Ascension St. Vincent Dunn

Implementation Strategy for the 2021 CHNA
Lawrence County, Indiana

Ascension

The purpose of this Implementation Strategy is to describe how the hospital plans to address prioritized health needs from its current Community Health Needs Assessment (CHNA). The significant health needs that the hospital does not intend to address are identified and a rationale is provided. Special attention has been given to the needs of individuals and communities who are more vulnerable, unmet health needs or gaps in services, and input gathered from the community.

Ascension St. Vincent Dunn
1600 23rd St
Bedford, IN 47421
812-275-3331
27-2192831

The 2021 Implementation Strategy was approved by the Ascension St. Vincent Dunn Board of Directors on November 14, 2022 (2021 tax year) and applies to the following three-year cycle: July 2022 to June 2025 (FY2023 - FY2025). This report, as well as the previous report, can be found at our public website.

We value the community's voice and welcome feedback on this report. Please visit our public website (Community Health Needs Assessments | Ascension) to submit your comments.

Table of Contents

Introduction

As one of the leading non-profit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable.

Ascension St. Vincent Dunn

As a Ministry of the Catholic Church, Ascension St. Vincent Dunn is a non-profit hospital governed by a local board of trustees represented by community members, medical staff, and sister sponsorships. For many years, the hospital has been providing medical care for residents of Lawrence County, Indiana, and neighboring areas. In 1904, St. Vincent Dunn, originally Lawrence County Hospital and formerly Dunn Memorial Hospital, was built in Bedford, Indiana. The hospital was presented with an Indiana Historical Marker in 2005. The hospital joined St. Vincent in 2010 as a 25-bed critical access healthcare facility. Ascension St. Vincent Dunn offers the following services: cardiovascular services, diabetes care, emergency medicine, immediate care, laboratory services, maternity services, medical imaging, nutrition support, pediatrics, primary care, rehabilitation services, respiratory care, spiritual care, surgery, wellness medicine, and women's health. St. Vincent Dunn's primary service area is Lawrence County which is in Southern Indiana.

For more information about Ascension St. Vincent Dunn, visit Ascension St. Vincent Dunn

Overview of the Implementation Strategy

Purpose

This Implementation Strategy (IS) is the hospital's response to the health needs prioritized from its current Community Health Needs Assessment (CHNA). It describes the actions the hospital will take to address prioritized needs, allocate resources, and mobilize hospital programs and community partners to work together. This approach aligns with Ascension St. Vincent 's commitment to offer programs designed to address the health needs of a community, with special attention to persons who are underserved and vulnerable.

IRS 501(r)(3) and Form 990, Schedule H Compliance

The CHNA and IS satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an Implementation Strategy every three years. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act are described in Code Section 501(r)(3) and include making the CHNA report (current and previous) widely available to the public. In accordance with this requirement, electronic reports of both the CHNA and the current Implementation Strategy can be found at Community Health Needs

Assessments | Ascension and paper versions can be requested at Ascension St. Vincent Dunn's information desk located in the main lobby.

Process to Prioritize Needs

Included in Code Section 501(r)(3) is the requirement that hospitals must provide a description of the process and criteria used to determine the most significant health needs of the community identified through the CHNA, along with a description of the process and criteria used to determine the prioritized needs to be addressed by the hospital. Accordingly, Ascension St. Vincent Dunn used a phased prioritization approach to identify the needs within Lawrence County. The first step was to determine the broader set of identified needs. Through the CHNA, identified needs were then narrowed to a set of significant needs which were determined most crucial for community stakeholders to address. For more information on the methods and analysis used to determine community health needs, please visit 2021 CHNA - Ascension St. Vincent Dunn - Lawrence County.

Following the completion of the CHNA, significant needs were further narrowed down to a set of prioritized needs that the hospital will address within the Implementation Strategy. To arrive at the prioritized needs, Ascension St. Vincent Dunn used the following process and criteria: hospital leaders reviewed the 2021 CHNA significant health needs and the data used to define each as significant, then voted on the top 3-5 needs they determined the hospital could address in the next three years.

The criteria used to prioritize the significant needs were:

- Alignment with the organization's mission, values, and strategic priorities.
- Alignment with existing service and area of expertise.
- Concern for low-income or vulnerable persons.
- Ability for organization to have an impact.
- Ability to leverage organizational assets.

Needs That Will Be Addressed

Following the completion of the current CHNA, Ascension St. Vincent Dunn has selected the prioritized needs outlined below for its FY2023 - FY2025 Implementation Strategy. Ascension has defined "prioritized needs" as the significant needs which have been prioritized by the hospital to address through the three-year CHNA cycle:

- **Access to Care** – This need was selected because access to care indicators such as adults reporting fair or poor health, low birthweight babies, per capita supply of healthcare providers, preventable hospital stays, and/or core preventive services compared unfavorably to peer counties or U.S. averages and because community meeting participants identified access to care (including preventive services) as a priority.

- **Mental Health** – This need was selected because mental health indicators such as number of mentally unhealthy days, number of mental health providers per population, depression rate and/or suicide rate compared unfavorably to peer counties or U.S. averages and because community meeting participants identified mental health and adverse childhood experiences (ACEs) as a priority.

- **Senior Services** - This need was selected because the percentage of the population aged 65 and older is higher than the state average and the senior population is anticipated to grow at a faster pace than the general population. Additionally, the majority of ZIP Codes ranked in the bottom quartile nationally for the percentage of older men and women who have received a set of core preventive services at recommended intervals (flu shot, pneumococcal vaccine, colonoscopy or sigmoidoscopy or fecal occult blood test, and mammogram).

Ascension St. Vincent Dunn understands the importance of all the health needs of the community and is committed to playing an active role in improving the health of the people in the communities it serves. For the purposes of this Implementation Strategy, Ascension St. Vincent Dunn has chosen to focus its efforts on the priorities listed above.

Needs That Will Not Be Addressed

Based on the prioritization criteria, the health needs identified through the CHNA that Ascension St. Vincent Dunn does not plan to address in this Implementation Strategy include:

- **COVID-19 Pandemic** - The hospital, together with Ascension Medical Group (AMG), a physician-led provider organization, continues to provide treatment for community members diagnosed with COVID-19, as it has done since the beginning of the pandemic. As federal, state, and local authorities are providing leadership for prevention and surveillance activities, the hospital will not directly address the COVID-19 pandemic in the current Implementation Strategy.
- **Maternal, Infant, and Child Health** - The hospital, together with AMG, provides health care services to pregnant women, infants, and children. Additionally, the hospital does address this need in various ways including participation in statewide committees and local community coalitions, offering support groups, and/or providing community education. The hospital will remain committed to partnering with community groups to address maternal, infant, and child health –and will continue to seek opportunities to do so. As federal, state, and local authorities, as well as community-based organizations, have focused efforts to improve maternal, infant, and child health, the hospital will not directly address this need in the current Implementation Strategy.
- **Obesity, Physical Inactivity, and Associated Chronic Disease** - The hospital, together with AMG, provides education on various health topics related to obesity, physical inactivity, and associated chronic disease through health fairs and screenings, health education, wellness programs, lectures, school health education programs, and/or community support groups. Additionally, the hospital remains committed to partnering with community groups to address

these identified health needs and will continue to seek opportunities to do so. As federal, state, and local authorities, as well as community-based organizations, are working to reduce this need, the hospital will not directly address this need in their current Implementation Strategy.

- **Social Determinants of Health, including poverty, affordable housing, food insecurity, and transportation** - The hospital, together with AMG, screens patients for needs related to social determinants of health. Moreover, supporting services and referrals are provided by Community Health Workers in the Ascension St. Vincent Health Access Department, to meet needs, such as transportation and housing. Additionally, the hospital remains committed to partnering with community groups to address needs related social determinants of health and will continue to seek opportunities to do so. As federal, state, and local authorities, as well as community-based organizations, are working to reduce this need, the hospital will not directly address this need in the current Implementation Strategy.
- **Smoking and Tobacco Use** - The hospital, together with AMG, screens patients for tobacco use and promotes the use of the evidence-based state tobacco cessation quitline (1-800-Quit-Now). Additionally, the hospital remains committed to partnering with community groups to address this identified health issue and will continue to seek opportunities to do so. As federal, state, and local authorities, as well as community-based organizations, are working to reduce smoking and tobacco use, the hospital will not directly address this need in the current Implementation Strategy.
- **Substance Use Disorders and Overdoses** - The hospital, together with AMG, does provide diagnoses, treatment, and counseling for community members with substance use disorders and overdoses, most notably through emergency services. Additionally, the hospital remains committed to partnering with community groups to address this identified health need and will continue to seek opportunities to do so. As federal, state, and local authorities, as well as community-based organizations, have focused efforts to reduce substance use disorders and overdoses, the hospital will not directly address this need in the current Implementation Strategy.

While these needs are not the focus of this Implementation Strategy, Ascension St. Vincent Dunn may consider investing resources in these areas as appropriate, depending on opportunities to leverage organizational assets in partnership with local communities and organizations. Also, this report does not encompass a complete inventory of everything Ascension St. Vincent Dunn does to support health within the community.

To find a list of resources for each need not being addressed, please refer to the 2021 Ascension St. Vincent Dunn CHNA.

Acute Community Concern Acknowledgement

A CHNA and Implementation Strategies (IS) offer a construct for identifying and addressing needs within the community(s) it serves. However, unforeseen events or situations, which may be severe and

sudden, may affect a community. At Ascension, this is referred to as an acute community concern. This could describe anything from a health crisis (e.g., COVID-19), water poisoning, environmental events (e.g., hurricane, flood) or other event that suddenly impacts a community. In which case, if adjustments to an IS are necessary, the hospital will develop documentation, in the form of a SBAR (Situation-Background-Assessment-Response) evaluation summary, to notify key internal and external stakeholders of those possible adjustments.

Written Comments

This Implementation Strategy is available to the public and is open for public comment. Questions or comments about this Implementation Strategy can be submitted via the website: Community Health Needs Assessments | Ascension.

Approval and Adoption by Ascension St. Vincent Dunn Board of Directors

To ensure the Ascension St. Vincent Dunn's efforts meet the needs of the community and have a lasting and meaningful impact, the 2021 Implementation Strategy was presented and adopted by the Ascension St. Vincent Dunn Board of Directors on <date>. Although an authorized body of the hospital must adopt the IS to be compliant with the provisions in the Affordable Care Act, adoption of the IS also demonstrates that the board is aware of the IS, endorses the priorities identified, and supports the action plans that have been developed to address prioritized needs.

Action Plans

The IS below is based on prioritized needs from the hospital's most recent CHNA. These strategies and action plans represent where the hospital will focus its community efforts over the next three years. While these remain a priority, the hospital will continue to offer additional programs and services to meet the needs of the community, with special attention to those who are poor and vulnerable.

GOAL: **Increase access to comprehensive, high-quality health care services.**
Hospital Name Ascension St. Vincent Dunn
Prioritized Health Need #1 Access to Care
Strategy #1 Increase the proportion of people with a usual primary care provider. (AHS-07)
Strategy Source Healthy People 2030, Healthcare Access and Quality
Objective

By June 30, 2025, Ascension St. Vincent Dunn will increase the number of patients established with a medical home by 2.0% each year, amongst individuals who complete a Medical Home Pathway, from baseline established in FY2023.

Target Population

- People with lower incomes, older adults, people with undocumented status, people experiencing homelessness, people with disabilities, people at risk for chronic conditions or with pre-existing medical conditions, Black or African American persons, Hispanic or Latino persons or other racial and ethnic minority groups who experience discrimination, and the LBGTQ community.
- Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.

Collaborators

- Health Access Department

Resources

- Community Health Workers (CHW) from Health Access Department
- Existing community partners

ACTION STEPS	ROLE/OWNER
Community Health Workers assess and address barriers to establishing a medical home, refers patients to a medical home, educates, assists with scheduling, confirms attendance at appointment, and follows up for ongoing concerns to complete the medical home pathway.	Health Access Department
Complete all reporting requested by the Community Development and Health Improvement (CDHI) Department, such as quarterly progress reports.	Health Access Department
Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	CDHI Department

Output and/or Outcome Objective

- Baseline: The number of medical home pathways completed in FY2023.
- Target: The number of patients established with a medical home will increase by 2.0% each year, from baseline.
- Data Source; Data Owner: Optum Care Coordination Program, Medical Home Completed Templates Report; Health Access Department

ANTICIPATED IMPACT

The anticipated impact of these actions is an increase in the number of community members who receive comprehensive, high quality health care services by establishing a medical home and connection to a provider.

GOAL:
Increase access to comprehensive, high-quality health care services.

Hospital Name

Ascension St. Vincent Dunn

Prioritized Health Need #1

Access to Care

Strategy #2

Increase the proportion of people with health insurance. (AHS-01)

Strategy Source

Healthy People 2030, Healthcare Access and Quality

Objective

By June 30, 2025, Ascension St. Vincent Dunn will increase the number of people enrolled in a health insurance plan by 5.0% each year, amongst individuals who complete an Enrollment Pathway, from baseline established in FY2023.

Target Population

- People with lower incomes, older adults, people with undocumented status, people experiencing homelessness, people with disabilities, people at risk for chronic conditions or with pre-existing medical conditions, Black or African American persons, Hispanic or Latino persons or other racial and ethnic minority groups who experience discrimination, and the LBGTQ community.
- Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.

Collaborators

- Collaborators: Family and Social Services Agency (FSSA)
- Health Access Department

Resources

- Community Health Workers (CHW) from Health Access Department
- Existing community partners

ACTION STEPS	ROLE/OWNER
Community Health Worker verifies appropriate application is completed, reviews referrals for social determinants of health (SDOH), assesses and addresses barriers, monitors patient progress, and provides ongoing management to complete the Enrollment Pathway.	Health Access Department
Complete all reporting requested by the Community Development and Health Improvement (CDHI) Department, such as quarterly progress reports.	Health Access Department
Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	CDHI Department

Output and/or Outcome

- Baseline: The number of completed enrollments in FY2023.
- Target: The number of patients established with a health insurance plan will increase by 5.0% each year, from baseline.
- Data Source; Data Owner: Optum Care Coordination Program, Completed Enrollments Report; Health Access Department

ANTICIPATED IMPACT

The anticipated impact of these actions is an increase in the number of community members who receive comprehensive, high quality health care services by establishing enrollment in a health insurance plan.

GOAL: Increase access to comprehensive, high-quality health care services.	
Hospital Name Ascension St. Vincent Dunn	
Prioritized Health Need #1 Access to Care	
Strategy #3 Strengthen community engagement by supporting coalitions and implementing partners.	
Strategy Source Centers for Disease Control and Prevention, Principles of Community Engagement 2nd Edition	
Objective By June 30, 2025, Ascension St. Vincent Dunn will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.	
Target Population ● People with lower incomes, older adults, people with undocumented status, people experiencing homelessness, people with disabilities, people at risk for chronic conditions or with pre-existing medical conditions, Black or African American persons, Hispanic or Latino persons or other racial and ethnic minority groups who experience discrimination, and the LBGTQ community. ● Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.	
Collaborators ● Local community coalitions ● Non-profit organizations ● Governmental agencies	
Resources ● ASVI Foundation ● ASVI staff for board and coalition support ● Community benefit funding	
ACTION STEPS	**ROLE/OWNER**
FY23: Identify a lead, assemble a workstream and identify or develop an assessment tool.	Regional President and Community Development and Health Improvement (CDHI) Department
FY24: Assess, identify opportunities, and make recommendations for strengthening community engagement.	Workstream group and CDHI Department
FY24: Develop strategy for community engagement.	Workstream group
FY25: Execute strategic plan for community engagement and investment at system and regional level.	Workstream Lead and CDHI Department
Ongoing: Complete all reporting requested by CDHI.	Workstream Lead
Ongoing: Track and enter all community benefit hours and dollars into CBISA per fiscal year.	Workstream Lead and CDHI Department

Output and/or Outcome ● Baseline: Current level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity. ● Target: Maintained or improved level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity. ● Data Source; Data Owner: Community Engagement Summary Report, Workstream Lead
ANTICIPATED IMPACT
The anticipated impact of these actions is an increase in the number of community members who receive comprehensive, high quality health care services by supporting and engaging with coalitions and implementing partners addressing access to health care services.

GOAL: **Improve mental health.**	
Hospital Name Ascension St. Vincent Dunn	
Prioritized Health Need #2 Mental Health	
Strategy #1 Reduce the suicide rate. MHMD-01	
Strategy Source Healthy People 2030, Mental Health and Mental Disorders	
Objective By June 30, 2025, Ascension St. Vincent Dunn, in collaboration with the Stress Center, will provide at least one session of QPR (Question, Persuade, Refer) Training for community members.	
Target Population ● Community members, first responders, educators, students, faith-based organizations ● Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.	
Collaborators ● ASVI Stress Center	
Resources ● ASVI Stress Center staff and QPR Trainers ● Substance Abuse and Mental Health Services Administration (SAMHSA) Grant	
ACTION STEPS	**ROLE/OWNER**
FY23: Identify a hospital lead, identify partners, and develop a resource list. Plan promotion activities.	Community Development and Health Improvement (CDHI) Department and President/Administrator
FY24 & FY25: Promote and offer the event.	CDHI Department and Hospital Lead
FY24 & FY25: Obtain applicable outputs and/or outcomes.	CDHI Department and Hospital Lead
Ongoing: Complete all reporting requested by CDHI.	Hospital Lead

Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	Hospital Lead

Output and/or Outcome

- Baseline: QPR Training currently not offered by the hospital.
- Target: Deliver at least one session of QPR Training by the hospital.
- Data Source; Data Owner: QPR Summary Report, Hospital Lead

ANTICIPATED IMPACT

The anticipated impact of these actions is an increase in the number of community members who can identify the warning signs of suicide crisis and respond appropriately to prevent suicide.

GOAL:
Improve mental health.

Hospital Name

Ascension St. Vincent Dunn

Prioritized Health Need #2

Mental Health

Strategy #2

Strengthen community engagement by supporting coalitions and implementing partners.

Strategy Source

Centers for Disease Control and Prevention, Principles of Community Engagement 2nd Edition

Objective

By June 30, 2025, Ascension St. Vincent Dunn will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.

Target Population

- Community members
- Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.

Collaborators

- Local community coalitions
- Non-profit organizations
- Governmental agencies

Resources

- ASVI Foundation
- ASVI staff for board and coalition support
- Community benefit funding

ACTION STEPS	ROLE/OWNER
FY23: Identify a lead, assemble a workstream and identify or develop an assessment tool.	Regional President and Community Development and Health Improvement (CDHI) Department
FY24: Assess, identify opportunities, and make recommendations for strengthening community engagement.	Workstream group and CDHI Department

FY24: Develop strategy for community engagement.	Workstream group
FY25: Execute strategic plan for community engagement and investment at system and regional level.	Workstream Lead and CDHI Department
Ongoing: Complete all reporting requested by CDHI.	Workstream Lead
Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	Workstream Lead and CDHI Department

Output and/or Outcome

- Baseline: Current level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Target: Maintained or improved level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Data Source; Data Owner: Community Engagement Summary Report, Workstream Lead

ANTICIPATED IMPACT

The anticipated impact of these actions is to improve mental health by supporting and engaging with coalitions and implementing partners addressing mental health concerns.

GOAL:
Improve health and well-being for older adults.

Hospital(s) Name(s)

Ascension St. Vincent Dunn

Prioritized Health Need #3

Senior Services

Strategy #1

Increase the proportion of adults who get recommended evidence-based preventive health care. AHS-08

Strategy Source

Healthy People 2030, Populations, Older Adults

Objective

By June 30, 2025, Ascension St. Vincent Dunn will collaborate with community partners to offer at least one community outreach event focused on education and promotion of recommended, evidence-based preventive health care for older adults.

Target Population

- Adults aged 50 and older, caregivers
- Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.

Collaborators

- Community partners focused on serving older adults
- Ascension Medical Group

Resources

- ASVI Staff

• Collaborators: Existing community partners	
ACTION STEPS	**ROLE/OWNER**
FY23 - Assemble a rural healthcare planning committee with applicable leaders and community collaborators.	Vice President of Rural Healthcare
FY24 and/or FY25 - Plan, promote, and offer the event.	Vice President of Rural Healthcare
FY24 and/or FY25 - Obtain applicable outputs and/or outcomes.	Vice President of Rural Healthcare
Ongoing: Complete all reporting requested by CDHI.	Vice President of Rural Healthcare
Ongoing: Track and enter all community benefit hours and dollars into CBISA per fiscal year.	Vice President of Rural Healthcare
Output(s) and/or Outcome(s) • Baseline: Community outreach event focused on education and promotion of recommended, evidence-based preventive health care for older adults (persons aged 50 and over) currently not offered. • Target: Deliver at least one community outreach event focused on education and promotion of recommended, evidence-based preventive health care for older adults (persons aged 50 and over). • Data Source; Data Owner: Community event summary report, Vice President of Rural Healthcare	
ANTICIPATED IMPACT	
The anticipated impact of these actions is an increase in the number of community members, aged 50 and older, who receive evidence-based preventive health care.	

GOAL: **Improve health and well-being for older adults.**
Hospital Name Ascension St. Vincent Dunn
Prioritized Health Need #3 Senior Services
Strategy #2 Strengthen community engagement by supporting coalitions and implementing partners.
Strategy Source Centers for Disease Control and Prevention, Principles of Community Engagement 2nd Edition
Objective By June 30, 2025, Ascension St. Vincent Dunn will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.
Target Population • Adults aged 50 and older, caregivers • Medically Underserved Population: People who are uninsured or underinsured, people who are underserved by mental and medical health resources, and Black women.
Collaborators • Local community coalitions

<table>
<tr><td colspan="2">

- Non-profit organizations
- Governmental agencies

</td></tr>
<tr><td colspan="2">

Resources

- ASVI Foundation
- ASVI staff for board and coalition support
- Community benefit funding

</td></tr>
<tr><th>ACTION STEPS</th><th>ROLE/OWNER</th></tr>
<tr><td>FY23: Identify a lead, assemble a workstream and identify or develop an assessment tool.</td><td>Regional President and Community Development and Health Improvement (CDHI) Department</td></tr>
<tr><td>FY24: Assess, identify opportunities, and make recommendations for strengthening community engagement.</td><td>Workstream group and CDHI Department</td></tr>
<tr><td>FY24: Develop strategy for community engagement.</td><td>Workstream group</td></tr>
<tr><td>FY25: Execute strategic plan for community engagement and investment at system and regional level.</td><td>Workstream Lead and CDHI Department</td></tr>
<tr><td>Ongoing: Complete all reporting requested by CDHI.</td><td>Workstream Lead</td></tr>
<tr><td>Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.</td><td>Workstream Lead and CDHI Department</td></tr>
<tr><td colspan="2">

Output and/or Outcome

- Baseline: Current level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Target: Maintained or improved level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Data Source; Data Owner: Community Engagement Summary Report, Workstream Lead

</td></tr>
<tr><th colspan="2">ANTICIPATED IMPACT</th></tr>
<tr><td colspan="2">The anticipated impact of these actions is to improve the health and well-being of older adults by supporting and engaging with coalitions and implementing partners addressing senior services.</td></tr>
</table>

Evaluation

Ascension St. Vincent Dunn will develop a comprehensive measurement and evaluation process for the Implementation Strategy. The Ministry will monitor and evaluate the action plans outlined in this plan for the purpose of reporting and documenting the impact these action plans have on the community. Ascension St. Vincent Dunn uses a tracking system to capture community benefit activities and implementation. To ensure accountability, data will be aggregated into an annual Community Benefit report that will be made available to the community.