Trinity Health

# Implementation Strategy Guide

A guide for ministries to address significant health needs in their communities, with particular focus on racial equity, inclusion, and impacting the social influencers of health.

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# Contents

## Why we developed the Guide and how to use it

This guide supports Trinity Health hospitals to develop their Implementation Strategy (IS), following the adoption of their Community Health Needs Assessment. Trinity Health is focused intentionally on engaging communities and residents experiencing poverty and other vulnerabilities, with a particular emphasis placed on Black, Indigenous, and People of Color (BIPOC). The Community Health Needs Assessment (CHNA) guide establishes minimum standards and recommends best-practices for Trinity Health hospitals as they conduct a collaborative and inclusive CHNA. Similarly, this IS Guide will assist Trinity Health hospitals and partners develop collaborative implementation strategies – with explicit emphasis on applying racial equity principles on how we partner, develop and implement the strategies outlined in the IS. This guide also outlines best practices on how to evaluate the impact of actions and resources directed toward addressing the prioritized community needs—all while ensuring compliance with IRS Section 501(r)(3) requirements for implementation strategies.

All Trinity Health hospitals are expected to use this guide, IS Template, process, tools and checklist (Appendix A) AND to collaborate with community organizations, and other hospitals as you develop the IS. Community members and communities most impacted by racism and other forms of discrimination that confront the greatest disparities and inequities in health outcomes should be inclusively engaged in all community health improvement efforts.

This guide, along with a four-part training series on *Community Engagement to Advance Racial Justice - Preparing for the Implementation Strategy,* are meant to serve as a foundation for our health ministry leaders to meaningfully engage communities to address the needs that matter most to the communities we serve. This guide will continue to evolve as our health system and community partner together to improve health. Community Health & Well-Being (CHWB) teams lead the development and implementation of the CHNA and IS as part of our purpose to optimize health for people experiencing poverty and other vulnerabilities in our communities through connecting social and clinical care, addressing social needs, dismantling racism and reducing inequities. BIPOC communities have lived this reality for centuries and since the onset of COVID-19, it is undeniable that racism and racial inequities stand in the way of achieving our purpose without specifically engaging BIPOC communities and identifying the root causes of poor health.

## Community Health Needs Assessment and Implementation Strategy

### What are they?

Together, the CHNA and IS foster collective action for the equitable allocation of resources from the hospital and other community sources, directed toward those needs being addressed and for those most impacted.

A Community Health Needs Assessment (CHNA) uses quantitative and qualitative data, inclusive of community input from systemically oppressed populations, to identify and understand community assets, needs, and the relative health and social well-being of a community. The CHNA results in a prioritized list of needs.

The Implementation Strategy (IS) is a plan of the collective strategies that the hospital and its partners intend to implement in order to address the identified needs in a defined geographic area with the greatest inequities and expand upon the assets that were identified through the CHNA.

### Why are hospitals required to conduct a CHNA?

Enacted in March of 2010, the Patient Protection and Affordable Care Act, Section 501(r) of the Internal Revenue Code requires each separately licensed 501(c)(3) tax-exempt hospital facility to conduct a CHNA at least once every three tax years, and to adopt an IS to meet the community health needs identified through the CHNA.

While CHNAs and Implementation Strategies are required by the IRS, Trinity Health ministries have been conducting CHNAs and developing Implementation Strategies, long before the IRS required it, as a way to meaningfully engage our communities and deliver on our Community Health & Well-Being strategy. This guide places particular emphasis on how the IS can dismantle systemic racism and reduce inequities through engagement of Black, Indigenous, and People of Color (BIPOC) communities.

## Developing the Implementation Strategy

The development of the IS should begin while finishing the final written CHNA. The IRS gives hospitals up to 4.5 months after the end of the fiscal year in which the last CHNA is completed to complete the IS (November 15 for most TH hospitals, February 15 for CT hospitals). Trinity Health expects all of its hospitals to develop the IS in collaboration with community partners and evaluated over the subsequent three years. The goal while developing the IS should be to have a positive impact on the community needs that are selected to be addressed and to successfully reach those most affected by the need, and to make meaningful, measurable progress toward reducing the inequities that were identified as the root cause of the prioritized need.


### Joint Implementation Strategies

Some hospitals may conduct a Joint IS and there are specific requirements. The IRS describes joint CHNAs and Implementation Strategies as the shared report that is produced by multiple collaborating hospital facilities, for the purpose of fulfilling their 501(r) requirements. The requirements for joint CHNAs are listed in the CHNA Guide. If a qualifying joint CHNA was not adopted, a formal joint IS cannot be adopted, however, separate, but similar, strategies may be adopted by all participating hospital facilities.

Qualifying joint Implementation Strategies, like individual Implementation Strategies, must meet all required components, in addition to all the following:

- Clearly identify the document as applying to each participating hospital facility.
- Clearly identify each individual participating hospital facility and community organization's particular role and responsibilities in taking the actions described in the IS and the resources each participant hospital facility plans to commit to such actions.
- Include a summary or other tool that helps the reader easily locate those portions of the joint IS that relate to each participating hospital facility and community organization.

## Getting Started on your Implementation Strategy

The following outlines the process that Trinity Health hospitals should follow while developing their Implementation Strategy. Each of these are described in detail below.

I. Questions to consider before getting started
II. Engage the community
III. Form and/or convene an Advisory Committee
IV. Develop a timeline and budget
V. Identify 1-3 significant health needs that will be addressed
VI. Determine how the significant health needs will be addressed – Form Workgroups
VII. Conduct the problem analysis and identify strategies to address
VIII. Develop a plan to evaluate
IX. Translate to a logic model
X. Write the Implementation Strategy using standard template
XI. Final approvals and published report

### I. Questions to consider before getting started

Before getting started, consider the following questions when reviewing your Ministry's most previous CHNA and IS, and your CHNA in progress:

- What changes should be made to the process to align with this new guidance, with a particular focus on using a racial equity lens – engaging those most impacted by the prioritized significant health needs to develop the three-year strategies?
- What organizations or partners are needed to begin developing the IS? Which organizations and partners are technical experts in the prioritized need? Do they serve and/or are they led by BIPOC and those with most proximity to need that is being addressed?
- What strategies were implemented to address the gaps after the last IS? Among new strategies, how will BIPOC organizations help lead the work? Consider the breadth of strategies that are possible, including and especially upstream strategies, such as policy, system and environmental change strategies.
- What successes from the last strategy can be expanded upon this time?

## II. Engage the Community

Trinity Health defines *Community Engagement* as the activities and process of working collaboratively with and through community members, groups, and organizations who are from, led by, and/or who partner closely with the populations we seek to benefit and who are most impacted by health inequities.

The community members, groups, and organizations that are needed for meaningful community engagement can be defined in three categories:

- *Grassroots:* "Grassroots" often refers to community members who do not have a formal or professional role in public life, and who are not in leadership of a local agency or organization. Grassroots organizations are primarily made up of civilians advocating a cause to spur change at local, national, or international levels, these are often small organizations that operate with unpaid staff members. Some grassroots engagement techniques—specifically community organizing—focus on identifying, involving, and empowering the community members who are most impacted by a problem to act on their own behalf and win change. Grassroots is also used as shorthand to describe strategies that involve reaching out to large segments of the public, such as door-knocking or open meetings.
- *Grasstops or Grasstips:* Generally used to describe community members or others who are recognized leaders in their neighborhoods or organizations due to their professional roles, public profiles, or positions of power and privilege. Grasstops leaders usually have access to, and can wield influence on, key decision-makers or segments of the *grassroots* community.
- *Partners:* Partners are people (and organizations) who are either impacted by a problem, either directly or indirectly, or who can have an effect on the outcome of a problem (often called "key partners"). Partners can refer to both grassroots and grasstops/tips.

Facilitating Power, a consulting company, developed the 'Spectrum of Community Engagement to Ownership' pathway model. The spectrum is designed to acknowledge marginalization, assert a clear vision, articulate a developmental process, and assess community participation efforts[1]. The developmental stages are pictured below. The spectrum can be a tool to identify where your community collaborative is on the engagement spectrum and set goals for collective practice that build on the culture of collaboration, which is essential to planning and achieving racial equity.

[1] Facilitating Power; https://movementstrategy.org/wp-content/uploads/2021/08/The-Spectrum-of-Community-Engagement-to-Ownership.pdf


Collaborate with community-based organizations (CBOs). Community Engagement is expected throughout the development of your IS. Outside of the IS Advisory Committee (described in section III), there are likely other partners or resources who can assist with data collection and act as sources for community input.

Engage with a variety of CBOs across sectors. Identify CBOs who are engaged in addressing or preventing the priority need, especially those who are led by and/or serve people who face racism and other forms of oppression. Asset mapping, often utilized in the development of CHNAs, can help identify potential partners—who work with those who are most impacted by the community needs and possess lived experience—to solicit input on your ministry's behalf.

The following is a sample list of government organization and CBO's the workgroup may engage to help shed light on emergent needs:

- Civic engagement organizations
- Local health departments
- Homeless shelters
- Area Agency on Aging
- Police and other law enforcement*
- Schools
- United Way
- YMCA/YWCA
- Salon/Barber shops
- LGBTQIA focused organizations
- Behavioral health/community mental health providers
- Food pantries
- Libraries
- CBO’s involved in community organizing and advocacy

*Before inviting law enforcement into a community partnership, there should be an assessment of how this impacts community members. BIPOC, immigrants, substance users, etc. may have mistrust of law enforcement and bringing that voice to the table may discourage others to participate.

Community Engagement Activities. When face-to-face engagement is not possible, substitute with virtual technology. The following includes a list of community engagement activities that support the development and implementation of an IS:

- Facilitate Community driven planning
- Host/organize meetings with CBOs, community members, etc.
- Facilitate Interactive workshops
- Develop Memos of Understanding (MOU's) with community-based organizations for implementation
- Develop/Host Resident/Community Advisory committees
- Host open planning community forums with resident polling
- Provide Health education
- Conduct Outreach, community organizing and advocacy
- Provide referrals to resources
- Engage in Community-based Participatory research (community resident driven data collection and review)

Barriers to Community Engagement. Some barriers that impede meaningful community engagement are listed below. Be mindful of these barriers and work to mitigate as early on as possible.

| Barrier | Ways to mitigate barrier |
|---|---|
| Meeting hours that do not match community availability | Offer multiple meeting opportunities at varying times and locations |
| No childcare, food, or cultural considerations such as scheduling during high holidays | Provide free childcare and healthy culturally appropriate food offerings, be mindful of holidays and cultural community events |
| No compensation for community members for their time and knowledge | Pay community members for their time |
| Language barriers and lack of resources for those who do not speak English | Engage multilingual facilitators and/or translators, and translate any and all surveys as appropriate |
| Use of community organizations' name in grant applications without their knowledge or consent | Ensure all CBOs who are named are aware and fully supportive of grant applications, and understand their role, if grant is approved |
| Community mistrust of institutions and staff; failed projects are re-implemented and community feedback is not considered, addressed or implemented | Trust is hard to rebuild. Don't rush this process. Be open to having fair and honest conversation about the ministry's role in failed projects |
| Engaging community because it is a requirement without understanding why it is important. | Shift mindsets by exploring why community engagement is essential to equitable, effective |

| | |
|---|---|
| | community health improvement. |
| Expecting community members to understand and adapt to organizational norms and practices. | Provide training and support for community members as well as organizational partners in how to engage in planning together. |
| Including a single community member and asking them to represent a whole community or group. | Balanced representation between community members, CBOs, and hospital staff. |

### *III.* Form and/or Convene the Advisory Committee

Hospitals cannot (and should not) develop the IS alone. Convene community partners who are engaged in addressing and preventing the need and those most impacted by the need should be engaged in the process to develop the strategies that will measurably impact the need, and provide ongoing feedback and support to implementation throughout the three-year cycle. The IS Advisory Committee drives the entire IS development process and ensures an inclusive and racially equitable approach. If the hospital was not already involved in a community collaborative for the CHNA process, begin to identify and convene a committee of internal and external partners who will manage and/or inform all aspects of the IS process. Include within this committee people from various disciplines who will help identify root causes of unfavorable health issues, ensure the strategies developed are focused on areas of greatest need, provide ideas for community initiatives and ensure an inclusive strategy development process. At a minimum, ensure the following are included in the Advisory Committee, workgroups, and/or community focus groups to develop the IS (more on the these in Sections V and VI):

- Those most impacted by the prioritized needs (ex. Food insecurity—are those experiencing food insecurity participating)
- Community members residing in the community/neighborhood most impacted by the need
- Technical experts in the prioritized area of need with particular emphasis on BIPOC led and/or BIPOC serving organizations

Offer volunteers and community members financial compensation, such as a $25-50 gift card for every 60-90 minutes (be mindful of State and Federal tax laws), for their contributions on the Advisory Committee and to the development of the IS. Ensure all capacities or skillsets of those listed below are included and/or consulted as part of the Advisory Committee, with particular emphasis on ensuring BIPOC representation from:

- Health System: Community Health & Well-Being, Population Health, Advocacy, Diversity, Equity & Inclusion, Strategy, Marketing & Communications and Mission.
- Community Organizations and Institutions: public health, other area hospitals, physician groups or clinics, any local FQHCs, school districts and educational institutions (pre-k through postsecondary), public safety, and youth and adult social service groups, organizing, advocacy and CBOs that engage in activism.
- Community Members and Other Community Organizations that serve those who have lived experience and are most impacted by the community needs (ex. Food—someone experiencing food access issues), community members of the area/neighborhood most impacted by the needs, and technical experts in this area of needs (ex. Food—food policy council leader).

- Hospital/Regional Health Ministry Board of Directors: each RHM may have a different governing body approving the IS. It is recommended that the Board, or representatives of the Board, are consulted throughout the process of the IS development.

The Advisory Committee have a at least 50% or more of its membership non-hospital participants and should convene at a frequency necessary to ensure the development of the IS in a timely manner and set a cadence for meeting in the years the strategies are being implemented (i.e. monthly, quarterly) to monitor and measure implementation and to course correct with quality improvement as needed. Meeting throughout the implementation period helps to hold organizations and groups accountable to their implementation role, discuss and solve for implementation challenges, and continually assess and plan for opportunities and threats related to the work.

## *IV.* Prepare a Timeline and Budget

The Advisory Committee will need to develop a timeline that ensures all IS process requirements are completed by the IRS deadline of the hospital required to publish the IS. One date should be established so that all committee members are working toward the same deadline. The timing for the development and approval of the CHNA and IS depends largely on the hospital Board, or governance authority's involvement. Trinity Health recommends that the CHNA and IS are approved at separate board meetings, in order to give the hospital and partners adequate time to develop the IS, in addition to gaining appropriate input from internal (executive leadership, Board of Directors, System Office) and external partners, (community members, grassroots organizations, and other partners).

### Timeline

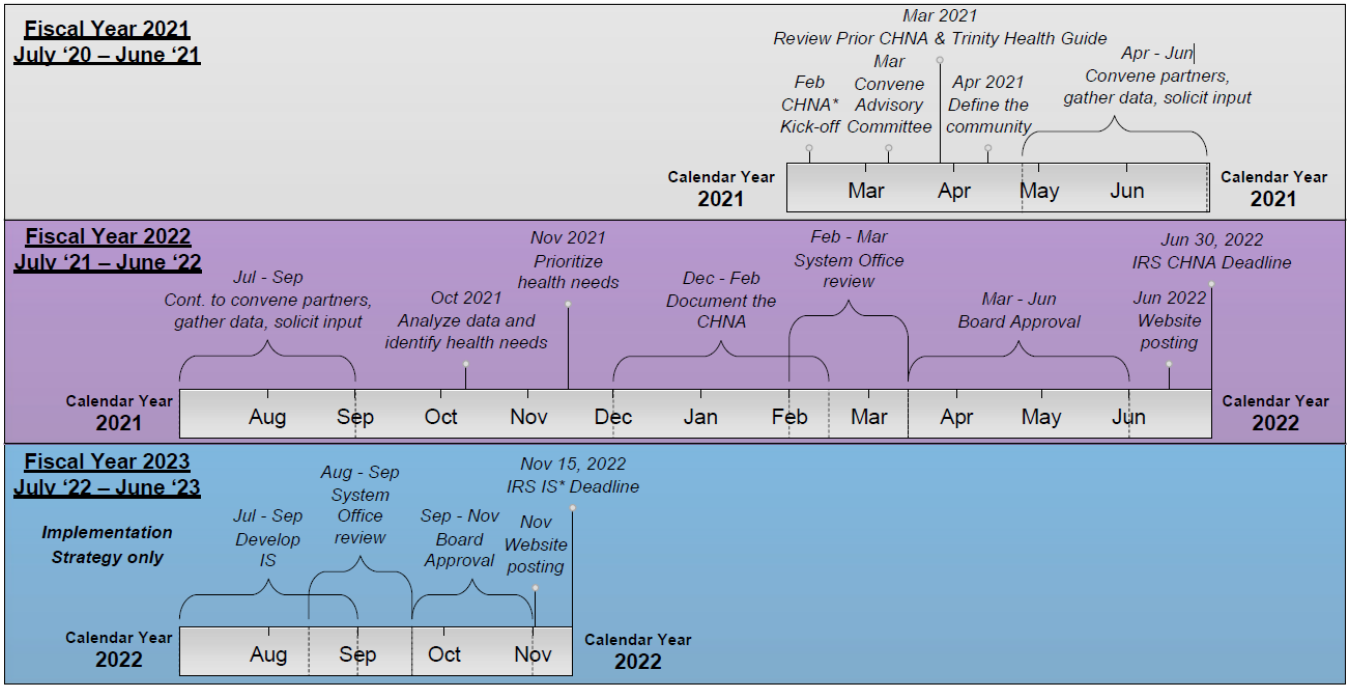
When preparing the timeline, identify the needs of each stakeholder (i.e. hospital's Board meeting dates within the timeframe that is required for compliance*, grassroots organization's fiscal years, public health department due dates for a community health improvement plan, etc.). Also keep in mind that community input, involvement and relationship building takes time, so build ample time into your schedule to account for the various voices that need to be heard during the development of the IS.

*Special IRS compliance considerations:

- Per IRS regulations, the IS must be completed on or before 4.5 months of the end of the hospital's fiscal year in which the last CHNA was conducted. Therefore, even if other partners have additional time, know the IS must be finalized, approved by the hospital's Board, and posted on the hospital's website by November 15 (February 15 for Connecticut hospitals).
- Hospital Board may appoint someone or a committee of the Board to approve the IS (via meeting or email), outside of a scheduled Board meeting.
- Allow adequate time to finalize the IS, including required input and community participation, preparing the written report, gaining appropriate approvals (internal leadership, System Office CHWB review, local Marketing & Communications formatting inclusive of local branding and photos, and final board approval), as well as making the document widely available via the hospital's website and at the hospital facility.

Below is an example timeline for the fiscal year 2022 CHNA and IS process. The hospital CHNA process should begin at least sixteen months before the conclusion of the fiscal year. Your hospitals timeline may be accelerated, however the key milestones indicated below must be met by these dates.

Example 16-month CHNA and 4.5-month Implementation Strategy Timeline
Fiscal Year 2022
June Year-end




CHNA – Community Health Needs Assessment
IS – Implementation Strategy

## Budget

Prepare a budget of the anticipated costs for engaging the community and implementing the strategy, and ensure that these costs are included in the CHWB quarterly forecast/annual plan. Keep in mind that all administrative costs associated with developing the IS "count" as Community Benefit and should be reported by the community benefit coordinator in category G2—Community Health Needs/IS in CBISA (the community benefit reporting database). These costs may include:

- Hiring consultants to facilitate focus groups
- Space, meeting materials and refreshments for all participants engaged in the planning sessions – as a reminder, all CHWB hosted meetings should provide healthy food and beverages per the Healthy Meeting Procedure
- Reimbursing community members to participate in the advisory committee, workgroups, or focus groups, or providing other incentives for participating in the process

The majority of your community benefit expenses (not including financial assistance and unpaid costs of Medicaid) should be spent on addressing the needs addressed in the IS (operations/staff time, contributions, community improvement and community building activities).

## V. Identify 1-3 significant health needs that will be addressed – Advisory Committee

The CHNA identifies the community's significant health needs and should provide data that allows for a deeper understanding of who is disproportionately affected by particular needs and where they reside. While "health needs" is the IRS terminology in 501 (r), health needs are inclusive of the physical, mental, and social influencers of health within our communities. The strategies implemented should mostly focus on policy, systems and environmental change as these systems changes are needed to dismantle racism and promote health and wellbeing for all members of the communities we serve.

The IS should focus on thoroughly and collaboratively addressing one to three priority needs, in order to concentrate resources and efforts toward making an impact in the communities experiencing inequities. This is a shift from the way most Trinity Health hospitals developed their implementation strategies previously. With your Advisory Committee, determine which top needs will be addressed and who should be involved in the individual workgroups that will make recommendations and develop the IS. The voices of community members should play a key role in identifying priorities, and your Advisory Committee should follow a defined process to determine which top needs will be addressed. Once priority needs are identified, workgroups can be formed to design the strategy to address each need. Workgroups should include partners beyond those identified for the Advisory Committee based on the needs.

## VI. Determine how the significant health needs will be addressed – Workgroups

Workgroups need to be formed around each of the needs that the Advisory Committee selected to address in the IS. Workgroups are responsible for developing and recommending the actions/strategies to address the need, who the strategies will be directed toward, where the strategies will be offered/delivered, and who will implement the strategies with what resources. Workgroups should include:

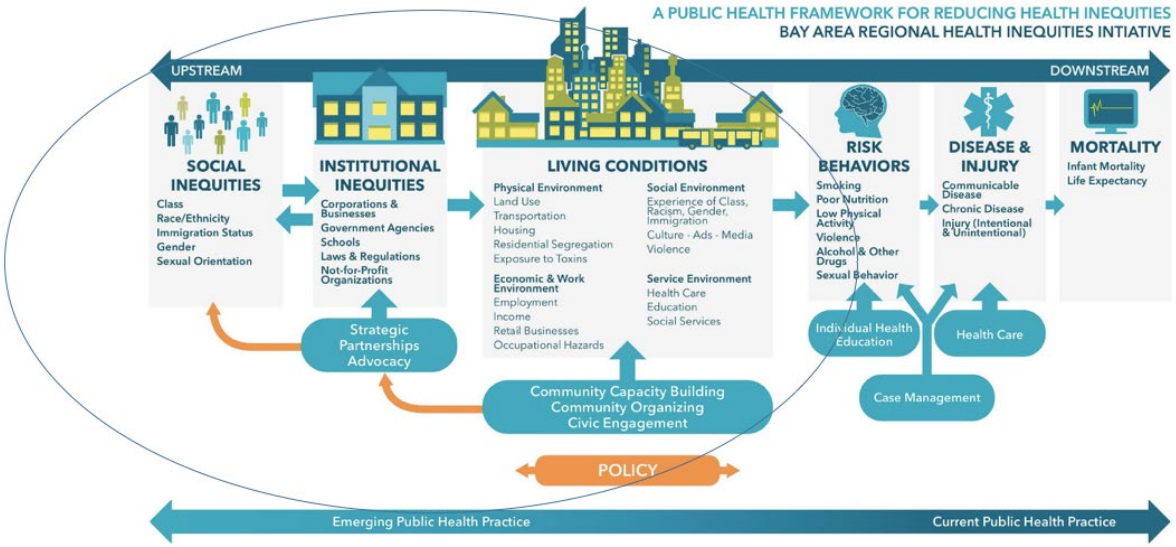
- Community members of the area/neighborhood most impacted by the needs – these members may need assistance directly from the hospital and those needs should be considered when the individuals are engaged.
- Community organizations that serve those who have lived experience and are most impacted by the community needs (ex. Food Insecurity—someone experiencing food access issues),
- Technical experts in this area of need (ex. Food—food policy council leader).

It is also useful to ensure the following capacities or skillsets of the following areas within the health ministry are included in the workgroups to help develop the strategies that will address the community needs: Strategy, DEI, Mission, Advocacy, Finance, Population Health (clinics, home health, hospice, skilled nursing, foundations, pharmacy, physician groups, etc.). Inclusion of these health system leaders will further integrate CHWB across the health ministry and utilize healthcare expertise in developing the strategies within the IS.

Workgroups need to review qualitative and quantitative data that pertains to their need. The CHNA is a good starting place for such information, including indicator data, focus group summaries, survey responses, etc. The Trinity Health Data Hub (password: CHWBdata) CHNA Report and map room can provide additional quantitative data.

Workgroups then conduct a problem analysis for the "problem" or need that they are working to address. The Bay Area Regional Health Inequities Initiative (BARHII) developed a conceptual framework that illustrates the connection between social inequalities and health. It illustrates how deep inequities underlie the living conditions that ultimately impact health and health inequities. By addressing upstream root causes, implementation

strategies can drive prevention at a population level. This framework has been used widely as a guide to health systems and health departments working to address health inequities.




One strategy for identifying the root causes of a particular area of need is the technique described in the Community Anti-Drug Coalitions of America (CADCA) 'Assessment Primer: Describing Your Community, Collecting Data, Analyzing the Issues and Establishing a Road Map for Change'.[2] CADCA's method not only asks "why?" a particular problem is prevalent, but also, "why here?" and uses this technique to achieve the following:

- Surface root causes of problems experienced within the community, particularly within populations disproportionally affected,
- Challenge the perceptions and assumptions about the root causes of a problem, while taking into consideration the community's data, unique experience, and scientific evidence,
- Help the collaborative build consensus around problem solving and prioritize actions that will have the greatest impact on those directly affected by a need,
- Create a framework that is easily translated to a logic model, which builds support for the actions that are eventually outlined in the IS and implemented by the collaborative to collectively address the need.

To embed an equity lens in this process, workgroups are asked to assess the following:

- Who is participating in this problem analysis?

[2] Assessment Primer: Describing Your Community, Collecting Data, Analyzing the Issues and Establishing a Road Map for Change | CADCA

- Are those who are most impacted by the need represented here? If not, how will they be recruited and retained?
- How is the BIPOC population, specifically, affected by this?
- How are other populations affected by this need (high/priority zip code community members, people who are systemically oppressed, people with disabilities, etc.)?
- What are the institutional barriers that communities have when trying to provide input and feedback?
- Is the health system set up to receive this input from community and how?
- What would the health equity impact be if not addressing the specified need?

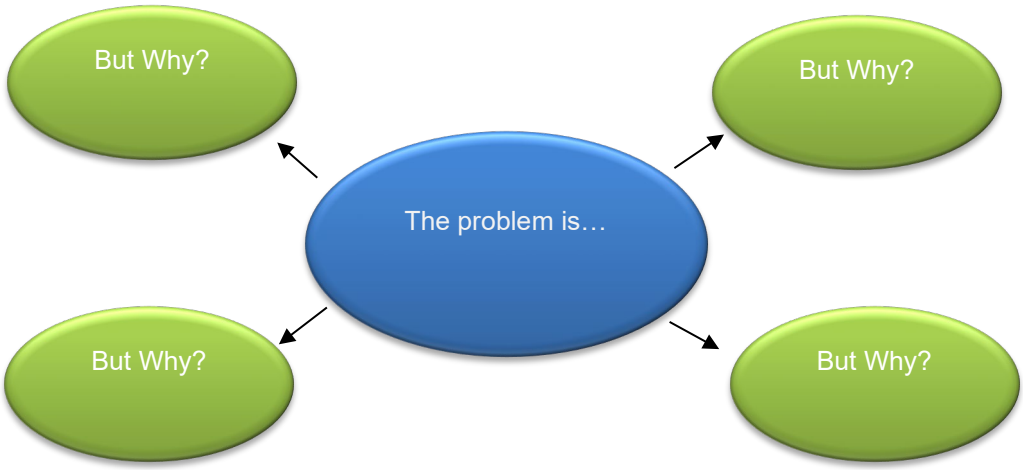
## VII. Conduct the Problem Analysis and Identify Strategies

### Conducting the Problem Analysis

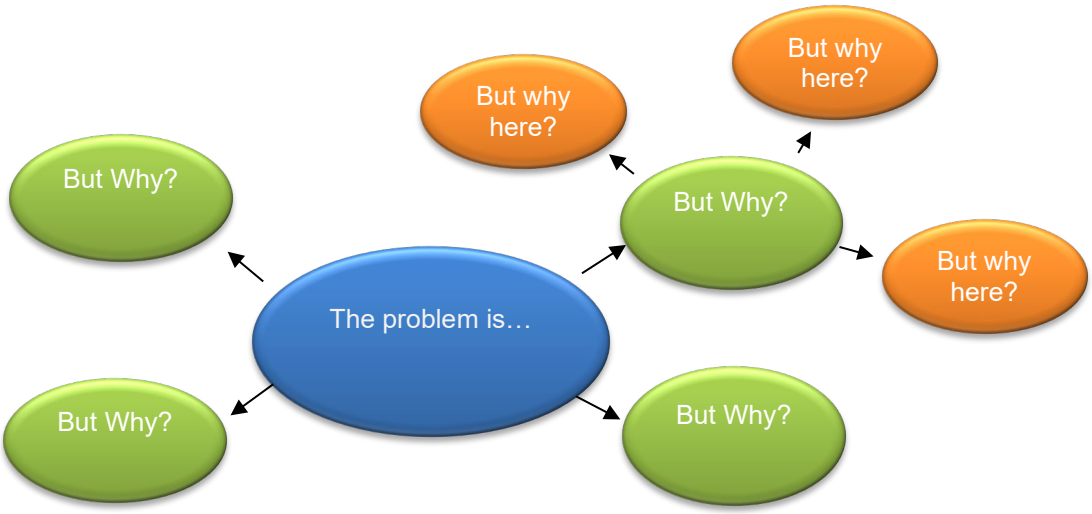
Step 1 – the workgroup describes the problem (need) in a brief statement and place in center circle (this can be done on a large piece of paper, whiteboard, or electronically with Word or PowerPoint).


Step 2 – the workgroup brainstorms and hears from those who are impacted reasons the problem exists, using data and evidence, by asking “but why?”. Focusing on the living conditions and social determinants of health identified in the BARHII model could any of these determinants contribute to into the problem?

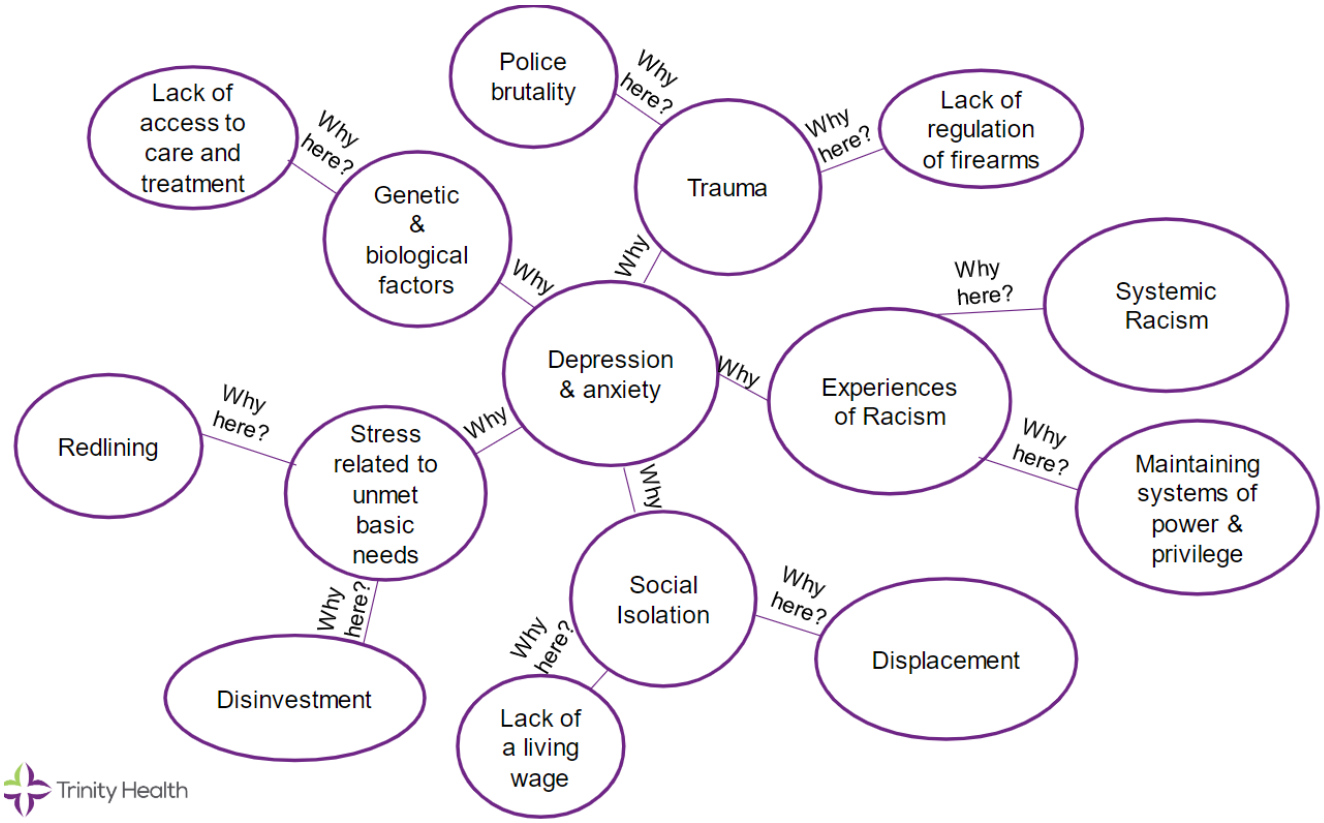
Arrange the answers to this question around the problem statement.



Step 3 – to focus in on the priority community and go deeper, the workgroup brainstorms reasons these conditions problems exist locally, by asking “but why here?”. At this point, the workgroup should consider the social and institutional inequities in the BARHII framework that created and perpetuate the conditions in the community. To further focus the problem analysis on the populations most impacted by a need, use the defined high priority/priority zip codes in your service area as the location to answer the ”but why here” tier. The high priority and priority zip codes for each community are listed in the CHWB Ministry-Wide folder in Teams. These zip codes were identified as meeting either federal poverty guidelines or racial demographic criteria (priority), or both (high priority). Areas of need may be more granular and concentrated to a particular block or neighborhood, or a particular demographic (such as persons of a certain race or age, or persons with a disability). Arrange the answers to this question around the “but why” tier. These responses should be locally tailored and draw from data and input gleaned from the CHNA process, as well as the focus groups convened for the development of the IS.



The following example shows how to progress through the problem analysis to describe how the root causes and local conditions were defined, using the systemic, structural, and social determinants of health, for the problem statement of depression and anxiety.



## Identify strategies that will have the greatest impact on the need

Review and Leverage Community Assets

The assets identified over the course of the community engagement process should be leveraged, when possible, to address the community's needs. In partnership with those managing the assets (grassroots organizations, etc.), determine if and how the asset can expand or grow to address the community needs in high/priority areas and demographics. For example, if a local organization runs a food distribution program, are those served by the program located in areas of greatest need or is the program reaching the demographic with the greatest food insecurity? How can hospital and partnership resources be allocated to expand this program to achieve greater reach?

Assets that should be considered include:


Human resources: the skills and capacity of local community members, organizations, governing bodies, existing programs, and associations (i.e. individuals, philanthropic institutions, business owners, local leaders, activists, volunteers, etc.)

Physical resources: public spaces that are available to community members for meeting space and recreation (i.e. library, community center, gardens, parks, farmer's markets, etc.)

Informational resources: associations and memberships, both formal and informal, available for networking, communication, and support (i.e. faith-based organizations, civic groups, etc.)

Political/governmental resources: elected officials and public and private institutions that currently advocate for resources and policy change within the community (i.e. advocacy groups, law enforcement, public health department, social services, colleges/universities, school district, pre-k/childcare, etc.)

Community intervention resources: initiatives and programs that are currently provided within the community (i.e. community benefit programs, food banks, youth programs, senior programs, etc.). The Community Resource Directory (CRD) is a great resource for free or reduced cost services such as medical care, food, job training, and more.

Cultural and Neighborhood Resources: faith-based organizations, advocacy and/or community organizing organizations, specific population organizations (BIPOC, LGBTQ+, etc.)

Additional information about asset mapping and ways of leveraging these strengths to improve community health, including a toolkit developed by the Association for Community Health Improvement, can be found here.

Define the Community that will be Served

While the CHNA is designed to assess the needs of the entire community served by the hospital and their

partners (often defined as your primary and secondary community based on discharge data), the IS should have focused interventions around areas of greatest need within the most impacted communities within the service area. Collaboration with community partners and members is essential to understanding what the specific needs are, who can be most impacted by addressing those needs, and where those most impacted live.

Define the Actions to Address the Need

Actions and interventions that are populated in the IS should be based on the workgroup problem analysis and logic model. They should be measurable, evidence-based policy, systems, and environmental change strategies, rather than one-on-one clinical interventions that the hospital and partners will implement in order to achieve the objective and address the selected need.

The following table is an excerpt from the IS Template:

- Describe the strategies, and focused populations and locations
- Check which years (one, two, and/or three) each strategy will take place
- List the committed resources, both financial and in-kind, that the hospital and partners are committing to address the need
- Clearly identify which partners are committing which resources toward implementing the different strategies.

| Strategy | Timeline | | | Hospital and Committed Partners (align to indicate committed resource) | Committed Resources (align by hospital/committed partner) |
|---|---|---|---|---|---|
| | Y1 | Y2 | Y3 | | |
| | | | | [Hospital name] | [$X or description of in-kind resources] |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | Focus location(s) | Focus Population(s) |
| | | | | | |

For Joint Implementation Strategies, this template meets the specific requirement to clearly differentiate the hospital's particular role, responsibilities, and allocated resources, from the roles, responsibilities, and resources of community partners.

Identify Evidence-based Strategies

Evidence-based strategies are programs and interventions that have been proven through research and evaluation to have made an impact. We strongly recommend that hospitals keep these in mind while identifying existing community-based strategies to support, or select from these strategies to address the significant community health needs within the IS when community-based strategies don't already exist. The following are several sources for evidence-based strategies and interventions:

Advancing Racial Equity and Justice – Center for American Progress outlines specific system change initiatives that communities and local governments can enact

Agency for Healthcare Research and Quality (AHRQ) – Offers practical, research-based tools and other resources to help a variety of health care organizations, providers, and others make care safer in all health care settings.

CDC 6|18 Initiative – The CDC prioritized six common and costly health conditions and identified proven interventions within each condition.

CDC Community Health Improvement Navigator – The navigator includes interventions within four action areas: socioeconomic factors, physical environment, health behaviors, and clinical care.

CDC High Impact in 5 Years (HI-5) – Shares community-wide approaches, targeted at the Social Determinants of Health (SDoH), that are evidence-based to have positive health impacts, results within 5 years and are cost effective or produce a cost-savings.

County Health Rankings and Roadmaps – They offer a menu of evidence-informed policies and programs for a wide variety of topic areas.

Substance Abuse and Mental Health Services Administration (SAMHSA) – This new Evidence-Based Practices Resource Center aims to provide communities, clinicians, policy-makers and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings

The Community Guide – The guide contains a collection of evidence-based findings for several "topics". Topics include both clinical and social interventions.

## VIII. Develop a Plan to Evaluate

Develop plans to evaluate the impact of actions upon selection of intervention. The evaluation should use an equitable evaluation framework, as outline by the Equitable Evaluation Initiative, using these guiding principles:

1. Evaluation and evaluative work should be in service of equity:
    - Production, consumption, and management of evaluation and evaluative work should hold at its core a responsibility to advance progress towards equity.
2. Evaluative work should be designed and implemented commensurate with the values underlying equity work:
    - Multi-culturally valid
3. Community driven implementation and evaluation is essential to Trinity Health's approach Evaluative work can and should answer critical questions about the:
    - Ways in which historical and structural decisions have contributed to the condition to be addressed,

- Effect of a strategy on different populations, on the underlying systemic drivers of inequity, and
- Ways in which cultural context is tangled up in both the structural conditions and the change initiative itself.

The evaluation plan should include the specific measures that will be evaluated, sources for the data, the measurement period (one, two, three years, etc.) and frequency (monthly, quarterly, annually, etc.) for collecting and analyzing the data. Evaluation is important to the IS process as it help partners understand if the IS is being implemented as designed and achieving the outcomes it intended Ongoing evaluation of the IS will help to identify opportunities for improvement within the program or the community health and well-being activities. At the end of the IS cycle, the results of the evaluation help hospitals document in their next CHNA written report what impact they have made since this CHNA and IS cycle. The evaluation plan should include both process and outcome evaluation. The results of the evaluations are summarized to describe the hospital's impact in the subsequent CHNA report.

### Process/Implementation Evaluation

A process or implementation evaluation assesses how a program or policy, system or environmental change (PSE) is carried out in order to improve the intervention or PSE, such as the flow of activities or making better use of resources. Questions to ask while evaluating program/PSE implementation are:

- Was the program/PSE implemented as planned?
- What adjustments were made to the program/PSE?
- Did the program/PSE reach those most impacted by the need?
- What problems were encountered?
- Was the intervention strong enough to make a difference?
- What are the barriers/facilitators to implementation of the program/PSE activities?
- Whose voice and power were included in the implementation? Whose were left out/missing?
- What were the facilitators and barriers to implementing PSE?

### Impact/Outcome Evaluation

Impact evaluation measures the changes or outcomes that result from the program or intervention. These outcomes can be short-term, intermediate, or long-term.

| Short-term Outcomes | Intermediate Outcomes | Long-term Outcomes |
|---|---|---|
| The observable effects or changes in knowledge, attitude, or skill. | The medium-term effects on participants' actions or behaviors and should link the short-term results with the long-term results. | The ultimate goals for the program or intervention. Long-term goals should be realistic for the program and timeframe. |

Questions to ask while evaluating program/PSE impact and effectiveness are:

- Did the program/PSE reach the intended population?
- Did the program/PSE change the participants knowledge, attitude, or skill?

- Is there improvement in the data indicators from benchmark as a result of the program/PSE?
- Did the program/PSE change the participants actions and behaviors?
- Were the ultimate goals/objectives for the program/PSE met?
- Have health disparities decreased?
- Have there been improvements in in systemic and structural racism?
- Where is the community in their journey to improve equity?

Catholic Health Association's (CHA) guide, 'Evaluating Your Community Benefit Impact', describes evaluation using the CDC's six-step framework:

1. Partner engagement
2. Describe the program
3. Focus the evaluation design
4. Gather credible evidence
5. Justify conclusions
6. Ensure use and share lessons learned

### Develop measurable impacts

Objectives describe the specific change(s) expected to occur as a direct result of the activities and support the attainment of the goal (1-3 per significant health need.) They should be Equitable and Inclusive, SMART, and achievable within the three-year timeframe of the IS. The E and I SMART Objective Worksheet, as presented in session three of the four-part community engagement and racial equity series, is linked here and is a useful tool for ensuring our objectives are equitable, inclusive, and SMART.

### Equitable and Inclusive SMART Objectives

| Specific | Measurable | Achievable | Relevant | Time-bound |
|---|---|---|---|---|
| • Who will act?<br>• Are communities engaged in ways that share power?<br>• What root cause(s) will be addressed?<br>• What systems will change? | • How will the change impact the lives of community members facing racism and other forms of oppression?<br>• Are these observable changes meaningful to the community? | • Is this a change that your partnership will commit to making together?<br>• Does it reflect the strengths of the community and the partners? | • Is the change important and meaningful to the community?<br>• Does it connect clearly with the goal?<br>• Does it speak to root causes(s)? | • In what timeframe can the community expect to see change? |

Monitoring and evaluation of the IS should be conducted at minimum annually. These impact measures, and their results, will be used to inform the next CHNA that is conducted within three years—specifically when fulfilling the IRS requirement to disclose the impact the hospital has made on community health needs since the last CHNA was conducted. This is also the chance to communicate to the community what resources were implemented to address the needs within the community and what impact those resources had on improving the need.

## IX. Translate to a Logic Model

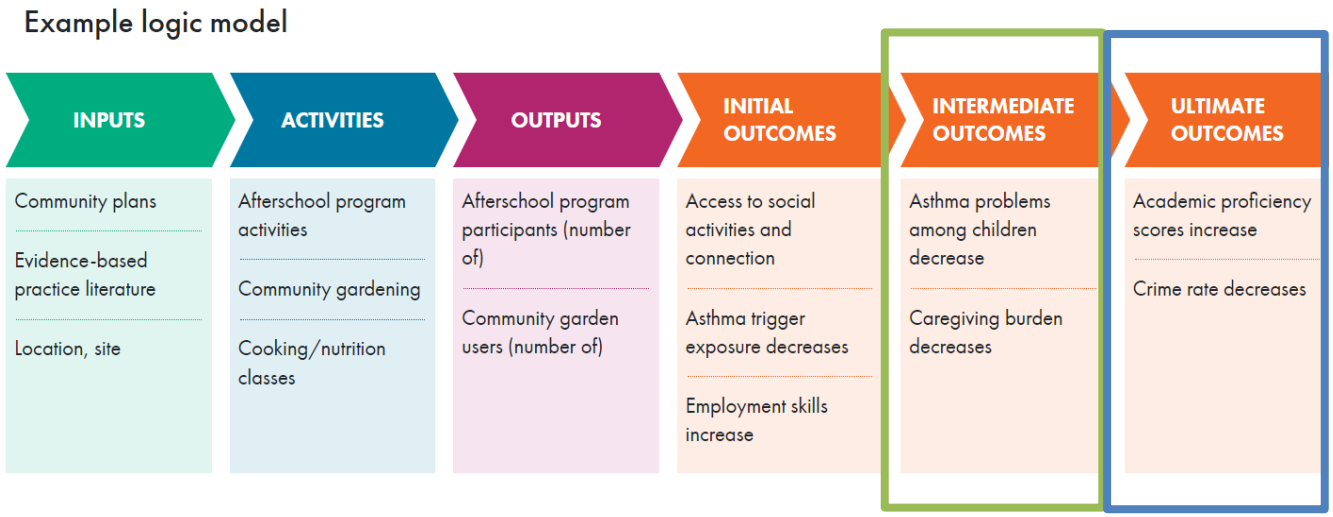
As outlined by Metrics for Healthy Communities, logic models are a road map to thinking through a problem—how to get from A to Z, the path from intervention to impact. Logic models can provide a way to see and agree on the interventions and outcomes, and the pathway between the two. Logic models also help you talk through assumptions about your work's impact.

Inputs—the resources that go into a program (e.g., the staff, supplies, or number of volunteers)

Activities—the services or programming provided (e.g., community gardens, cooking classes)

Outputs—the direct results of an organization's activities (e.g., number of garden plots created, or the number of people who took a cooking class)

Outcomes—the intended changes, or the difference the organization expects to make in someone's life, both short and long-term (e.g., short-term: greater awareness of value of a balanced diet; longer-term: lower obesity)



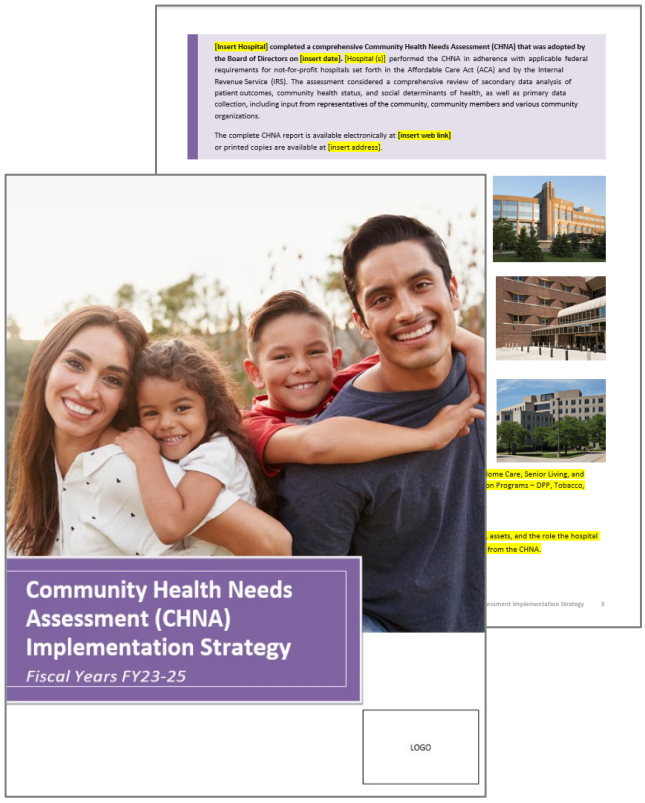

## X. Write the Implementation Strategy

Once the logic model has been created, the workgroup will document the needs, along with the equitable and inclusive SMART objectives for the next three years, the actions the hospital and other community partners intends to take to address the needs, and the anticipated impact of these actions using Trinity Health's standard IS template.

Trinity Health's IS template must be used by all hospitals for publication. The template is concise and understandable for public review, and ensures that the IRS 501(r) requirements are met. An evaluation of the actions taken by the hospital is necessary and is a critical component of the CHNA written report. For this reason, the standard template stresses the importance of having evaluation measures in place from the beginning, and will help hospitals evaluate their effectiveness for reporting in the future CHNA cycle and the upcoming IRS Form 990 Schedule H. Each hosptial, in collaboration with community partners, should plan to develop a detailed community action plan that outlines the more detailed annual strategies, timelines, and specific responsibilities of each partner/entity.

The IS template features prompts within the body of the document for descriptions for the following:

- Mission Statement
- Hospital Description
- Community Based Services Offered
- Community Description
- Approach to Health Equity: standard language. If you would like to change any wording in this section, please connect with Rachael Telfer or Toni Conley.
- Health Needs of the Community: Include a brief description of the need, which can be copied from the CHNA written document and reformatted using dot points. The description should tell readers why that particular need was identified and prioritized, including where and who in the community is most impacted by the need.
- Hospital Implementation Strategy: the significant health needs that were identified are then broken down in the IS between those that the hospital will address, and those in which it does not plan to address. Determination for which needs will and will not be addressed is made collectively by the hospital and its partners, based on all available facts and circumstances. Limit the needs that are selected for intervention to no more than three health needs to ensure sufficient focus and resources are allocated to effectively address a need.




For each need being addressed, the root causes identified in the problem analysis conducted by the workgroups may overlap across more than one need. The problem analysis likely identified the social, systemic and structural influencers of health that impact your community, and can become a common thread in the IS. There may be actions taken that address multiple needs. For example, developing policy, systems, and environmental changes that focus on poverty and racism may address maternal/infant health and access to healthy foods.

For the significant health needs that *will not* be addressed, the hospital must include in the IS a brief explanation as to why they will not be addressed through the IS. Example reasons for not planning to address include:

  - To avoid duplication of efforts because other organizations are addressing the need
  - Resource constraints
  - Competing priorities
  - Relative lack of expertise or competency to effectively address the need
  - The need being relatively low priority

- Priority Needs to Be Addressed
  - Title of the significant need should match exactly to what it was called in the CHNA written-report.
  - Hospital facility addressing the need
  - Page of the CHNA written document where reference to this need can be located and numerical priority of the need.
  - The brief description of the need can be copied from the CHNA written document and should tell readers why that particular need was identified and prioritized.

- Objectives are specific changes expected to occur as a direct result of the activities. Include up to three equitable and inclusive SMART objectives that are achievable within the three-year timeframe of the IS.
- Actions the Hospital Intend to Take to Address the Health Need
    - Strategies – The listed actions should be measurable, evidence-based policy, systems and environmental change strategies.
    - Timeline - Check the year(s) that the strategy will take place.
    - Committed Resources, and Partners Source - Financial and in-kind resources committed by the hospital and other sources (if known). This could include estimated dollar amounts or more generic sources such as "staff time".
    - Focus locations
    - Focus populations

- Anticipated Impact of these Actions: should directly align with the objectives. List the indicators that will be measured throughout the duration of the implementation strategy timeframe. For each measure, record the following:
    - Baseline (current status of the indicator)
    - Anticipated target
    - Plan to evaluate with data sources the hospital will use and describe the measurement period and frequency. Consider periodic evaluations throughout as it may be necessary to make adjustments.

## XI. Final Approvals and Published Report

### Implementation Strategy CHWB System Review Process

All Implementation Strategies must be submitted to the Trinity Health System Office (SO) for review and approval no later than six weeks prior to your hospital's Board of Directors meeting to approve the IS (or four weeks prior to the board materials due date). Please allow at least four weeks turnaround time and additional time to make edits, if necessary, prior to submitting the documents for the Board packets. We will also accept and encourage drafts for review prior to the finalized written report submission.

After System Office approves your IS, work with your local Marketing & Communications teams to finalize the template with local branding.

### Formally Gain Board Approval and Publish

It is necessary that the final IS written report (not a draft or a summary) is formally approved by your hospital's Board of Directors on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA: November 15 for most Trinity Health ministries and February 15 for Connecticut ministries.

The IRS regulations allow for the Board to appoint an authorized person or committee to adopt the CHNA and Implementation Strategies (this needs to be documented in board meeting minutes, if applicable). The adoption, which can be done via email or in person, must be documented in writing. This documentation is required to be retained for the two most recent CHNAs conducted. Maintain the minutes from the Board meeting that describes the action taken on the IS written report and the date on which it was approved. If a joint IS was conducted for two or more hospitals, the IS must be approved by all hospitals' board of directors.

The two most recent final and approved CHNA written reports and implementation strategies must be publicized via the following means:

- Conspicuously posted on the hospital's website, 1 or 2 clicks from the hospital-specific homepage. If a ministry does not have a Community Benefit or Community Health & Well-Being landing page, please post these documents to the "About Us" page. The CHNA must be posted to the website by June 30 for most Trinity Health ministries and September 30 for Connecticut ministries, and must remain posted through two CHNA cycles. The IS must be posted by November 15 for most Trinity Health ministries and February 15 for Connecticut ministries. For a record, save a screenshot of the posted CHNA and IS by their respective due dates.
- Available - upon request - at the hospital facility, free of charge.

## Appendix A – Implementation Strategy Checklist

| | |
|---|---|
| | Review prior IS and consider all of the questions before getting started |
| | Employ strategies detailed in Section II to engage the Community |
| | Form and/or convene an Advisory Committee |
| | Develop a timeline and budget |
| | Identify no more than three needs that will be addressed in IS |
| | Form workgroups for each need to be addressed |
| | Conduct a root cause analysis on each need via workgroup |
| | Identify strategies that will have the greatest impact on the need<br>a. Review and leverage assets<br>b. Define the community that will be served<br>c. Identify the actions to address the need |
| | Develop a plan to evaluate the impact and monitor implementation |
| | Develop a logic model |
| | Write the Implementation Strategy using standard template |
| | Work with your local Marketing & Communications team for local branding, photos and graphics (stock images may be used) |
| | Submit to System Office for review |
| | Submit for Board approval |
| | Publish on your local website |
| | Upload final IS to CHWB Ministry-Wide/CHNA and Implementation Strategies Team, under the appropriate fiscal year cycle folder. |

## Appendix B – IRS Requirements and Compliance

The Patient Protection and Affordable Care Act (ACA), enacted March of 2010, added Section 501(r) to the Internal Revenue Code, which effects charitable hospital organizations that are 501(c)(3) tax-exempt. Section 501(r)(3) of the Code requires each separately licensed hospital facility to conduct a CHNA at least once every three tax years, beginning in 2011, and to adopt an IS to meet the community health needs identified through the CHNA. A Notice of Final Rule was published December 2014 and provides the requirements for tax-exempt hospitals to conduct the CHNA and prepare Implementation Strategies, as well as the consequences for failing to comply with Section 501(r).[3]

Tax-exempt hospitals are required to report on the most recently conducted CHNA and IS on the annual IRS Form 990, Schedule H, which is made publicly available to regulators, press, community organizations and members by the Trinity Health Tax Department.

[3] Notice of Final Rule - https://www.federalregister.gov/documents/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable

## Appendix C – Glossary of Terms and Acronyms

ACA – Affordable Care Act

CBISA – Community benefit reporting database from Lyon Software

CHNA – Community Health Needs Assessment

Community Engagement - the activities and process of working collaboratively with and through community residents, groups, and organizations who are from, led by, and/or who partner closely with the populations we seek to benefit and who are most impacted by health inequities.

Community Served – Used interchangeably with service area. This area is defined as the geographic boundaries of a hospital's patient service area or market.

FQHC – Federally Qualified Health Centers

Health – Throughout the guide, health is used as a comprehensive term to include the social influencers of health

IRS – Internal Revenue Service

Ministry – Refers to one Mission Health Ministry, National Health Ministry, or a Regional Health Ministry. In this guide, it is used to describe an individual hospital.

Minority populations – The IRS uses this term, we expand it to mean Black, Indigenous, and People of Color (BIPOC), persons with disabilities, the LGBTQIA+ community, and those who are systemically oppressed.

Root Causes – the underlying, and sometimes long-standing, reasons that there is poor health in a community. Poor health outcomes—like high rates of asthma, heart disease, and cancer—are often symptoms of root causes.

Significant Health Needs – The "significant health needs" include both social influencers of health and the physical and mental health needs that surface as significant through a community-driven need identification process

SO – System Office

Social Influencers of Health (SIoH) – Also known as Social Determinants of Health, are the conditions in which people are born, grow, live, work and age (WHO). Examples include education, neighborhood and built environment, social context, economic stability, and health care access.

Qualitative Data – Data that described the qualities or characteristics

Quantitative Data – Data that can be counted or compared on a numeric scale

Workgroups – A group dedicated to developing the strategy to address a single need, comprised of at minimum: someone most impacted by the need, a representative or grassroots organization located in an area most impacted by the need, and a subject-matter expert.