August 8, 2016

MERCY HOSPITAL SAINT LOUIS
COMMUNITY HEALTH IMPROVEMENT PLAN (2016-2019)

An IRS-mandated Community Health Needs Assessment (CHNA) was recently completed for each hospital within the Mercy East Community:

- Mercy Hospital Saint Louis
- Mercy Hospital Washington
- Mercy Hospital Jefferson
- Mercy Hospital Lincoln

The CHNA reports for each hospital may be accessed at:
https://www.mercy.net/about/community-benefits.

Upon completion of these assessments, the IRS requires hospitals to implement a three-year plan to improve the community's health through strategies that address a significant community health need, as identified through the CHNA. The Community Health Improvement Plan (CHIP) must:

1. Describe the actions that the hospital intends to take to address the health need, the anticipated impact of these actions, and the plan to evaluate such impact
2. Identify the programs and resources that the hospital plans to commit to address the health need
3. Describe any planned collaboration between the hospital and other agencies in addressing the health need.

Attached is the CHIP for Mercy Hospital Saint Louis (MHSL). The health needs that have been prioritized in this CHIP are:

- Access to Care
  - Navigation
  - Health Insurance Coverage
- Mental Health
- Substance Use
- Health Equity

The Community Health Council for Mercy Hospital St. Louis will oversee the Community Health Improvement Plan and monitor its progress.

MERCY HOSPITAL SAINT LOUIS
COMMUNITY HEALTH IMPROVEMENT PLAN (2016-2019)

Priority Area/Community Need: ACCESS TO CARE

Narrative: As outlined in the 2016 MHSL Community Health Needs Assessment (CHNA), accessing health care is a challenge for many St. Louis County residents. St. Louis County has one of the highest numbers of uninsured individuals in Missouri. Additionally, cost of care, a shortage of providers who accept Medicaid and will see uninsured patients, poverty, and unmet health-related social needs contribute to access challenges.

MHSL implements targeted initiatives, which align with the goals of the St. Louis County Department of Public Health (DPH), the Missouri Foundation for Health (MFH), Healthy People 2020, and the Center for Medicare & Medicaid Services, to remove barriers to health care access.

Goal #1: **NAVIGATION** – Increase the number of patients who receive **follow-up and preventive care** from a healthcare provider, with emphasis on the uninsured and underinsured

Objective: A Community Referral Coordinator (CRC) will provide patients without a medical home assistance in finding a primary care or specialty care provider, along with social service support, as appropriate.

- **Activity:** Include information on how and why to contact a CRC on ED patient discharge paperwork
- **Activity:** Evaluate current data on encounters/demand/capacity/outcomes of the existing full-time CRC to determine expansion potential of CRC services

Objective: CRC patient encounters will result in scheduled appointments

- **Activity:** Strengthen transition of care processes by developing a communication plan to enhance relationships with key Mercy hospital and clinic leaders/co-workers
- **Activity:** Refer uninsured and underinsured ED patients to the CRC prior to these patients' discharge to facilitate face-to-face CRC patient encounters
- **Activity**: Monitor/report patient encounters and scheduled appointments

Objective: Patients will keep the CRC-scheduled appointments (show rates will improve from that of baseline data)

- **Activity:** Provide social service support, as appropriate, to patients to address needs that may impede their ability to keep a medical appointment

- **Activity:** Monitor/report show rates and encounter types

Leaders/Departments Involved: Care Management, Emergency Department, Mercy Clinic, Finance/Eligibility Services, and Community Health

Community Partners: Saint Louis Integrated Health Network (IHN), including area Federally Qualified Health Centers (FQHC); St. Louis University for outcomes data/research

Evaluation Plan for Goal:

CRC team will establish **baseline data and 3-year measureable outcomes** to include:

Outputs:
- Referrals to CRC
- CRC patient encounters
- Referrals for patients to receive follow-up/preventive care
- Referrals for patients to address health-related social needs

Short-Term Outcomes: (*Data Source: IHN)*
- CRC patient encounters with an emphasis on increasing "in person" encounters
- CRC encounters resulting in scheduled appointment
- Show-rates for CRC scheduled appointments

Long-Term Outcomes:
- Reduced ED utilization for non-emergent care
- Reduced inpatient utilization with emphasis on patients with chronic conditions

Goal #2: **NAVIGATION** – Increase the number of Medicaid and Medicare recipients who receive services from a community resource to address **health-related social needs**

Objective: Co-workers in MHSL's emergency, behavioral health, and obstetrics departments will implement the evidence-based Accountable Health Communities (AHC) Model to identify Medicaid and Medicare beneficiaries' unmet health-related social needs (at minimum, core screening areas will include: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation)

- **Activity:** Secure federal funding from the Center for Medicare & Medicaid Services (CMS) in the amount of $4.5 million to implement Track 3: Alignment of the AHC Model in the St. Louis Region over the next five years
- **Activity:** Produce a standardized health-related social needs screening tool in collaboration with CMS and other AHC Community Collaborative members
- **Activity:** Train co-workers from MHSL's emergency, behavioral health, and obstetrics departments on AHC Model screening requirements, tools, and activity/outcome reporting.

Objective: Medicaid and Medicare beneficiaries' health-related social needs will be addressed, following the guidelines of the AHC Model

- **Activity:** Develop and maintain a comprehensive community resource inventory
- **Activity:** Train co-workers on how to access and use the community resource inventory
- **Activity:** Provide community referrals to all Medicaid and Medicare beneficiaries determined to have unmet health-related social needs
- **Activity:** Provide intensive community service navigation (in-depth personal interviews and planning/follow-up until needs are resolved or determined to be unresolvable) to high-risk (per CMS guidelines) beneficiaries with identified unmet health-related social needs

- **Activity:** Evaluate the Mercy Neighborhood Ministry (MNM) emergency referral and assistance program for opportunities to support the AHC Model

Objective: CMS will evaluate whether increasing Medicare and Medicaid beneficiaries' awareness of and access to community services impacts total health care costs and recipients' health outcomes

- **Activity:** Report data regarding screening activities/results to AHC Community Consortium
- **Activity:** Exchange data concerning community service referrals and navigation activities with AHC Community Consortium members
- **Activity:** Share MHSL Medicaid and Medicare claims data with the lead/bridge agency of the AHC Community Consortium

Leaders/Departments Involved: Care Management, Emergency Department, Obstetrics, Behavioral Health, and Community Health

Community Partners: Center for Medicare & Medicaid Services (CMS), Missouri Primary Care Association, Saint Louis Integrated Health Network (IHN), Behavioral Health Network (BHN) and AHC Community Consortium members

Evaluation Plan for Goal:
AHC Community Consortium will reach a minimum of 75,000 "community dwelling beneficiaries" per year, establishing **baseline data and reporting 5-year measureable outcomes** as outlined in the CMS application to include:

Outputs:
- Application for federal funding to implement the AHC Model **(*pending*)**
- Standardized Health-Related Social Needs Screening Tool
- Patient screenings
- Community Resource Inventory
- Co-worker trainings on AHC Model and Community Resource Inventory
- Tailored community referrals
- Intensive community navigation services
- Emergency assistance for community members
- AHC Model reporting

Short-Term Outcomes: (*Data Source: Mercy)*
- Medicaid and Medicare recipients in targeted MHSL departments become aware of community resources
- Medicaid and Medicare recipients in targeted MHSL departments receive referrals and navigation assistance with health-related social needs

Long-Term Outcomes: *(Data Sources: Mercy, CMS)*

- Reduced cost of care, ED visits and admissions for high-risk Medicare and Medicaid beneficiaries
- Improved health and quality of care

Goal #3: **COVERAGE** – Increase the percentage of Missouri lives, aged 0-64, that are covered by quality, affordable **health insurance**

Objective: Mercy Certified Application Counselors (CACs) will assist 225 uninsured individuals within the Mercy East Community with acquiring health insurance through the Missouri Health Insurance Marketplace

- **Activity:** Train and certify Mercy CACs
- **Activity:** Educate 10,000 Missourians on health insurance coverage options and obligations through participation in 200 health insurance awareness/education events

Objective: Missouri will expand Medicaid, making insurance coverage a possibility for a greater number of Missouri residents

- **Activity:** Mercy Advocacy Team leads strategies, such as engaging with state and local legislative officials, in support of Missouri Medicaid expansion
- **Activity:** Actively participate in the Catholic Charities Advocacy Council

Leaders/Departments Involved: Finance/Eligibility Services and Advocacy

Community Partners: Missouri Foundation for Health and Missouri Coverage Assistance Program (MCAP) partners

Evaluation Plan for Goal

MCAP team will establish **baseline data and report 2-year measureable outcomes**, as outlined in the MFH application to include:

Outputs:
- Certified CACs
- Education/awareness events
- Co-worker training on referring to CACs

Short-Term Outcomes: (*Data Source: Mercy CAC Program)*
- Enrollments

Long-Term Outcomes: *(Data Source: Missouri Foundation for Health)*
- The percent of uninsured Missouri residents under the age of 65 falls to 5%.

Priority Area/Community Need: MENTAL HEALTH/SUBSTANCE USE

Narrative: As outlined in the 2016 MHSL Community Health Needs Assessment (CHNA), residents of St. Louis County experience a higher than average degree of mental health challenges. The total number of individuals accessing behavioral health services in 2014 increased 120% from the number served in 2005. Additionally, St. Louis County (particularly north St. Louis County) exhibits higher rates of inpatient hospitalizations for psychoses, depression, bipolar disorder, and schizophrenia than Missouri rates.

St. Louis County residents also demonstrate high rates of substance use across several measures. The rates of drug-poisoning deaths involving heroin are significantly higher than regional or national rates; the reported rates of excessive drinking are higher than regional and national rates; and the reported number of incidents involving methamphetamines are higher for St. Louis County than that for 36 states. Prescription drug use is another major concern, exacerbated by Missouri being the only state in the nation to lack a Prescription Drug Monitoring Program (PDMP).

Due to a shortage of behavioral health providers, behavioral health access must be addressed on a regional level. Mercy will implement regional strategies, building on the services of its hospitals and clinics in the Mercy East Community (St. Louis, Washington, Jefferson, and Lincoln), and other community partners to address mental health and substance use needs. These strategies will be in alignment with the behavioral health goals of the St. Louis County Department of Public Health (DPH), the St. Louis Behavioral Health Network (BHN), the St. Louis County Children's Service Fund, the Centers for Disease Control, the Missouri and United States Departments of Health and Human Services, and Healthy People 2020.

Goal #1: **SUBSTANCE USE** –Reduce and manage patients' pain without increasing their risk of addiction to **prescription opioid/opiates**

Objective: The opioid/opiate prescribing rates within MHSL and Mercy Clinics will decrease

- **Activity:** Partner with Mercy's Opiate R_x Task Force to implement risk mitigation strategies for prescription opioid addiction and diversion
- **Activity:** Review and incorporate, as feasible, the current Centers for Disease Control opioid/opiate prescribing guidelines
- **Activity:** Investigate employing alternative pain management practices, such as non-pharmacologic treatments and non-opiate/opioid pain medications

- **Activity:** Acquire data on the volume of opiates prescribed by physician and the number of adverse opioid-related events to establish benchmarks for individual physician metrics

- **Activity:** Educate and promote informed choices and best practices in pain therapies among Mercy physicians

Objective: Missouri will implement a state-wide Prescription Drug Monitoring Program

- **Activity:** Participate in the St. Louis County/City Prescription Drug Monitoring Program and collect data to illustrate its benefit

- **Activity:** Mercy's Opiate R_x Task Force member(s) advocate for the implementation of a state-wide Prescription Drug Monitoring Program

Leaders/Departments Involved: Behavioral Health, Mercy Clinics, Quality, Pharmacy, Advocacy and Community Health

Community Partners: NCADA and BJC West County facilities

Evaluation Plan for Goal

Regional CHIP Behavioral Health team will establish **baseline data and report 3-year measurable outcomes** to include:

Outputs:

- Risk mitigation strategies, such as patient urine screenings, prescribing algorithms and guidelines, or medication management agreements
- Data on volume of opioids/opiates prescribed by physician
- Number of advocacy events/activities

Short-Term Outcomes: (*Data Source: Mercy)*

- Pain management practices improve

Long-Term Outcomes: *(Data Source: Mercy)*

- Reduced opioid/opiate prescribing rates

Goal #2: **SUBSTANCE USE** – Increase the number of Mercy East Community members able to **access** appropriate, quality substance use treatment

Objective: Substance use treatment services in the Mercy East Community will expand and/or be enhanced

- **Activity:** Implement and develop the Psychiatric Nurse Liaison program for hospitalized patients with addiction disorders
- **Activity:** Evaluate implementing Medication-Assisted Treatments (Vivitrol, Suboxone) with patients, as appropriate
- **Activity:** Explore potential partnerships, particularly with agencies that have residential detoxification programs, to enhance transitions of care/recovery outcomes (Preferred, C-Star, Harris House, Aviary Recovery Center, Queen of Peace)
- **Activity:** Improve the clinical competency of behavioral health providers in the area of addiction treatment

Objective: The number of low income/uninsured patients able to access substance use treatment will increase

- **Activity:** Improve the process for expedited Charity Care applications for patients with substance use disorders

Leaders/Departments Involved: Behavioral Health, Mercy Clinic, Pain Management Specialists, Holistic Health, Quality, Pharmacy, and Community Health

Community Partners: NCADA , Preferred Family Healthcare, C-Star Programs, Harris House Treatment and Recovery Center, The Aviary Recovery Center, Queen of Peace Center, and BJC West County facilities

Evaluation Plan for Goal

Regional CHIP Behavioral Health team will establish **baseline data and report 3-year measurable outcomes** to include:

Outputs:

- Number of patients referred/served
- Number of Psychiatric Nurse Liaisons
- Number of co-workers trained on Medication-Assisted Treatments
- Number of behavioral health providers who participate in professional development

Short-Term Outcomes: (*Data Source: Mercy)*

- Number of Partnerships Developed

Long-Term Outcomes: *(Data Source: TBD)*

- Addiction & Death rates from substance use decrease

Goal #3: **MENTAL HEALTH** – Increase the number of Mercy East Community members able to **access** appropriate, quality mental health treatment

Objective: Services to address mental health needs in the Mercy East Community will expand and/or be enhanced

- **Activity:** Collaborate with community partners to identify the mental health service gaps in the region
- **Activity:** Engage in strategic planning regarding where to add resources/partner in order to serve more people (Mental Health Navigators in primary care offices, Advanced Practice Registered Nurse (APRN) in targeted locations)
- **Activity:** Open new adult psychiatry clinic at MHSL
- **Activity:** Expand the Psychiatric Nurse Liaison program for hospitalized patients with mental health needs
- **Activity:** Recruit new mental health providers, including Psychiatrists, Counselors, Nurse Practitioners, and Psychiatric Pharmacists
- **Activity:** Expand Intensive Outpatient Programs and clinic services at Mercy Hospital Washington and Mercy Hospital Jefferson
- **Activity:** Implement the Columbia Suicide Severity Rating Scale (CSSRS) as an evidence-based suicide screening tool in EPIC
- **Activity:** Remain involved in Alive & Well STL Health Collaborative
- **Activity:** Advocate for legislation to improve mental health service delivery through continued participation in the Behavioral Health Network's Board of Directors

Objective : The number of low income/uninsured patients able to access mental health treatment will increase

- **Activity:** Improve the process for expedited Charity Care applications for patients with substance use disorders

Leaders/Departments Involved: Behavioral Health, Mercy Clinic, Virtual Care, Finance, and Community Health

Community Partners: Behavioral Health Network (BHN), Behavioral Health Response (BHR), National Alliance on Mental Illness (NAMI), Provident, and Alive & Well STL

Evaluation Plan for Goal

Regional CHIP Behavioral Health team will establish **baseline data and report 3-year measurable outcomes** to include:

Outputs:

- Inventory of mental health services currently available
- Number of resources added/partnerships formed
- Number of patients served
- Number of mental health providers recruited

Short-Term Outcomes: (*Data Source:)*

- TBD

Long-Term Outcomes: *(Data Source:)*

- TBD

Priority Area/Community Need: HEALTH EQUITY

Narrative: As outlined in the 2016 MHSL Community Health Needs Assessment (CHNA), health is not equally distributed throughout St. Louis County. There are differences in a number of health factors – including health literacy, health insurance coverage, health care access, and health outcomes – that appear to be based on where one lives. These differences, illustrated by such factors as Wildwood in west St. Louis County having a life expectancy of over 91 years, whereas Kinloch in north St. Louis County has a life expectancy of less than 56 years, have a negative and significant impact on the St. Louis County community.

MHSL has signed the American Hospital Association's "Equity Pledge to Act" to eliminate health care disparities. As a partner in the "National Call to Action to Eliminate Health Care Disparities," MHSL will align/expand its existing efforts to deliver quality, culturally competent care to all patients by focusing on three core areas:

- Race, Ethnicity, and Language preference (REAL) data collection
- Cultural Competency training
- Leadership/Governance Diversity

Focusing on these areas will assist MHSL in eliminating a disparity in maternal/child health in support of the maternal, infant, child health goals of the St. Louis County Department of Public Health and Healthy People 2020. Currently, north St. Louis County has several areas where infant mortality rates exceed that of the national average, in some cases by more than twice the national average, and the County demonstrates disparities in preterm birth rates and babies' birth weights.

Goal #1: Address and significantly reduce a disparity in maternal/child health among MHSL patients

Objective: Race, Ethnicity, and Language preference (REAL) data will be collected in the **maternal/child health** area and used to identify and address a health care disparity

- **Activity:** Assess current maternal/child practices for the collection of reliable REAL data
- **Activity:** Define goals for data collection
- **Activity:** Stratify maternal/child data by race/ethnicity, household income/payor, and language
  - Birth Outcomes (low birth weight, preterm, death)
  - Mother Outcomes (postpartum depression, c-section rate)
  - Mother Resource Utilization (onset of prenatal care, choice to breastfeed)

- **Activity:** Identify disparities or confirm none exist

- **Activity:** If a disparity does exist, design a plan to address it

Objective: MHSL co-workers and leaders will be trained in cultural competence

- **Activity:** Conduct an internal assessment of existing MyEducation courses

- **Activity:** Evaluate the degree to which cultural competency and diversity & inclusion education is currently incorporated within other professional development offerings at Mercy, such as Foundations of Leadership, New Leader education, and life-long learning academies for frontline co-workers, leaders, and physicians

- **Activity:** Identify any existing training gaps and develop a plan to address training needs/opportunities

Objective: The leadership and governance of MHSL and Mercy Clinics will be reflective of the St. Louis Metropolitan Area community

- **Activity:** Meet with HR to better understand the current Diversity & Inclusion plan and progress to date, as well as talent selection processes

- **Activity:** Share Health Equity Pledge with MHSL Leadership and Board to invite ideas for review of current leadership and governance composition and identify opportunities that may exist for improvement

- **Activity:** Develop and implement a Diversity & Inclusion Scorecard to measure how Mercy's diversity composition and strategies add value to the organization and influence patient care outcomes

- **Activity:** Celebrate diversity and inclusion at the leadership level via Diversity Moments

Leaders/Departments Involved: Administration, Board of Directors, Women's Services, Quality, Human Resources, Diversity & Inclusion, and Mission

Community Partners: The Missouri Hospital Association, the American Hospital Association, The Maternal, Child and Family Health Coalition, the St. Louis Chapter of the National Association of Health Services Executives (NASHE), and the St. Louis Business Diversity Initiative

Evaluation Plan for Goal

HR team will **further develop and report measureable outcomes** to include:

Outputs:

- Number of cultural competence and diversity and inclusion training options offered
- Number of co-workers attending cultural competence or diversity and inclusion training
- Maternal/child disparity identified or confirmed that none exists
- Diversity & Inclusion scorecard

Short-Term Outcomes: (*Mercy)*

- If maternal/child disparity exists, pilot program is developed to address disparity

Long-Term Outcomes: *(Mercy)*

- Identified disparity is eliminated or reduced
- Co-workers are trained in and demonstrate cultural competence (pre/post-testing)
- Executive leadership and governance boards voice ongoing satisfaction with board/leadership diversity

Additional Needs Being Addressed

- Violence: Domestic, Elderly, Child Abuse, and Trafficking

  MHSL will continue to partner with ALIVE, a local Domestic Violence agency, to implement Project HOPE, the only program in the Greater St. Louis area that allows domestic violence survivors to file for, and potentially have granted, orders of protection while still in a hospital setting. Information regarding ALIVE's programming and services is distributed throughout MHSL, with Spanish translations provided to better reach patients who speak limited English.

  MHSL is also actively involved in the Coalition Against Trafficking and Exploitation (CATE), and partners with St. Martha's Hall, a Catholic Charities organization that provides shelter and services to women and children who have survived domestic violence. Mercy will continue its collaboration and involvement with these groups, as well as the awareness and education campaigns it has begun with restroom resource posters, a training video, and the incorporation of a screening question/referral process in Mercy's Electronic Medical Record (EMR). However, it was felt by Mercy's CHC that while continued attention to this issue was important, the issues of access, health equity, and the community's crisis with behavioral health and addiction demanded Mercy's focus at this time.

- Obesity/Poor Nutrition/Physical Inactivity

  Although MHSL did not choose healthy lifestyles as a *priority* community health need to be addressed, Mercy has focused on its own coworkers, 10,000+ in the St Louis region, as a start to addressing this need. A robust initiative, Mercy's *Healthification* program, provides comprehensive health evaluation, screening, education, and incentives to increase healthy behaviors and improve health among Mercy coworkers.

- Chronic Conditions: Heart Disease, Diabetes, or Asthma and Allergies

  A significant concern relating to chronic conditions is the disparity in health outcomes and treatment for Blacks/African-Americans and Whites/Caucasians. MHSL recently signed an American Hospital Association Health Equity pledge and is beginning to implement "Call to Action" goals aimed at identifying and, subsequently, addressing areas of health disparity and service gaps. As the leader

in St Louis County for newborn deliveries, MHSL has decided to take on the significant issue of health equity by beginning with maternal/child health disparities and addressing some of the region's needs with low birth weight babies. Mercy has also committed to addressing health equity in the Inner North region community of Wellston; Mercy is outlining a collaborative community plan to address overall health equity with these community members.

- Cancer: Lung/Tobacco Use

Efforts to address tobacco cessation will continue through Mercy's Certified Health and Wellness Coach/Mercy Road to Freedom program though Mercy's Cardiopulmonary Rehab area. Additionally, Mercy will continue to advocate around measures that promote tobacco cessation, such as Tobacco 21, a bill a MHSL physician introduced in 2016 to raise the tobacco products purchase age to 21 in St. Louis County. The bill was passed and the new tobacco products purchase age law will go into effect on December 1, 2016.

Other identified needs not being addressed and why not, if applicable.

- Sexually Transmitted Infections

Infectious disease physicians at Mercy will continue to address this issue through collaborative work. Mercy will not, however, take a lead role on this issue as there are some limitations to the organization's partnerships in this area as a Catholic Health System.

Community Health Council
Mercy Hospital St. Louis

Leadership

SPONSOR
Jeff Johnston: President

MEMBERS
Steve Fowler: Dir, Mission Services
Trish Geldbach: VP, Women's Services
Terry Herbert: Dir, Marketing & Communications
Paul Hintze, M.D.: VP, Medical Affairs
Don Kalicak: VP, Business Development & Planning
John Kelly: Board Member
Allison Lageose: Outreach Coordinator, Mercy Neighborhood Ministry
Tanya Lieber: Regional VP, Philanthropy
Patty Morrow: Exec. Dir, Behavioral Health
Sharon Neumeister: Dir, Mercy Neighborhood Ministry
Annette Richardson-Latham: Regional Dir, Inpatient Care Management
Laura Richter: VP, Mission Services
Denise Scoffic: Regional VP, Finance
Roger Steinbecker: Board Member
Janice Vespa: VP, Operations

The local Community Health Council is accountable for ensuring Community Benefit meets mission, compliance and IRS guidelines. Mercy Hospital St. Louis, in partnership with the St. Louis County Department of Public Health and other community organizations, continues to participate in the Mobilizing for Action through Planning and Partnerships (MAPP) model for assessment and planning.

Responsibilities:

1. Completes:
   a. Community health needs assessment every three years
   b. Annual written implementation plan
   c. Annual community impact plan
2. Develops & manages a Community Benefit budget
   a. Annual Community Benefit amount falls between 5-8%
3. Assures Community Benefit activities:
   a. Meet a prioritized community health need
   b. Make a measurable impact on a community health indicator
   c. Involve collaboration/partnership with key community stakeholders and advocacy with key legislators
   d. Connect programs to service line and community master planning strategies
   e. Develop innovative programs/medical management of charity & Medicaid populations
4. Reports:
   a. Community Benefit activities accurately and thoroughly
   b. Information for 990H/990, especially narrative questions
   c. Community Benefit activities quarterly to local boards and ministry oversight group

To comply with new IRS guidelines, the following timeline will guide Community Benefit program development and reporting.

1. Community Health Needs Assessments (CHNA) are completed (including posting) – **6/30/2016**
2. Community Health Improvement Plans (CHIP) are written and approved by local boards – **11/15/2016**