Community Health Needs Assessment

2017 Implementation Guide

MHA
MISSOURI HOSPITAL ASSOCIATION

Table of Contents

INTRODUCTION

The community health needs assessment implementation strategy is the nonprofit hospital's plan for addressing the health needs identified through a CHNA. It is a systematic process involving multiple stakeholders to deploy meaningful and pragmatic steps to act upon a community's priority health needs. This plan is used by health, governmental, education and human service agencies, in collaboration with community partners, to set priorities and provide key resources. It is critical for developing policies and defining actions to target efforts that promote health. The implementation plan should define the vision for the health of a community through a collaborative process and should address strengths, weaknesses, challenges and opportunities that exist to improve the health status of the community. The implementation plan should be updated as community needs and priorities change, hospital resources change, or based on evaluation results. The Missouri Hospital Association's Completing a Community Health Needs Assessment 2017 Guidance document serves as a valuable resource.

TOP HEALTH ISSUES IDENTIFIED BY MISSOURI HOSPITALS

After careful review of CHNAs across Missouri hospitals, the following 14 priority health issues were identified. These health issues are highly prevalent and cause significant health burdens to Missouri residents. Bringing the right people to the table and deploying best practice implementation strategies can help address these issues, leading to better outcomes.

- Access to Health Care
- Asthma
- Cancer
- Cardiovascular Health
- Chronic Disease Care
- Dental Health
- Diabetes
- Health Literacy
- Mental Health
- Obesity
- Smoking Cessation
- Substance Abuse
- Wellness and Prevention
- Women's Health Services

MHA has developed evidence-based resources and strategies to address the aforementioned issues and provide hospitals with important information to begin working toward solutions. Different settings require different interventions; thus, choosing the right approach can be a key determinant of success or failure.

The answers to the following questions will help determine the appropriate strategy for each health issue selected for action.

- Is it critical that the initiative be included on the hospital's IRS Form 990 as part of its community benefit report?
- Is it efficient to align a community health issue with a current service and market expanded continuity of care without considering the initiative a community benefit?
- Is it important that all community benefit contributions also be considered initiatives to improve community health outcomes?
- Is improvement likely if funding is provided, but not personnel or other resources?
- Is participating as a member in a broad, community-based initiative an appropriate role for a particular cause or health issue?
- Is it important that the hospital lead an initiative with other invited partners to implement a focused and specific initiative targeting one specific population?

ENVIRONMENTS FOR IMPLEMENTATION

Below are examples of common settings to consider when implementing initiatives.

Community-Based Settings

This multifaceted approach focuses on strategies and activities to create change in the knowledge, attitudes, beliefs and skills that impact health. It is geared toward individuals and families with the ultimate goal of making changes to organizational and environmental factors that impact health.

School-Based Settings

Prevention and interventions are aimed at helping students, parents, teachers and administrators prevent and manage chronic illnesses by providing programs, policies and environments that support healthy lifestyles.

Worksite-Based Settings

This group targets employees who spend most of their time away from home. Creating the necessary infrastructure to enable healthy diets and lifestyles is critical in helping prevent or manage many chronic illnesses.

Faith-Based Settings

Some communities believe that information delivered from the pulpit is more truthful, especially if delivered by their leaders, as opposed to information that is coming from other sources. This is an important consideration when implementing initiatives — it can result in the difference between success and failure.

Health Care Facility-Based Settings

This initiative typically occurs in a health care or public health setting, such as a doctor's office, hospital, local public health agency, etc.

Home-Based Settings

The home-based approach involves entire families in an effort to prevent and manage chronic illnesses, forming the basis for much needed social support for disease prevention and management.

REGULATORY

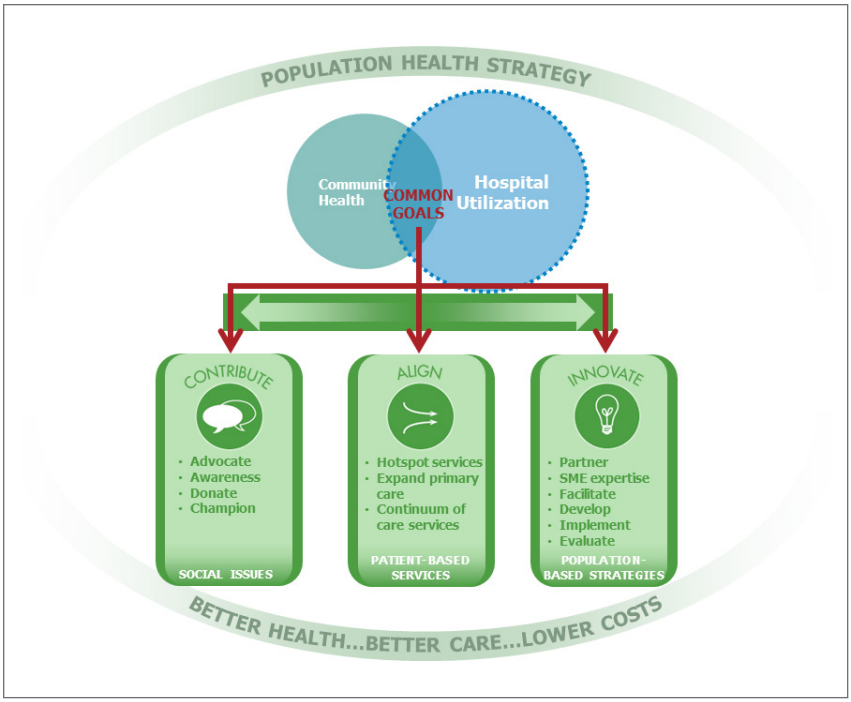
The Internal Revenue Service and the U.S. Treasury Department released the final regulations implementing the Affordable Care Act provisions that add more obligations on charitable organizations covered by the 501(c)(3) IRS code. Provisions under Section 501(r), added to the code by the ACA, impose new requirements on 501(c)(3) organizations that operate one or more hospital facilities or organizations. These hospitals must conduct a CHNA and adopt an implementation strategy that meets the needs identified at least once every three years. These requirements are effective for tax years beginning after March 23, 2012.

In addition, hospitals must complete an IRS Schedule H (Form 990) annually to provide information on the activities and policies of, and community benefit provided by, the hospital. The IRS requires the implementation strategy to be adopted on the 15th day of the fifth month after the end of the taxable year in which the CHNA was completed. Hospitals are required to attach the implementation strategy to its Form 990 or a link to the organization's website that provides public access to the document.

MHA has prepared a guide to help hospitals in using this provision while promoting charitable programs and services. Hospitals must adopt an implementation strategy (as submitted to the IRS) to meet the identified community health needs by the end of the same taxable year in which it conducts its CHNA.

Although hospitals can collaborate with other organizations when conducting CHNAs and developing implementation strategies, the U.S. Treasury Department and the IRS requires a "hospital organization operating multiple hospital facilities to document separately the CHNA and the implementation strategy for each of its hospital facilities." It is acceptable and expected that their implementation strategies may be very similar, but each hospital still will need to customize the shared implementation approach to produce an implementation strategy report with its name, specific programs and resources, and priorities. This is in keeping with the law's intent to ensure transparency and accountability for all nonprofit hospitals.

The implementation strategy should be thought of as an action plan to address pressing health needs in the community, not simply as an IRS requirement. Therefore, each hospital's strategy should be customized to state what health needs the hospital plans to meet; what needs the hospital will not address and the reasons why; a description of the resources the hospital plans to commit; and planned collaborations. This information should be described in enough detail so that community members can clearly understand what the hospital plans to do. It is recommended that hospitals consult with legal counsel to review what has been reported in recent guidance and what should be included in the implementation strategy, keeping in mind that the IRS wants hospitals to be transparent and accountable.



It is required that a hospital provide annual updates on its Form 990 describing the actions taken during the tax year to address the significant health needs identified in the CHNA. Also, Form 990 requires a hospital to report certain community benefit program information (including whether the hospital has prepared and made public a community benefit report). Since the hospital's CHNA report, implementation strategy and Schedule H are publicly available, policymakers, researchers, the media and community groups are able to view how the hospital's program accomplishments align with prioritized needs.

HOSPITAL INDUSTRY DATA INSTITUTE AND MISSOURI FOUNDATION FOR HEALTH — COLLABORATIVE COMMUNITY HEALTH DATA PLATFORM

Newly Enhanced Community Health Data Platform

Where we live, work, learn and play affects our health. Access to data regarding health factors and health outcomes in the places where Missourians live, helps provide communities and organizations with the information necessary to take action, and create and sustain a healthy state. Effectively engaging communities to address the social, economic, environmental, clinical and behavioral factors that affect health is critical for improving population health outcomes. In standardized comparative measures across these domains, Missouri

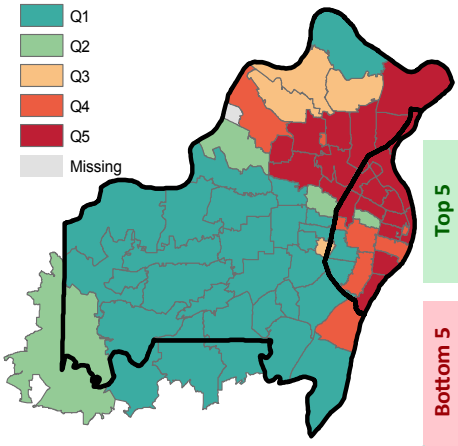
has ranked below the national average for overall health since 1990 (America's Health Rankings).

Access to sub-county-level health data is a common gap in assessing community health and designing effective health improvement interventions. In collaboration with the Washington University School of Medicine, Robert Wood Johnson Foundation and County Health Rankings & Roadmaps, researchers at HIDI, MHA's data company, developed the following Missouri ZIP Health Rankings model that provides detailed data on health factors and outcomes at the ZIP-code level in Missouri.

Based on the County Health Rankings population health framework, this data offers community health practitioners a rich set of information to explore sub-county variation in health, and formulate targeted intervention strategies to deliver scarce population health improvement resources to areas in most need. More information on the research behind these data can be found in the *Journal of Public Health Management & Practice*.

As a result of the study, HIDI is working in collaboration with the Missouri Foundation for Health to develop a publicly available, shared platform designed to leverage the data in CHNAs. The system will be hosted on the Community Commons platform of the University of Missouri, Center for Applied Research and Environmental Systems. The platform will feature customizable data displays and interactive mapping functionality of content at both county and ZIP-code levels, graphic and tabular data visualization, and expandable data layers to accommodate novel data sources, locations of hospitals, federally qualified health centers, local public health agencies, and access to other community-based amenities that influence health, such as access to groceries and transportation. The platform will allow users to evaluate data to prioritize health and socioeconomic indicators in defined service areas, design customized reports, and generate downloadable content in editable formats (Word, PDF, Excel) to assist in preparing personalized CHNAs. Enhancing the availability of community health data at the county and ZIP-code levels in Missouri will help improve health outcomes by informing health improvement initiatives and how best to allocate scarce population health resources.

Missouri ZIP Health Rankings Example of Subcounty Variation in the St. Louis Area



	ZIP	Community	HF Rank (of 955)	HO Rank (of 955)	Social Factors of Concern	Health Factors of Concern
Top 5	63005	Chesterfield	1	1		
	63131	Town & Country	3	3		
	63105	Clayton	4	4		
	63124	Ladue	5	5		
	63141	Creve Coeur	6	7		
Bottom 5	63115	North City	940	941	Unemployment	Assault Diagnoses
	63120	Pine Lawn	941	942	Sing Parent House	Preventable Hosp
	63106	Saint Louis Place	942	945	Renter Occ. Housing	Preventable ED Visits
	63107	College Hill	943	949	Children in Poverty	Premature Mortality
	63113	The Ville	944	950	Vacant Housing	STIs

Source: Hospital Industry Data Institute

Developing an Implementation Strategy

As stated previously, the IRS requires the implementation strategy to be adopted on the 15th day of the fifth month after the end of the taxable year in which the CHNA was completed. Hospitals are required to attach the implementation strategy to its Form 990 or a link to the organization's website that provides public access to the document.

1 STEP ONE

PLANNING FOR THE IMPLEMENTATION STRATEGY

Good planning is essential. It can mean the difference between success and failure. Key elements to consider during this phase of the implementation process include the following.

- Has your organization completed the community readiness survey to assess whether or not the organization is prepared for the implementation strategy?
- Does your organization have a sustainable community benefit infrastructure with adequate staffing, budget, policies and leadership commitment to support the implementation strategy?
- Has your organization's CHNA been completed and priority issues identified?
- Does your organization have solid community support of members and groups, including persons knowledgeable about the community and public health?
- Does your organization have the required political support of key decision-makers that will be essential in the execution of the implementation plan?
- Does your organization have an implementation team capable of executing the implementation plan?
- Does your organization have a designated team leader capable of leading the implementation team in the right direction? This is extremely important as it can determine the success or failure of the implementation strategy. It is recommended that you select a team leader who is knowledgeable about the key requirements of the community benefit program and has a vast knowledge of the CHNA and implementation process. Important qualities to consider when selecting a team leader for the implementation strategy include the following.
  - **Effective Communicator:** The leader must present expectations to team members in a way that will be easily understood.
  - **Organized:** Team leaders put processes and systems in place that maintain order and guide team members toward meeting desired goals and objectives.
  - **Confident:** Team leaders must be confident in their abilities and those of their team.
  - **Respectful:** Team leaders empower team members by encouraging them to offer ideas about decisions and voice suggestions.
  - **Equitable or Fair:** This kind of leader ensures all members receive the same treatment.
  - **Integrity:** This kind of leader will gain the trust of team members because they follow through and treat others with the utmost respect.
  - **Influential:** This quality will help motivate others to work toward meeting the goals and objectives set forth to be accomplished.
  - **Delegator:** A team leader's ability to delegate tasks to others and trust them to complete the job.
  - **Facilitator:** The ability to help team members stay on task and guide them to meet the desired goals and objectives effectively.
  - **Negotiator:** The ability to negotiate helps to streamline the decision-making process, as well as solving complex problems swiftly and decisively in the best interest of the team.

It also is extremely important to select a diverse implementation team to ensure that issues are viewed from different perspectives, which provides a key strength to achieving a well-rounded plan.

"Select a combination of doers and influencers. Doers are those that will be willing to roll their sleeves and to do the physical work needed to see the assessment is planned and implemented properly. Influencers are those who, with a single phone call or signature on a form, will enlist other people to participate or will help provide the resources to facilitate the assessment. Make sure that the staff team is large enough to accomplish the work, but small enough to make decisions and reach consensus. If necessary, subcommittees should be formed to handle specific tasks."
– CHA Assessing & Addressing Community Health Needs, 2015 Edition 11

2 STEP TWO

DEVELOPING GOALS AND OBJECTIVES PER IDENTIFIED HEALTH ISSUE

The entire group tasked with working on the implementation plan should always decide what aspects need to be evaluated. Also, what do organizations that are funding the intervention anticipate in terms of the evaluation? It is recommended that organizations evaluate the different processes used in identifying priority health issues, implementing the intervention process, findings of the intervention as it relates to attainment of goals and objectives, and finally, the effectiveness of the group in planning, implementation and intervention processes and outcomes. Traditional program evaluation involves a study with very specific and measured interventions for a targeted population. Ideally, such an evaluation allows for baseline assessments, control groups and the elimination of factors that would threaten the validity of findings. However, communities are complex and dynamic, creating significant challenges in program evaluation.

Further, use of mutually-reinforcing strategies among multiple stakeholders creates opportunities for efficiency and effectiveness, but reduces the ability to demonstrate how much impact each intervention has on improving the health issue. However, the purpose of most community health initiatives is to demonstrate reasonable evidence of the following.

- Deliberate interventions likely are contributing to a positive change on a community health issue.
- Efficient, but not excessive, resources are contributing to the positive impact.
- The positive change may be sustained or improved with continued effort.

To achieve this, it is necessary to develop measures that will monitor activities, progress and change throughout the initiative. Typically, process and outcome measures are used to monitor progress.

A **process** measure monitors the effectiveness of program implementation, allowing program revisions as necessary. Process indicators may include the following.

- type of programmatic activity
- frequency of service provided
- size of group receiving service

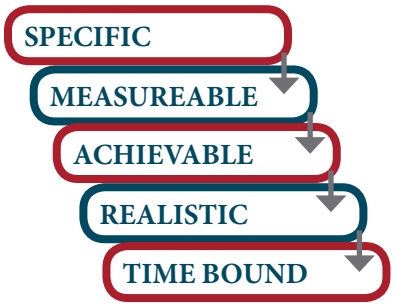
An **outcome** measure is used to determine whether the change produced the desired result.

- Short-term examples include immediate organizational policy or program changes enacted as a result of the program.
- Long-term examples include measured change, during a period of time, based on program implementation.

Process and outcome measures must be specific, measurable, attainable, relevant and time bound, referred to as SMART criteria. Process measures often must be written specifically for each intervention to effectively monitor the specific program implementation. However, many national resources have reliable and valid indicators for health behaviors and outcomes that serve as well-written outcome measures. These indicators are established and provide credibility to your initiative and results. Whenever possible, use national indicators as outcome measures.

Using SMART Goals

Your organization should aim for goals that are specific, measurable, attainable, relevant and timely. This helps the team involved know what to focus on during the predetermined timeframe, thus, helping them to prioritize tasks as they determine how their work will affect the established goals. Clear goals help increase motivation, group cohesion and engagement, and offer the team an opportunity to assess their progress and determine how their efforts are having an impact.



Below are two examples of SMART goals.

- Decrease the rate of readmissions in Missouri hospitals from 12 percent to 11 percent by 2018, as measured by the Centers for Medicare & Medicaid Services.
- Increase the rate of employee vaccination rates in Missouri from 90 percent to 95 percent by 2018, as measured by the Centers for Disease Control and Prevention.

It is important to develop an evaluation plan and specific measures at the onset of the initiative. The evaluation plan must include the following.

- what will be measured
- how each measure will be collected (e.g., data, interviews, observation)
- how each measure will be counted
- who will collect the data or information
- when, or at what intervals, will the data be collected
- how will each measure be calculated (e.g., totals, averages, ranges)
- how the results will be labeled and identified (e.g., blinded)
- how the results will be shared with the stakeholders (e.g., aggregated by target populations)
- how the results will be shared with the community (e.g., summary report)

In a collaborative initiative, the measures should be the same and shared among all partners. For example, if a hospital and public health agency are sharing responsibility for collecting body mass biometric data during two school health fairs, the same test, procedures, criteria and environment should be used by both health care organizations to ensure consistent results.

3 STEP THREE

CONSIDER APPROACHES TO ADDRESS PRIORITIZED NEEDS

During this phase of implementation, it is critical for the team to review the organization's presence in the community (i.e., activities already being done to address community need), potential collaborators, an assessment of the health indicators of the community through available secondary data, and an evaluation of the feedback received from other community partners, including the local public health department. Contrary to the saying "one size fits all," this data will help garner the information necessary to help the team determine the range of possible approaches to address prioritized needs effectively.

The IRS requires community input when prioritizing significant health needs from the following three groups: 1) at least one representative of a state, regional or local governmental health department with

SOURCES FOR OUTCOME MEASURES

Missouri Department of Health and Senior Services, Missouri Information for Community Assessment

Centers for Disease Control, Behavioral Risk Factor Surveillance System

U.S. Department of Health, Community Health Status Indicators

Healthy People 2020, Leading Health Indicators

County Health Rankings

Community Commons

knowledge of the health needs of the community; 2) members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations; and 3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy. These prioritized needs form the basis for developing the implementation plan. IRS CHNA Rule 12/31/14.

Evidence-based strategies and interventions include practices, procedures, programs or policies that have been proven effective. The effects are clearly linked to the activities themselves, not to outside, unrelated events. This is an extremely important step to address the priority health issues identified. Examples of evidence-based programs aimed at diabetes prevention and management include the following.

- Diabetes Empowerment Education Program (DEEP)
- Stanford Diabetes Self-Management Program (DSMP)
- Dining with Diabetes
- National Diabetes Education Program (NDEP)

This step is critical as it helps teams identify gaps and resources needed to address priority issues, set realistic timeframes on when some of the tasks may be completed, and any other essential components necessary to ensure successful implementation of the plan.

4 STEP FOUR

SELECT APPROACHES

Community input ensures that everyone's voice is taken into consideration. The IRS' newest provision requires for hospitals to take into account input from people who represent the broad interests of the community served by the hospital, including those with a special knowledge of, or expertise in, public health. Involving the right people ensures engagement and leads to a successful intervention.

According to Intervention MICA (Missouri Information for Community Assessment), "Partnerships are formed for many different reasons including: 1) increasing opportunities to learn and adopt new skills; 2) securing access to resources; 3) sharing financial risks and costs; 4) gaining input from more or different members of the community; and 5) enhancing the ability to respond rapidly to the changing needs of the community."

Using evidence-based approaches, such as Mobilizing for Action through Planning and Partnerships, is recommended instead of trying to reinvent the wheel. MAPP is a community-driven strategic planning process that aims to improve community health. It has widely been used in the public health sector successfully, and has helped communities apply strategic thinking to prioritize issues and identify resources to address them effectively. Including local public health agencies in the

initial stages of the implementation process is critical because they can help model the MAPP process in addressing priority health issues identified in the CHNA.

Free web-based resources, such as the Healthy NC Improvement App, are designed to bring together the best knowledge available on community health improvement interventions across the country. IMAPP helps identify the applicable interventions by setting, identify available resources, and link together communities working on the same intervention, to share vast ideas and create a knowledge hub for all community interventions that have been practiced and effectively implemented in other locations.

Considering approaches used by organizations like the 100 Million Healthier Lives can help communities select the most appropriate interventions that match the needs of their community. The 100 Million Healthier Lives global initiative recognizes that mental, physical and spiritual wellbeing are interconnected and should be considered heavily while seeking solutions for health issues. Driven by the insights of those who are affected and powered by innovative best practices, communities have access to an unlimited and unprecedented amount of resources with multifaceted approaches that have worked in other communities across the nation.

The diagram below shows the dimensions organizations should consider when implementing initiatives within their communities.

Source: 100 Million Healthier Lives

5 STEP FIVE

INTEGRATE THE IMPLEMENTATION STRATEGY ACCORDINGLY

It is highly recommended that organizations link their implementation plan with their strategic and operational plans. This creates the necessary alignment that is critical to ensure a strong connection between strategic and operational components, creating the required efficiency, streamlining the organizational goals, uncovering potential pitfalls, and helping the organization identify any internal gaps that pertain to internal efficiencies and efficacies.

6 STEP SIX

DEVELOP A WRITTEN IMPLEMENTATION STRATEGY

Written hospital implementation strategies can include:

- the organization's mission statement
- priority health issues
- special populations
- description of how the implementation plan was developed and adopted
- prioritization methodology used to determine priority health issues
- health needs the hospital anticipates to address directly and those it will address in collaboration with other community partners
- planned collaborations
- explanation of how the organization will address the identified issues
- major health needs that the organization will not address in the implementation strategy and the rationale behind this decision

Source: Catholic Health Association of the United States

7 STEP SEVEN

ADOPT AND REPORT THE IMPLEMENTATION STRATEGY

Adopting the Implementation Strategy

According to the IRS final rule, an implementation strategy is considered to be "adopted" on the date the strategy is approved by the organization's Board of Directors, by a committee of the board, or other parties legally authorized by the board to act on its behalf. Further, the formal adoption of the implementation strategy must occur by the end of the same taxable year in which the written report of the CHNA findings was made available to the public. Hospitals are required to have a policy that highlights the process for adopting the implementation plan, including how it is adopted and operationalized.

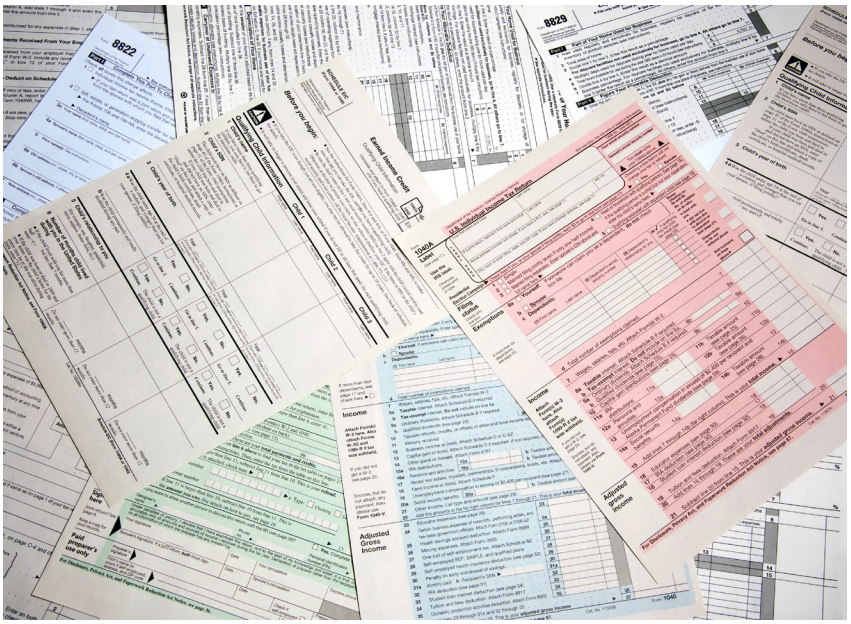
Reporting the Implementation Strategy

Additional reporting requirements were added to the IRS code relating to Section 501(r) for hospitals to include in their annual reporting on Schedule H (Form 990). A description of the actions taken during the taxable year to address significant health needs identified in the CHNA now is required. If the organization did not address the issues identified in the CHNA, they are required to document the reasons why no action was taken.

8 STEP EIGHT

UPDATE AND SUSTAIN THE IMPLEMENTATION STRATEGY

According to IRS requirements, a CHNA and implementation plan should be done every three years to be in compliance with federal law. However, implementation strategies may need to be updated more frequently based on factors such as changing community needs and priorities, changes in resources, and evaluation of results. It is not any different from performance improvement processes used in health care and other industries, and should be ongoing to sustain the required momentum. This step of the process helps the implementation team determine the next course of action. Based on evaluation of the results, the team may decide to keep doing what they are doing, tweak the process, or use a completely different approach.



EXAMPLES OF COMMUNITY-BASED INITIATIVES

Blue Zones Project®

"The Blue Zones Project approach to improved well-being is to enhance the environment within critical sectors of the community by implementing evidence-based best practices. Coupled with an extensive community engagement and marketing program, and active support from civic and faith-based leaders, the Blue Zones Project drives heightened awareness, support, tools and programs for individuals and community organizations to improve well-being." *Blue Zones Community Impact Summary — 2015*

National Diabetes Prevention Program

"The National Diabetes Prevention Program — or National DPP — is a partnership of public and private organizations working to reduce the growing problem of prediabetes and type 2 diabetes. Partners work to make it easier for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health." *National Diabetes Prevention Program — 2016*

Diabetes Empowerment Education Program

"DEEP was developed to provide community residents with the tools to better manage their diabetes in order to reduce complications and lead healthier, longer lives, based on principles of empowerment and adult education."

Diabetes and Cardiovascular Disease Self-Management Curriculum

"This program utilizes training that is focused on community and cultural approaches in prevention and management of diabetes and cardiovascular diseases."

Missouri Million Hearts

"The partnership of key health organizations in Missouri to raise awareness by highlighting the cooperation and individual work of partners to achieve the shared goal of saving lives from heart disease and stroke."

Missouri Diabetes Prevention and Control Program

"Collaborative members form practice teams to improve care of their patients with diabetes using proven models to manage disease."

Missouri Diabetes Shared Learning Network

A network of organizations across Missouri working together to identify best practice approaches to address diabetes.

SUGGESTED CITATION

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100 Million Healthier Lives. Retrieved from http://www.100mlives.org/

Appendix A:
CHNA Implementation Plan Timeline

The U.S. Treasury Department and the IRS consider an implementation strategy as being "adopted" on the date the implementation strategy is approved by an authorized governing body of the hospital organization. Below is a basic timeline to assist hospitals in meeting the requirements of the CHNA implementation plan. It is anticipated that the process outlined below will take approximately one year to complete to thoroughly review and address all key aspects pertaining to the plan.

	TIER 1	TIER 2	TIER 3
Month 1	• Establish implementation infrastructure • Meet leadership team • Identify process facilitator • Identify steering committee members • Identify data "gatherer"	• Establish implementation process timeline • Review requirements • Review steps • Tailor timeline to hospital and community	• Identify community representatives • Begin discussions on identifying "community" • Identify interest groups for representation • Discuss key community representatives to include in the collaboration
Month 2	• Convene CHNA Implementation Committee • Educate Community Committee on implementation requirements • Process • Timeline • Resources needed • Roles	• Establish meeting schedule • Decide how often and when the committee will meet • Survey - Readiness Gap Analysis using the Assessing Your Readiness Worksheet	• Establish scope of plan (county, region, etc.) • Discuss results and agree on strategies to close identified gaps • Establish focus groups to make progress on different fronts • Identify team leads • Assign tasks, roles and expectations
Month 3	• Data collection and gathering (Steering Committee) • Identify appropriate and reliable data resources that will be used for various goals, based on priority health issues identified in the CHNA	• Demographic data • Gather and review demographic data to better understand community for area to be covered • Data team to review data with group	• Health status data • Priority health issue per CHNA • Special health populations should be noted from the implementation start • Data team to review data with group and communicate information vital to the group
Month 4	• Data collection and gathering (Steering Committee) • Review utilization data • Patient origin and migration • Top diagnoses by REal data (if applicable) • ZIP-code analysis for specificity	• Review of availability of other health providers in community • Primary care and specialty • Review access of care • Insurance coverage	• Establish data summary report • Let the data speak to you • Data team to review relevant data with group • Group to brainstorm on emerging trends and possible recommendations for focus groups

continued

	TIER 1	TIER 2	TIER 3
Month 5	• Reconvene entire CHNA Implementation Committee • Review data summary report • Report focus group findings • Facilitate brainstorming sessions	• Establish preliminary list of needs identified and assign to-do's for future reporting	• Identify potential community events/ activities completed and planned by focus groups • Review all areas completed relating to activities included on the implementation template • Grade progress toward achievement of goals set and strategize as needed
Month 6	• Focus groups to review progress • Barriers • Successes • Next steps	• Facilitator to update group on progress of entire project	• Align focus group progress report with the project timetable
Month 7	• Report focus group findings on progress made in addressing group focus as assigned, highlighting successes and challenges	• Review working document template and update the event form as required	• Grade completion of tasks against initial timeline set at the beginning of the project
Month 8	• Steering Committee to review information gathered from focus groups	• Develop draft report of data collected and analyzed to date	
Month 9	• Convene Community Committee • Review current implementation process status • Identify successes and challenges • Determine next steps	• Identify needs • Ask Community Committee to make recommendations on current progress • Identify opportunities to address any unmet needs	• Steering Committee finalizes needs list • Review data and input from community and community committee
Month 10	• Develop Draft CHNA Implementation Report for public		
Month 11	• Convene Community Committee Provide draft report overview • Seek final recommendations		
Month 12	• Finalize report for publication and reporting in Schedule H (Form 990) • Convene Community Committee for final time • Provide draft report overview • Seek final recommendations	• Make available on hospital website	

Appendix B

This form can be completed electronically at
http://www.irs.gov/pub/irs-pdf/f990.pdf

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
▶ Do not enter social security numbers on this form as it may be made public.
▶ Information about Form 990 and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047
2016
Open to Public Inspection

A For the 2016 calendar year, or tax year beginning , 2016, and ending , 20

B Check if applicable:
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization
Doing business as
Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
City or town, state or province, country, and ZIP or foreign postal code

D Employer identification number
E Telephone number
G Gross receipts $

F Name and address of principal officer:

H(a) Is this a group return for subordinates? ☐ Yes ☐ No
H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)
H(c) Group exemption number ▶

I Tax-exempt status: ☐ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶

K Form of organization: ☐ Corporation ☐ Trust ☐ Association ☐ Other ▶ | **L** Year of formation: | **M** State of legal domicile:

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities:		
	2	Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	
	5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	
	6	Total number of volunteers (estimate if necessary)	6	
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	
	b	Net unrelated business taxable income from Form 990-T, line 34	7b	

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)		
	9	Program service revenue (Part VIII, line 2g)		
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)		
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)		
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)		
	14	Benefits paid to or for members (Part IX, column (A), line 4)		
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		
	16a	Professional fundraising fees (Part IX, column (A), line 11e)		
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)		
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)		
	19	Revenue less expenses. Subtract line 18 from line 12		

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	20	Total assets (Part X, line 16)		
	21	Total liabilities (Part X, line 26)		
	22	Net assets or fund balances. Subtract line 21 from line 20		

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here
▶ Signature of officer | Date
▶ Type or print name and title

Paid Preparer Use Only
Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN
Firm's name ▶ | Firm's EIN ▶
Firm's address ▶ | Phone no.

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Cat. No. 11282Y Form **990** (2016)

Appendix C:
Community Health Improvement Implementation Plan – Diabetes

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #1 (very specific): Obesity and Sedentary Lifestyle — Diabetes				
Contributing FACTORS to Health Issue #1 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults in [Missouri county] reporting a *BMI* >30 from 20% to 19.5% by 2019.**				
BUDGET for Health Issue #1 (consider direct and indirect costs): Money allocated by hospital for this health issue				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes and sponsorship of community walking/running/ biking events for individuals and families • Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity	**Example of key actions** • Sponsor annual day of dance community event, promoting fun exercise options and free screenings, reaching at least 1,000 attendees • Support community fitness events (walking/ running/biking) for adults and families • Offer low-cost weight management courses three times/year with participants' average weight loss of at least 3% • Offer low-cost fitness classes to the community, as well as medically supervised exercise classes specifically targeting those with osteoporosis, Parkinson's disease, cancer, diabetes and pelvic floor issues	**Example of key partners** • Medical group physicians • American Heart Association • American Diabetes Association • Health department • Area employers, i.e. hospitals, schools and other employers as needed • Chamber of Commerce • County government	**Example of key process measures** • Increased level of physical activity • Increased access to screenings • Increased fitness events • Increased weight management educational offerings Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased BMI among adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #2 (very specific): Obesity and Sedentary Lifestyle — Diabetes				
Contributing FACTORS to Health Issue #2 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults in [Missouri county] reporting *a lifestyle without physical activity* from 21% to 20% in 2020.**				
BUDGET for Health Issue #2 (consider direct and indirect costs): Information not available				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes and sponsorship of community walking/running/ biking events for individuals and families • Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity	**Example of key actions** • Sponsor annual day of dance community event, promoting fun exercise options and free screenings, reaching at least 1,000 attendees. Baseline: 2016 - 800 • Support community fitness events (walking/ running/biking) for adults and families. Baseline: 5 • Offer low-cost weight management courses three times/year with participants' average weight loss of at least 3%. Baseline: FY16 - 2.73% • Offer low-cost fitness classes to the community, as well as medically supervised exercise classes specifically targeting those with osteoporosis, Parkinson's disease, cancer, diabetes and pelvic floor issues.	**Example of key partners** • Medical group physicians • American Heart Association • Health department • Area employers, i.e. hospitals, schools and other employers as needed • Chamber of Commerce • County government	**Example of key process measures** • Increased level of physical activity • Increased access to screenings • Increased fitness events • Increased weight management educational offerings Please include baseline and target for each strategy.	**Example of key outcome measures** • Increase in people participating in a lifestyle with physical activity leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #3 (very specific): Prevent Chronic Conditions — Diabetes				
Contributing FACTORS to Health Issue #3 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults diagnosed with *high blood pressure* in [Missouri county] from 154 per 100,000 in 2015 to 100 per 100,000 in 2020.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): Information not available				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension screening and education in prevention of chronic conditions in your county	**Example of key actions** • Provide free blood pressure screenings to community and increase number of screening offerings annually • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace • Partner with health department	**Example of key partners** • American Diabetes Association • American Heart Association • Local school nurses/dietitians • Wellness groups • Community partnerships • Medical group physicians	**Example of key process measures** • Increased blood pressure screenings • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased blood pressure diagnosis for adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #4 (very specific): Prevent Chronic Conditions — Diabetes				
Contributing FACTORS to Health Issue #4 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/ community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults diagnosed with *high cholesterol* in [Missouri county] from 20% in 2014 to 18.5% in 2020.**				
BUDGET for Health Issue #4 (consider direct and indirect costs): Information not available				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension and diabetes prevention screening and education in prevention of chronic conditions in your county	**Example of key actions** • Provide free blood pressure screenings to community and increase number of screening offerings annually • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace • Partner with health department	**Example of key partners** • American Diabetes Association • American Heart Association • Wellness centers, YMCA • Community centers • Grocery stores - Hy-Vee, etc. • Health departments • Local hospitals • Chamber of Commerce • Elected officials - as needed	**Example of key process measures** • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with programs to increase outreach to individuals at risk in the community • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased blood pressure diagnosis for adults • Decreased high cholesterol diagnosis • Decreased diabetes hospital admission rate • This will eventually lead to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #5 (very specific): Prevent Chronic Conditions — Diabetes				
Contributing FACTORS to Health Issue #5 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the *diabetes hospital admission rate* for [Missouri county] from 174 per 100,000 in 2015 to 150 per 100,000 in 2020.**				
BUDGET for Health Issue #5 (consider direct and indirect costs): Information not available				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension and diabetes prevention screening and education in prevention of chronic conditions in your county.	**Example of key actions** • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace • Wellness programs • Partner with health department	**Example of key partners** • American Diabetes Association • American Heart Association • Wellness centers • Area employers • Physicians	**Example of key process measures** • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Increase outreach to women and their families • Partner with local public health agency to provide educational programs on chronic disease management • Partner with churches on screening programs Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased blood pressure diagnosis for adults • Decreased high cholesterol diagnosis • Decrease diabetes hospital admission rate • This will eventually lead to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

Activity Document — This is a working document for each goal identified per health issue.

HEALTH ISSUE: OBESITY AND SEDENTARY LIFESTYLE — DIABETES				
SMART Goal: **Example: Decrease the percentage of adults in [Missouri county] reporting a BMI >30 from 20% to 19.5% by 2019.**				
Strategy: Promote an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes and sponsorship of community walking/running/biking events for individuals and families. Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity.				
	Activities/Tactics	Person Responsible	Met or Not Met	Barriers Identified
Activities to be completed in **1-3 months**	1.			
	2.			
	3.			
Activities to be completed in **3-6 months**	1.			
	2.			
	3.			
Activities to be completed in **6-9 months**	1.			
	2.			
	3.			
Activities to be completed in **9-12 months**	1.			
	2.			
	3.			
Year 2 activities	1.			
	2.			
	3.			
Year 3 activities	1.			
	2.			
	3			
Partners involved in this goal: Medical group physicians, American Heart Association, American Diabetes Association, health department, area employers, Chamber of Commerce, county government				

Community Health Improvement Implementation Plan – Heart Disease

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #1 (very specific): Prevent Chronic Conditions — Heart Disease				
Contributing FACTORS to Health Issue #1 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults diagnosed with *high cholesterol* in [Missouri county] from 20% to 18.5% by 2019.**				
BUDGET for Health Issue #1 (consider direct and indirect costs): Information not available				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension and heart disease prevention screening • Education on prevention of chronic conditions in your county is important	**Example of key actions** • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace • Wellness programs • Partner with health department	**Example of key partners** • American Diabetes Association • American Heart Association • Wellness centers, YMCA • Community centers • Grocery stores - Hy-Vee, etc. • Health departments • Local hospitals • Chamber of Commerce • Elected officials - as needed	**Example of key process measures** • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with programs to increase outreach to individuals at risk in the community • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased blood pressure diagnosis for adults • Decreased high cholesterol diagnosis • Decreased diabetes hospital admission rate • This will eventually lead to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #2 (very specific): Prevent Chronic Conditions — Heart Disease				
Contributing FACTORS to Health Issue #2 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults diagnosed with *high blood pressure* in [Missouri county] from 300 per 100,000 in 2016 to 100 per 100,000 in 2019.**				
BUDGET for Health Issue #2 (consider direct and indirect costs): Information not available				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension screening and education in prevention of chronic conditions in your county	**Example of key actions** • Provide free blood pressure screenings to community and increase number of screening offerings annually • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace • Partner with health department	**Example of key partners** • American Heart Association • Local school nurses/dietitians • Wellness groups • Community partnerships • Medical group physicians	**Example of key process measures** • Increased blood pressure screenings • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased blood pressure diagnosis for adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION PLAN				
HEALTH ISSUE #3 (very specific): Obesity and Sedentary Lifestyle — Heart Disease				
Contributing FACTORS to Health Issue #3 (including social determinants): Lifestyle and diet-related (environmental factors/ food/education/ community and social context factors)				
Three-Year GOAL for Improvement (SMART objective): Specific, Measurable, Achievable, Realistic, Time bound **Example: Decrease the percentage of adults in [Missouri county] reporting a *BMI >30* from 20% to 19.5% in 2020.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): Money allocated by hospital for this health issue				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three-Year Process Measure(s) for Each Strategy	Specific Three-Year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes and sponsorship of community walking/running/ biking events for individuals and families • Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity	**Example of key actions** • Sponsor annual day of dance free community event, promoting fun exercise options and free screenings, reaching at least 1,000 attendees • Support community fitness events (walking/running/ biking) for adults and families • Offer low-cost weight management courses three times/year with participants' average weight loss of at least 3% • Offer low-cost fitness classes to the community, as well as medically-supervised exercise classes, specifically targeting those with osteoporosis, Parkinson's disease, cancer, diabetes and pelvic floor issues	**Example of key partners** • Medical group physicians • American Heart Association • Health department • Area employers, i.e. hospitals, schools and other employers as needed • Chamber of Commerce • County government	**Example of key process measures** • Increased level of physical activity • Increased access to screenings • Increased fitness events • Increased weight management educational offerings Please include baseline and target for each strategy.	**Example of key outcome measures** • Decreased BMI among adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome.
Remember: Change as needed to align with the desired strategy.	Remember: Target above baseline performance in these categories.	Remember: Add more categories representing your community.	Remember: Add more process measures as needed.	Remember: Make changes as needed.

Activity Document — This is a working document for each goal identified per health issue.

HEALTH ISSUE: OBESITY AND SEDENTARY LIFESTYLE — HEART DISEASE				
SMART Goal: Example: Decrease the percentage of adults in [Missouri county] reporting a BMI >30 from 20% to 19.5% in 2020.				
Strategy: Promote an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes and sponsorship of community walking/running/biking events for individuals and families. Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity.				
	Activities/Tactics	Person Responsible	Met or Not Met	Barriers Identified
Activities to be completed in **1-3 months**	1.			
	2.			
	3.			
Activities to be completed in **3-6 months**	1.			
	2.			
	3.			
Activities to be completed in **6-9 months**	1.			
	2.			
	3.			
Activities to be completed in **9-12 months**	1.			
	2.			
	3.			
Year 2 activities	1.			
	2.			
	3.			
Year 3 activities	1.			
	2.			
	3			
Partners involved in this goal: Medical group physicians, American Heart Association, health department, area employers, Chamber of Commerce, county government				

From January through December 2015, the following events included information for chronic disease prevention relating to diabetes and heart disease. Hospitals should customize this document to reflect their specific activities.

DATE OF EVENT	EXAMPLE — EVENT DESCRIPTION
January 14, 2015	(Name of Hospital) sponsored the annual "Healthy Heart Day" at the local mall where free blood pressure screenings were provided to 204 attendees and free prevention information on stroke, heart attack and cardiac arrest was distributed.
February 20, 2015	(Name of Hospital) offered a free lecture focused on "diabetes prevention." A total of 200 attendees were provided free blood pressure screenings.
March 27, 2015	(Name of Hospital) participated in the annual 5K Run for Stroke Awareness and provided free screenings and educational materials to 253 participants.
May 1, 2015	(Name of Hospital) hosted a "Walk to Wellness" program in partnership with other area hospitals and the local county Parks and Recreation Department. Staff provided free information on nutrition and chronic disease prevention to 208 participants.
July 15, 2015	(Name of Hospital) hosted its annual "Night Out" event. It was attended by 400 community members in the service area and provided free information on diet and exercise. Brochures on preventing chronic illnesses also were provided.
September 21, 2015	(Name of Hospital) participated in the local county fair. Staff provided free information on nutrition, chronic disease prevention and blood pressure screenings to 142 attendees.
November 28, 2015	(Name of Hospital) organized a local health fair and provided free information on stroke and heart health to 200 attendees.
December 12, 2015	(Name of Hospital) coordinated a free community outreach event in partnership with local organizations. The event focused on diabetes and stroke prevention and was advertised to the primary service area. More than 600 participants attended and a total of 204 participants received free hyperlipidemia and blood pressure screenings.
December 20, 2015	(Name of Hospital) sponsored a free wellness check day in the hospital parking lot. The event was attended by 523 community members. Heart disease prevention screenings and other screenings targeting blood pressure, cholesterol and glucose were also done.

***Documentation of the different events and when they were done is essential as it provides the information and data necessary to complete the implementation plan.*

Appendix D

Assessing Your Readiness Worksheet

Show Me Am I Ready Scale

The *Show Me Am I Ready Scale* is designed to help you and your partners decide if you are ready to develop and implement an intervention. You may use this worksheet to assess if your partnership is ready to begin or if there are areas you need to work on first. For each of the numbered items, circle the most appropriate response for each item ("Good," "Fair," or "Poor"). To determine the most appropriate responses, please consider the supporting questions for each item. For example:

- For a "Good" response: You and your partners should have considered most of the supporting questions and have taken some action to address them.
- For a "Fair" response: You and your partners may have considered some of the supporting questions and have brainstormed ways to work on them.
- For a "Poor" response: You and your partners may have not considered most of the issues and still have some work to do before you can answer the questions.

Once you have determined your answers, enter your responses online in the CHIR Show Me Am I Ready page to receive your readiness score!

1. The level of support we have from those who will be affected by the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• Who is the priority population that will be affected?			
• Have we talked with representatives of the priority population about the need to plan and implement an intervention to address the health issue of concern?			
• Was there support expressed for planning and implementing an intervention?			
• Were any barriers expressed about moving forward with an intervention?			

continued

2. The level of political support we have from key-decision makers is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• Who are the key decision-makers (e.g., organization administrators, legislators, or advocacy groups?)			
• Have we talked with these individuals about the need to plan and implement an intervention and asked their opinions on working with the priority population?			
• Have we received buy-in from these key decision-makers that shows that they will support your work?			
• Have we considered ways to involve key decision-makers in the planning and implementation processes?			
3. The extent to which we've engaged partners-individuals or organizations-to assist us in the planning and implementing the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• Who are the partners we've identified to assist and support planning and implementing an intervention?			
• Are individuals or groups with public health experience and other important fields of expertise engaged as partners (e.g., in public policy, education, or social services)?			
• Are individuals who will be affected by the intervention engaged as partners to help you plan the intervention?			
• Have we thought about how partners will participate in shared decision making?			

continued

4. The level of administrative support we have from our organizations is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• Who are the key decision-makers and administrators for our organizations? Are they aware of our plans and do they support them, including the time we will spend on the project?			
• Have we identified the resources needed from our organizations and received approval for them?			
• Have we identified other organizations that will support our work and potentially contribute resources?			
• Have we received positive responses and encouragement from our administrators to pursue planning an intervention?			
5. The amount of funding we have for planning and implementing the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• What funding do we have for planning an intervention?			
• To implement and evaluate an intervention?			
• Have we identified and/or applied for funding from other sources?			

continued

6. The number of people we have to work on the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• How many individuals do we have to plan and implement the intervention?			
• How much time can each individual spend? Will this change over time?			
• Have we have defined roles and duties for individuals?			
• Do we need individuals with special skills or expertise?			
7. The resources we have readily available to plan and implement the intervention are…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• What are our space and equipment needs?			
• What are our technology needs?			
• Where can we find resources we might need out in the community?			
8. Our team's level of skills and expertise to plan and implement the intervention is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• What are the skills and expertise of our team?			
• What training needs do our members have?			
• What are our technical assistance needs?			
• Will we need to bring in other outside help (e.g., consultants or contractors)			

continued

9. The strength of our team's leadership is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• Who are the leaders of our team?			
• Do the leaders motivate and support the team?			
• Do we have shared leadership? How do we define leadership roles?			
• Does our team respond favorably to the leaders?			
10. Our ability to work together as a team is…	**Good**	**Fair**	**Poor**
Before you answer, have you and your partners considered or addressed the following?			
• Does our team communicate effectively?			
• Do team members trust one another and work well together?			
• Is our team organized and efficient?			
• Does our team speak with a unified voice?			
• What steps have we taken to incorporate team members in intervention process and activities?			
• Do all of our team members actively contribute?			

See **CHIR Show Me Am I Ready page** to evaluate your score.

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07/17