severe forms of illness and disease.

Vulnerable populations – target populations that face financial or non-financial barriers to care (legal, transportation, language, culture, etc.) and/or physical or psychological disabilities.