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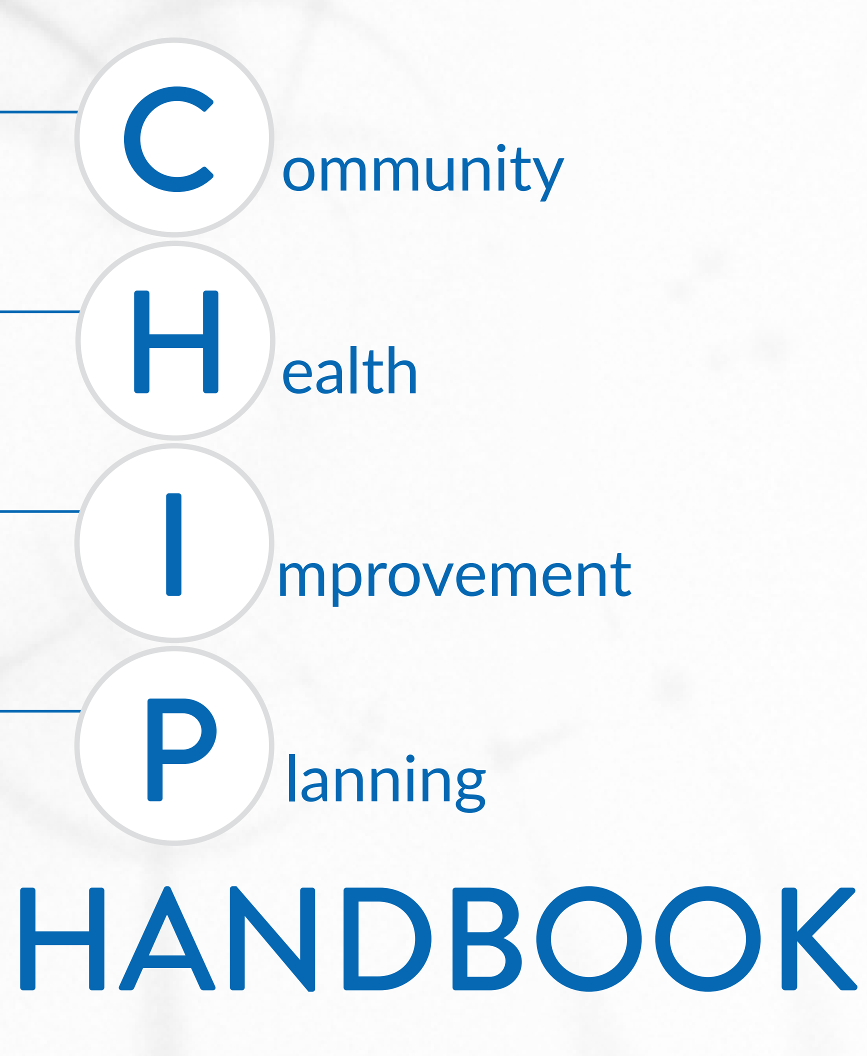

Community Health Improvement Planning HANDBOOK

KHI/15-05

APRIL 2015

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COMMUNITY HEALTH IMPROVEMENT PLANNING (CHIP) HANDBOOK

APRIL 2015

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Table of Contents

1 BACKGROUND

5 STEP 1: SET PRIORITIES

7 STEP 2: SET GOALS

9 STEP 3: SET OBJECTIVES AND OUTCOME MEASURES

13 STEP 4: IDENTIFY ASSETS, STRENGTHS, CURRENT EFFORTS AND RESOURCES

14 STEP 4.1: RE-ENGAGE EXISTING AND NEW PARTNERS

15 STEP 5: IDENTIFY EVIDENCE-BASED INTERVENTION STRATEGIES

17 STEP 5.1: IDENTIFY BARRIERS AND ADAPT INTERVENTION STRATEGIES

18 STEP 6: COMPOSE AN ACTION PLAN

19 STEP 7: PRODUCE THE CHIP DOCUMENT

21 STEP 8: RELEASE AND DISSEMINATE THE CHIP

22 STEP 9: IMPLEMENTATION AND MONITORING

24 CHIP DEVELOPMENT WORKSHEETS

Attachments

1 CHIP TEMPLATE FOR FINAL DOCUMENT

2 CHIP LOGIC MODELS

What is a Community Health Improvement Plan (CHIP[I])?

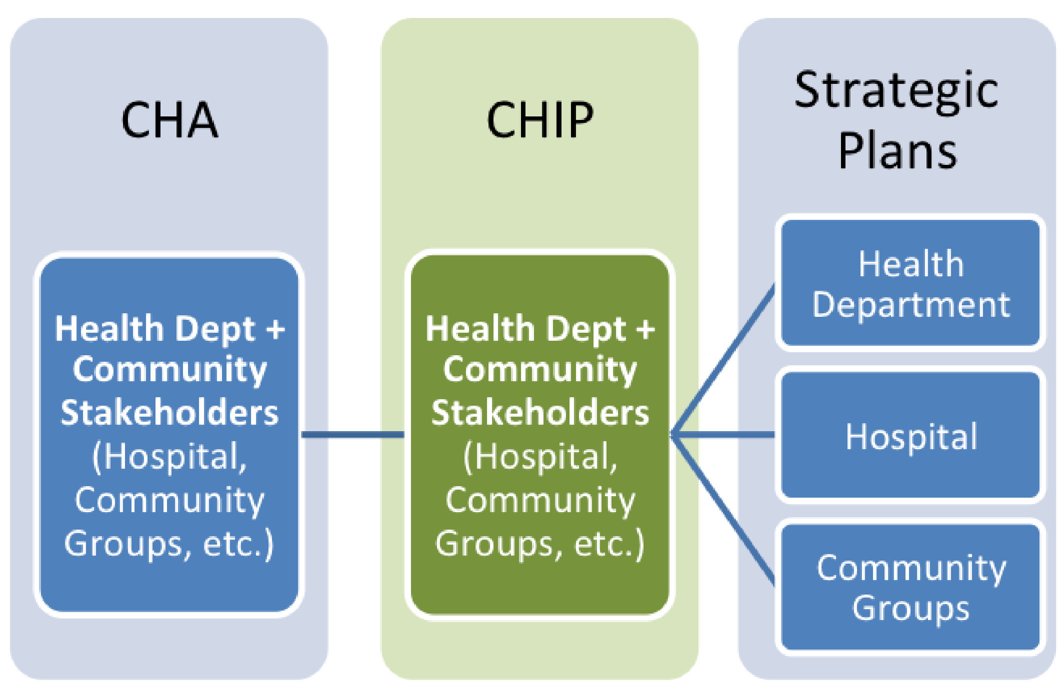
The *Community Health Improvement Plan* (CHIP) is the "roadmap" for improving public health system performance, improving population health and keeping community health planning visible to local decision-makers and communities. It lays out a long-term, strategic effort to address public health issues based on the *Community Health Assessment* (CHA) results.

The CHIP is developed after the CHA and priority setting process through a consensus process involving members of the community, partner organizations and the health department.

The Public Health Accreditation Board (PHAB) recommends the CHA and CHIP be developed as community-based documents to be used by all the stakeholders involved in the process. Each organization involved in the CHIP should then develop a Strategic Plan including the actions for which the organization is responsible, as well as other strategies specific to that organization. The CHA, CHIP and agency Strategic Plan make up the three pre-requisites for PHAB accreditation.

Developing a CHIP represents a natural output of the CHA process. An assessment with an accompanying plan maximizes its usefulness; therefore a CHIP is used to describe *how* community stakeholders will address the health priorities identified through the CHA.

The CHIP should address the full range of strengths, weaknesses, challenges and opportunities existing in the community. It should look beyond *individual* health departments' actions, responsibilities and performance and instead look for ways *many* organizations will contribute to the community's overall health and well-being.



What are the main components of the CHIP?

The CHIP should be detailed and is often combined with the CHA into one document.

Generally, the CHIP should include:

- A vision for the community's health
- Description of the CHIP process
  - Participants
  - Community engagement
- Community health priority areas (results from CHA data)
- Goals
- Objectives
  - Outcome measures: How change in behavior, environment and/or policy will be measured
- Evidence-based intervention strategies
  - Specific populations to be reached
- Action steps (timeline, responsible parties)
  - What participating agencies plan to invest (time, money, equipment, etc.)
  - Process measures (how progress in implementation will be measured)
- Description for planned follow-up and implementation monitoring and evaluation activities

Definitions

Sometimes terms are defined differently depending upon their use.

Below are the definitions for these terms (as we are using them) along with examples of each.

Priority Areas are broad, health-related areas identified through the prioritization process, which was informed by CHA data. These areas could significantly improve community health and well-being when addressed. A CHIP should include between two or six priority areas.

Example Priority Area: "High rates of obesity."

Goals are broad targets addressing each priority. There may be several goals for each priority in the CHIP.

Example Goal: "Decrease obesity in the county through promoting healthy lifestyles."

Objectives are statements specifying what the efforts or actions are intended to attain or accomplish in the community. The objective statement is about the measure of change. It is written in terms of 'what,' 'by whom,' and 'by when.'

Example Objective: "By 2016, 35 percent of our county's adults are consuming the recommended amount of fruits and vegetables."

Outcome Measures answer the question, "Is the community changing in the way we said we were going to change it?" These measures will be tracked over time to see if goals are being met.

Example Outcome Measure: "100 percent of schools have a healthy vending policy by 2016."

Intervention Strategies These are evidence-based actions or decisions to carry out and meet the objectives (these are tangible things to change—such as rules, policies, procedures, mandates, services, requirements, resources or operations).

Example Intervention Strategy: "Work with school board to create and implement healthy vending policy."

Action Steps are the individual responsibilities assigned to each organization participating in the CHIP process. These action steps have specific timelines and—as part of the intervention strategies—help the group to achieve the objectives.

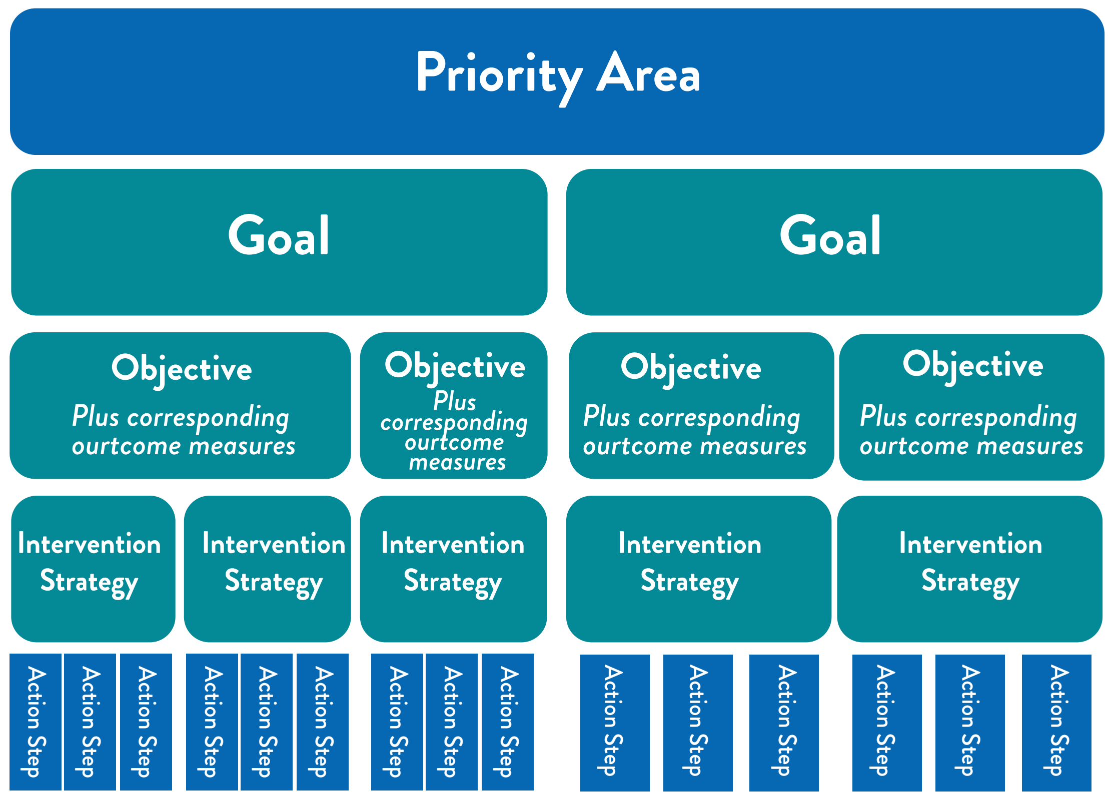
Example Action Step: "Research model policies and prepare written summary by August 2014."

Process Measures are a representation of whether or not the activities in the action plan were carried out and if they met their deadline. The process measure answers the question, "Are we doing what we said we were going to do?"

Example Process Measure: "Written summary of model policies completed."

CHIP Organizational Structure

This table illustrates how the parts of the CHIP fit together.



Developing a CHIP

This workbook walks through the steps of developing a CHIP.

STEP 1: SET PRIORITIES

Priority Areas

Priority areas are broad, health-related areas identified through CHA data and are the focus of the CHIP. If addressed, these areas could significantly improve community health and well-being.

After reviewing the health assessment results, the steering committee/advisory group uses a prioritization process to select and name the specific priorities to be included in the CHIP. These priorities create the foundation for building a set of action plans to improve community health over the next three to five years.

The draft document of PHAB Standards and Measures, Version 1.5, requires that a CHIP's priority areas include addressing the social determinants of health and health inequities. It is considered best practice to include these in at least one of the priority areas.

How to Set Priorities for Health Improvement

Most communities will not have sufficient resources to address all the identified health issues. A priority setting process needs to be implemented to ensure interventions are selected which meet the community's needs and wishes and to ensure resources are concentrated appropriately on those interventions. The results of this process will be reflected in the CHIP.

"The Community Health Assessment Guide Book," [2] published by the North Carolina Division of Public Health, contains an excellent chapter on priority setting, including practical tools to be used and adapted in a variety of situations. A quick overview of some important aspects for setting priorities is provided in this section.

Community Involvement

A steering committee/advisory group should not set priorities alone; priorities should be defined with the full participation of stakeholders and community members. It is important broad community involvement occurs when reviewing the data collection and analysis results as well as when deciding what priorities should be pursued.

Varying methods can be used to report assessment findings to the community. Written reports, oral presentations and public meetings are a few examples. Using multiple methods is recommended. Whatever methods are adopted, it is important to allow feedback and input from stakeholders and community members. Sometimes it is helpful to use a set of pre-defined questions and ask people to react to them (rather than having a free-flowing, unstructured discussion).

Criteria to Select Priorities

Prioritizing and selecting community health issues requires careful consideration of each issue and how the community views the issue.

The combination of factors, rather than any single factor, is important in determining whether or not an issue will become a priority.

Factors usually considered in the ranking process are:

- *Magnitude*: How many people are affected by the issue are being considered.
- *Seriousness*: How the issue affects quality of life, the economic burden on the community, and other criteria as appropriate.
- *Strategies*: This question examines whether public health strategies are available to successfully address the issues. Is the problem responsive to interventions?
- *Level of concern*: Issues the community perceives as most severely affecting its health should be considered. A high level of concern in the community is also likely to produce more community engagement to resolve the issue.
- *Feasibility/Do-ability*: Places all the community health issues into a broader context including political will, community concern or readiness, the availability of resources or designated funding, and legal concerns.

Quality improvement tools can be used during this process. These tools often help build consensus and move from a long list of health issues to a shorter list of priorities. Other tools include: brainstorming, affinity diagram, Pareto charts, nominal group and prioritization matrices. Details about these tools can be found in various forms online.

One good resource for priority-setting tools can be found at: http://bit.ly/toolboxprioritizationmatrix.

If interested, communities may request additional information from the Kansas Health Institute.

Using a scoring system is often helpful in producing a ranking list from which priorities can be selected. The number of priorities to be included in the CHIP will vary among communities depending upon available resources and the scope of the problems being addressed. Some CHIPs may include two or three priorities, while others may have six or more.

There are many methods for priority setting. Complete Worksheet 1 (page 26) as a priority setting exercise.

STEP 2: SET GOALS

Setting one or more goals for each priority area is the next step in developing a CHIP. A goal statement is used to communicate the intended achievement to stakeholders and the community by describing the desired change and identifying (in broad terms) how the initiative is going to address the identified health priority.

Conduct a Root Cause Analysis or Other QI Process

One way to begin setting goals and objectives is to use a Quality Improvement (QI) tool such as root cause analysis, which is used to dig deeper into problems and see what underlies the issue. This will help strategic thinking concerning the best ways to address the priority in the community and ensure the 'root' of the problem is addressed, rather than the symptoms. Conduct a root cause analysis for one or all of the set priorities.

Review the CHA report and other community data available to describe the priority. What contributes to the community's issue? What contributes to the community and residents being "high-risk" related to this issue? What is causing this problem or making it a bigger issue? The answers to these questions will help in understanding what is causing the issue and help plan specific actions for improvement.

Complete Worksheet 2 (page 27).

Goals

Next, you will write one or more goals for each priority area. Look at the questions in Worksheet 3 (page 28) and use them to write goals into the CHIP Framework on Worksheet 4 (pages 29-30).

Questions to Ask:

- What is the desired state or outcome for this priority area?
- What is trying to be achieved for the county/region/team?
- What needs to be done in this priority area to significantly change the way things are now and move toward a vision of how things should be?

Example Goals:

- Reduce new diabetes cases among community members through nutrition education.
- Promote emotional well-being among families in the community.
- Decrease obesity by promoting healthy lifestyles.

STEP 3: SET OBJECTIVES AND OUTCOME MEASURES

An objective is a statement about what specific efforts or actions are intended to be attained or accomplished in the community. The objective statement is about the measure of change. It is written in terms of 'what,' 'for whom (target population),' and 'by when.' When writing objectives, focus on the desired outcomes being sought in the community. These objectives are the intermediate steps between goals and intervention strategies. Objectives should specifically describe what change in health status or change in a system to be accomplished and how it will be measured. Also, consider aligning objectives with similar efforts happening in the county, state or at the federal level (e.g. Healthy Kansans 2020).

SMART Objectives:

SPECIFIC	*Specify what is to be achieved, by how much and by when.*
MEASURABLE	*Make sure the objective can be measured (i.e., data is or will be available to measure progress).*
ACHIEVABLE	*Set feasible objectives.*
RELEVANT	*Align objectives with the goal to be reached.*
TIME-ORIENTED	*Establish a timeframe for achieving the objective.*

Reference Worksheet 3 (page 28) and write your brainstormed objectives in Worksheet 5 (page 31). To meet PHAB standards, plan to have a mix of long-term and short-term objectives and outcome measures.

Questions to Ask

- What awareness must be increased or created and with whom?
- What knowledge or skill must be improved and by whom?
- What behaviors must change? How and by whom?
- What policies must be changed?
- What types of system changes are needed (think big systems, such as social system, health care system, employment system, government system, etc.)?

Example SMART Objectives:

- By August 2014, increase the use of the farmers' market among Hispanic/Latinos in [community] from 20 to 60 percent.
- By August 2016, increase the number of elementary school students in [community] who eat at least five servings of fruits and vegetables per day from 30 to 60 percent.

After brainstorming, finalize one or two SMART objectives for each goal. Write the finalized objectives into the CHIP Framework Grid in Worksheet 4 (pages 29-30).

Outcome Measures

When writing a SMART objective, the highest measure for the desired outcome is typically stated within the content of the objective. Accomplishing goals and objectives hinges on the evidence/metrics of progress and ultimately outcome or impact. "Without those metrics, the plan is a group of intentions always on the verge of greatness…" [3], therefore, one cannot know or measure what has been achieved.

The "outcome measures" section is among of the most important areas for reporting progress and success; therefore it is important to ensure the specific measure(s) are articulated here to evidence achieved successes.

Consider the following questions to develop solid outcome measures:

- At the highest level ask:
  - – How will we know we are making a difference in this priority?
  - – What can be tracked over time to demonstrate progress?

Then, also consider:

- Is there a commonly used national/regional standard measure which reflects the desired change?
- Does the outcome measure specify a baseline value and a target value?
- Can progress toward achieving the outcome measure be measured in a reasonable and feasible way?
- Is a timeframe for attainment specified (or implied)?
- Are there reasonable outcome measures reflecting short, intermediate, long-term success?

** If an objective aligns with an effort at the regional, state or national level, reference some of their outcome measures. Sources for reference include Healthy Kansans 2020 (www.healthykansans2020.org) and at the national level, Healthy People 2020 (www.healthypeople.gov).*

Write one or more outcome measures for each objective using Worksheet 5 (page 31). Then, write your finalized outcome measures into the CHIP Framework Grid in Worksheet 4 (pages 29-30).

Note: Make sure an outcome measure is a measure of meaningful change in the community, not the result of an action step. Action steps and their measures of accomplishment (called process measures) belong in the plan's "action steps" section.

STEP 4: IDENTIFY ASSETS, STRENGTHS, CURRENT EFFORTS AND RESOURCES

A CHIP should build upon what already exists in the community to support the work. Through this process, identify additional people who need or want to participate in the action planning team.

The goal is to accomplish the following:

- Identify current efforts in the community to address the priority issues.
- Define existing strengths and community readiness to address the issues which can be built upon.
- Identify any existing (concrete and tangible) assets or resources to help support the work.

As a team, complete Worksheet 6 (page 32).

STEP 4.1: RE-ENGAGE EXISTING AND NEW PARTNERS

After evaluating the community's assets and resources, there may be additional people or organizations to engage in the CHIP. Consider the people/organizations involved in the CHA process and identify any additional individuals who need to be engaged to address the priority areas.

Engage community members who are passionate about the issue or who are well-connected in the community to help recruit people for the team.

Some members of the community to consider asking to join the action-planning group include:

- Influential people from all parts of the community affected by the issue (e.g. from churches, the school system, law enforcement, etc.).
- People who are directly involved in the problem (e.g. local high school students and their parents might be involved in planning a coalition trying to reduce teen substance abuse).
- Members of grassroots, community-based or voluntary organizations.
- Members of the various cultural groups in the community.
- People who are known to be interested in the problem or issue.

For practical ideas and tools for working together with community partners, visit the County Health Rankings website: http://www.countyhealthrankings.org/roadmaps/action-center/work-together#activity-1861.

STEP 5: IDENTIFY EVIDENCE-BASED INTERVENTION STRATEGIES

What are Intervention Strategies?

Intervention strategies outline the types of tactics to be utilized in achieving each objective. Intervention strategies are action-oriented programs or areas of policy change, which will be implemented to improve health. An objective is WHAT is going to be done; the intervention strategy is HOW it will be done.

In order to make sure effective intervention strategies are chosen, consider:

- Reviewing existing resources and the literature for evidence-based and best-practice interventions to achieve the desired level of change in accomplishing the objectives.
- Identifying intervention strategies at all levels of change (individual, workplace, school, community/environmental, etc.).

Example Intervention Strategies:

- Implement a policy requiring all school districts serve at least one serving of fresh fruits and vegetables at every meal in the school cafeteria.
- Increase the number of farmers' markets in the community.
- Work with schools and local city and county partners to implement joint-use agreements allowing the public to use athletic facilities and outdoor recreational facilities on a regular basis (school gyms, parks, outdoor sports fields, public pools and playgrounds).

Resources for Evidence-Based and Best Practices:

- Kansas Health Matters Promising Practices: *http://www.kansashealthmatters.org/index.php?module=PromisePractice&controller=index&action=index.*
- County Health Rankings Roadmaps to Health/Effective Policies and Programs: *http://www.countyhealthrankings.org/roadmaps/action-center/choose-effective-policies-programs.*
- The CDC Guide to Community Preventive Services: *http://www.thecommunityguide.org/index.html.*
- NACCHO Model Practices Database: *http://www.naccho.org/topics/modelpractices/.*
- KU Community Toolbox: *http://ctb.dept.ku.edu/en/databases-best-practices*.
- National Association of Counties Healthy Counties Initiative: *http://www.naco.org/programs/csd/Pages/HealthyCountiesInitiative.aspx*.
- Healthy Kansans 2020: *http://healthykansans2020.org/#&panel1-1*.
- HP 2020 Interventions and Resources: *http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx.*

Note: PHAB encourages—and sometimes requires—evidence-based intervention strategies in the standards and measures. A document is available from the Community Guide which outlines PHAB standards, and provides links to interventions existing in the Community Guide repository. Reference the document at: *http://www.thecommunityguide.org/uses/Table%202%20Community%20Guide-PHAB%20Crosswalk%20Version%201.pdf.*

Using Worksheet 4 (pages 29-30), choose one or more intervention strategies that will help accomplish each objective. If needed, reference the questions in Worksheet 3 (page 28).

Note: If possible, try to select intervention strategies with evidence (research and data proving this strategy really works), which will create the targeted change (outcome) in the goals and objectives.

STEP 5.1: IDENTIFY BARRIERS AND ADAPT INTERVENTION STRATEGIES

Change is hard and it is not uncommon for people to resist it. While trying to implement intervention strategies, resistance and barriers are likely to emerge.

Identifying barriers is necessary to help acknowledge which changes may be more realistic and feasible, to plan for necessary resources and think of strategic ways to implement the plan.

Use Worksheet 7 (page 33) to identify potential barriers for each of the changes previously brainstormed.

To ensure success, use the identified barriers and solutions to adapt intervention strategies to the community.

Interventions, strategies, methods, messages and materials will need to be adapted to the community's specific characteristics. The process of "cultural tailoring" considers the beliefs, values, languages and circumstances of the specific people in the community.

This process helps develop programs in a culturally relevant context.

Consider if the proposed strategy fits with the community's characteristics, size and culture. If not, develop a list of needed changes or modifications to the strategy in order to overcome any barriers for it to be a good fit.

For each strategy included in the action plan, ask if there are ways to ensure that:

- Cultural values are reflected in goals, objectives and intervention strategies.
- Modes and style of communication fit cultural norms.
- Visual representations, colors, symbols are consistent with cultural beliefs.
- Language is integrated throughout the activities.
- Location of meetings and activities are appropriate for the target audience.

STEP 6: COMPOSE AN ACTION PLAN

Action Steps

Action steps help turn a vision into a reality. They ensure the work completed so far is made concrete and feasible, and detail how the group will implement intervention strategies to meet the objectives by describing who is going to do what and by when.

Outline the details of the work in the "action steps" section to:

- Ensure details are not overlooked.
- Understand what *is* and *is not* possible to accomplish.
- Be efficient (save time, energy and resources in the long-run).
- Establish accountability (increase the chances people will do what needs to be done).
- Lend credibility to the organization. An action plan shows community members (including grant-makers) that the group is well-organized and dedicated to getting things done.
- Explicitly clarify specific milestone activities or "process measures" reflecting specific accomplished actions to achieve intervention strategies, objectives and outcomes measures.

What are the Criteria for Good Action Steps?

The action steps for the CHIP should meet several criteria. To judge the quality of the action steps, ask:

Are these steps…

Complete? *Do the steps represent changes for all relevant parts of the community, relative to accomplishing the intervention strategy (e.g., schools, business, government, faith community)?*

Clear? *Is it apparent who will do what by when?*

Current? *Do the action steps reflect the current work? Do they anticipate newly emerging opportunities and barriers?*

Process Measures

Be sure the action steps are being completed according to plan. In order to measure this, monitor the process measures for the action steps and determine whether or not the team is on track. The process measures answer the question, "Are we doing what we said we were going to do?" The process measures will likely be a representation of whether or not the activities in the action plan were carried out and if they were carried out by the established deadline.

Complete the CHIP Framework: Action Steps Detail Template Worksheet 8 (pages 34-35) with the information gathered thus far. This template will show ideas in a systematic manner and prepare the group for the future.

STEP 7: PRODUCE THE CHIP DOCUMENT

The CHIP document compiles the plan for both the team and the public. This document should be clear, concise and understandable for those who read it.

The CHA and CHIP can be presented either together or as separate documents, depending upon the community's need and preference. In some cases, the decision is made based on timing (when the two processes are completed).

Regardless, the following outline is suggested:

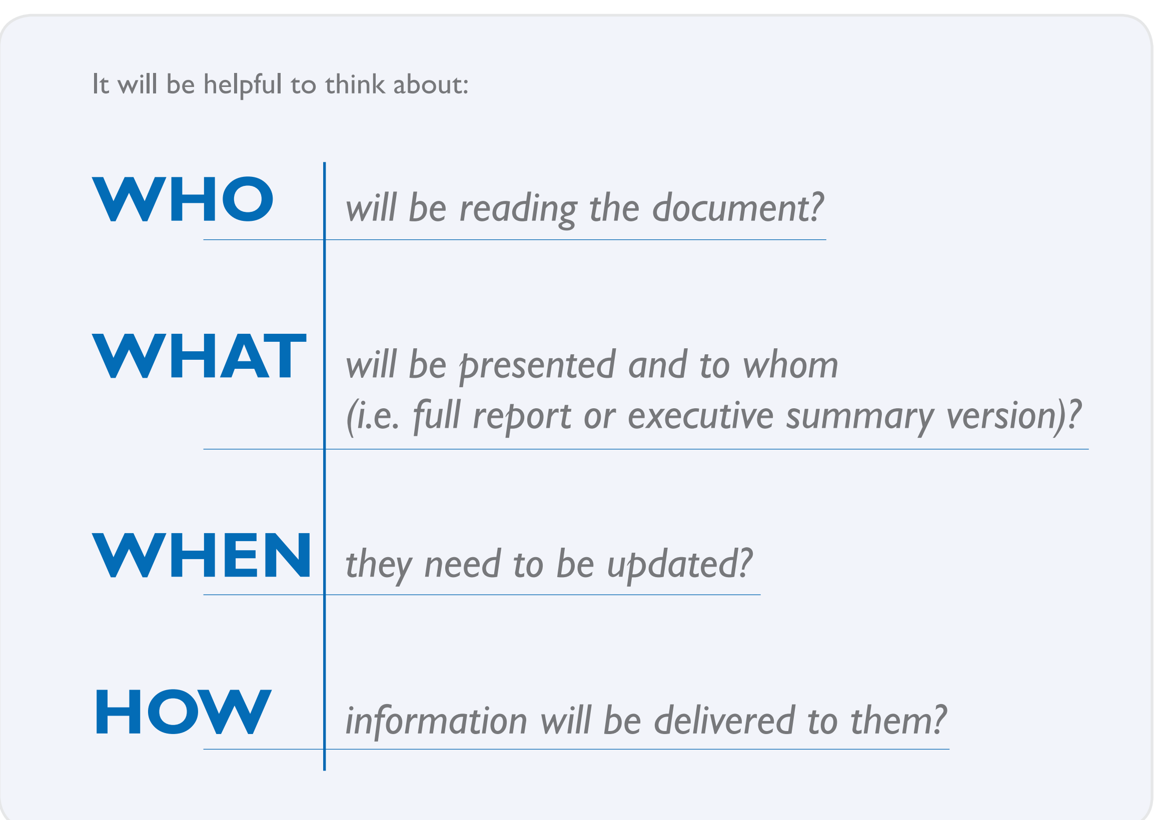
- **Background**
- **Describe the Community**
- **CHA**
  - – Data collection and analysis methods
  - – Results (Community Health Profile)
  - – Community strengths and challenges: public health issue statements
- **Community Health Priorities**
- **CHIP**
  - – Goals
  - – Objectives
    - - Outcome Measures: How change in behavior, environment, and/or policy will be measured
  - – Evidence-based Intervention Strategies
  - – Action Steps (timeline, responsible parties)
    - - What participating agencies plan to invest (time, money, equipment, etc.)
    - - Process Measures: How progress in implementation will be measured
  - – Description of planned follow-up and implementation monitoring and evaluation activities

A template CHIP document (attachment #1) can be used and/or modified when putting together the CHIP report. There are also several examples of quality CHIP documents from accredited health departments that may provide additional ideas and examples.

STEP 8: RELEASE AND DISSEMINATE THE CHIP

It is important to think about how the CHIP will be communicated to stakeholders and community members. The CHIP is the planned action that has resulted from a CHA process. The community stakeholders likely participated in or heard about the CHA.

It is important the community knows action on their recommendations is taking place. A communications plan is not a requirement for PHAB, but it is required that the document is made widely available to the public. To accomplish this, it is a good idea to have a coordinated plan woven into the entire process.



Incorporate a mix of communication methods (paper and electronic versions of the report and communication via social media website and/or other media).

It is considered best practice to assign a lead individual to think about these things when moving through the CHIP process, disseminating the final report and during the implementation phase.

STEP 9: IMPLEMENTATION, MONITORING AND EVALUATION

Until work begins on the CHIP, it is simply a *plan*. The CHIP's implementation is perhaps the most important and most challenging part of the process. Having the plan (as developed in previous steps) reinforces preparedness in implementing the proposed activities.

However, many factors can affect the success of planned activities, regardless of how well-thought-out they are. It is important to know whether the intervention strategies are effective in the community (if they produce the desired results). For this reason, the monitoring and evaluation plan is essential to understanding the success of a plan.

Monitoring and Evaluation Plan

In order to track results throughout the implementation of the CHIP, determine a central place to evaluate the results of the indicators being monitored. *Worksheet 9* provides a single location to record outcome measures and will help determine where data will come from, who will collect it and at what frequency it will be gathered. The worksheet also has a place to record the baseline, target, results and adjustment methods if the results do not align with goals. Finally, summarize any unanticipated outcomes, lessons learned and success stories that may influence future actions on the current CHIP and inform upcoming cycles of the CHA, CHIP and Strategic Plan.

Worksheet 9 (pages 36-37) provides a single location to record outcome measures.

Endnotes

1. Public Health Accreditation Board (2013). Acronyms and Glossary of Terms. Version 1.5. Available online: http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf.

2. http://publichealth.nc.gov/lhd/cha/docs/guidebook/CHA-GuideBook-June2014.pdf

3. Talley & Fram, Using Imperfect Metrics Well: Tracking Progress and Driving Change. Winter 2010 edition - Leader to Leader.

CHIP DEVELOPMENT WORKSHEETS

These worksheets are meant to accompany the CHIP session handbook and guide the CHIP process with relevant exercises. Please note these are only a sampling of many online resources to assist with each of these steps. The handbook and accompanying exercises are meant as a guide and can be modified, substituted or skipped to fit individual processes.

The worksheets in this packet include:

1. *Priority Setting*
2. *Root Cause Analysis: Fish Bone Diagram*
3. *Goals, Objectives, and Intervention Strategies: Questions and Definitions*
4. *CHIP Framework*
5. *Objectives and Outcome Measures*
6. *Addressing Community Assets and Resources*
7. *Identifying Barriers and Solutions*
8. *CHIP Framework: Action Steps Detail*
9. *Monitoring and Evaluation Table*

Worksheet 1. Priority Setting

Step 1: Rate Key Health Issues using Criteria

Instructions: Rate each health issue based on how well it meets each of the criteria provided
1=very low, **2**=low, **3**=medium, **4**= high, **5**=very high
Add your five ratings for each health issue and enter the total in the Total Column.

Step 2: Rank Health Issues

Referring to your Total Rating numbers, rank order each of the Heath Issues with "1" being the Health Issue with the highest total score, "2" being the Health Issue with the second highest total score, etc.

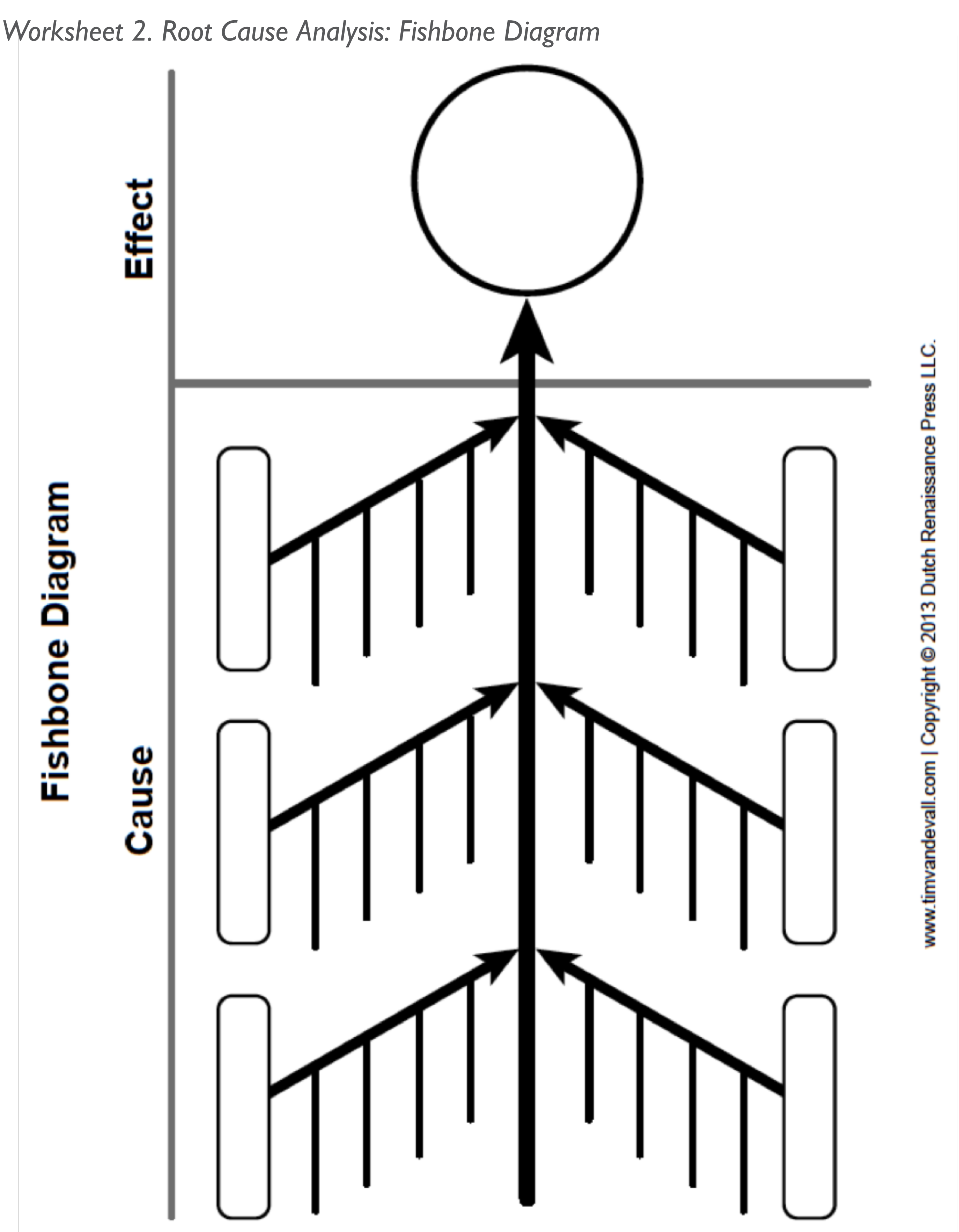
In the case of identical totals, use your best judgment to assign a unique rank number to each health issue to break the tie.

Key Health Issues (list below):	**Selection Criteria**					**Total Rating**	**Rank Order** of **Health Issues** (use each number only once):
	MAGNITUDE *How many people are affected?*	**SERIOUSNESS** *To what extent does this issue affect quality of life or economic burden?*	**CONCERN** *What do the community and stakeholders think about this issue?*	**FEASIBILITY** *Can We do It?*	**STRATEGIES** *Is the problem responsive to interventions?*		
a.							
b.							
c.							
d.							
e.							
f.							
g.							
h.							
i.							
j.							

Developed by Health Resources in Action and adapted for this training. Accessed from:

http://nnphi.org/CMSuploads/RatingKeyHealthPrioritiesWorksheet_HRiA_201305.docx

Worksheet 2. Root Cause Analysis: Fishbone Diagram



Worksheet 3. Goals, Objectives, and Intervention Strategies: Questions and Definitions

	Definition	Questions to Ask
GOALS	• A projected state of affairs that a person or a system plans or intends to achieve. • Identifies in broad terms how your initiative is going to change things in order to solve the problem you have identified. • A result that one is attempting to achieve.	a. What is the desired state or outcome for this priority area? b. What are we trying to achieve for our county/region/team? c. What do we need to do in this priority area to significantly change the way things are now and move toward our vision of how things should be?
OBJECTIVES	• Break down goal statements into manageable parts — typically 2–4 action-oriented phrases to further break down/specify what you are trying to achieve in each goal. • Are SMART: Specific: *Does it clearly state what will be achieved?* Measurable: *Is it measurable? How will I know when it is accomplished?* Achievable: *Is it action-oriented and attainable?* Realistic: *Is it realistic with the resources you have?* Time-bound: *When will it be achieved?* **GOALS and OBJECTIVES** describe the "WHAT" of your plan. **GOALS** are broad and **OBJECTIVES** lend specificity and precision to the goal.	a. What awareness must be increased or created and with whom? b. What knowledge or skill must be improved and by whom? c. What behaviors must change? How and by whom? d. What policies must be changed? e. What types of system changes (think big systems, such as social system, health care system, employment system, government system, etc.) are needed?
OUTCOME MEASURES	• A specific, observable, and measurable characteristic or change that will represent achievement of the objective. (United Way of America. Measuring Program Outcomes: A Practical Approach. Alexandria, VA: United Way of America; 1996.)	a. How will we know we are making a difference in this priority? b. What can we track over time to demonstrate progress, and that we are "moving the needle"?
INTERVENTION STRATEGIES	•Intervention strategies are action-oriented programs or areas of policy change that you'll implement to improve health. •The objective is WHAT you are going to do, the intervention strategy is HOW you will do it. (HOW will we achieve this objective, in broad terms?) Review existing resources and the literature for evidence-based and best-practice interventions.	a. What do we need to do to achieve this goal and objective? b. Will these strategies, when combined, fulfill our objective and goal?

Adapted from Health Resources in Action, accessed via NACCHO website:
http://www.naccho.org/topics/infrastructure/CHAIP/upload/Goal-Obj-Strat-Def-and-Probes-9-14-12.docx

Worksheet 4. CHIP Framework

Priority Area:

GOAL # _____:	
Objective: **Intervention Strategy:** **Intervention Strategy:** **Intervention Strategy:**	**Outcome measure(s)** • • •
Objective: **Intervention Strategy:** **Intervention Strategy:** **Intervention Strategy:**	**Outcome measure(s)** • • •
Objective: **Intervention Strategy:** **Intervention Strategy:** **Intervention Strategy:**	**Outcome measure(s)** • • •

Worksheet 4 continued. CHIP Framework Examples

Priority Area: *Obesity*

GOAL #1: *Increase the consumption of healthy foods by County residents.*	
Objective: *1.1 Youth Healthy Food Consumption: Increase the percent of children and teens (ages 2-17) who consume five or more servings of fruits and vegetables daily to 22% by 2017. (2012 baseline: 18.3%)* **Intervention Strategy:** *1.1.1 Work with school board to create and implement healthy vending policy.* **Intervention Strategy:** *1.1.2 Develop education and awareness efforts regarding the health impacts of sugar-sweetened beverages through increased organizations adopting wellness policies.*	**Outcome Measure(s)** • *By 2017 22% of youth ages 2 – 17 consume 5 or more servings of fruit and vegetables daily, as measured by school-based survey.* • *100% of schools have a healthy vending policy by 2015.* • *Increase sales of healthy foods in vending machines from 10% to 30% by 2017.* • *Children and adolescents who consume 2 or more glasses of soda/sugary drinks on average daily equal to/less than. 15% by 2017 (could list by ethnic groups to demonstrate consideration of equity/health disparities).*
Objective: *1.2 By 2016, 35% of County adults are consuming the recommended amount of fruits and vegetables.* **Intervention Strategy:** *1.2.1 Increase hours of operation and awareness of Farmers market.* **Intervention Strategy:** *1.2.2 Provide healthy food classes at local community center.*	**Outcome Measure(s)** • *By 2016, 35% of County adults are consuming the recommended amount of fruits and vegetables.* • *Increase in population who buy food at farmers' market from 20% to 50%.* • *Increase participation in healthy food classes at local community center to 10 participants per 6-week session.*

GOAL #2: *Increase the level of physical activity of County residents.*	
Objective: *2.1 By 2016, 60% of County adults will participate in recommended levels of physical activity.* **Intervention Strategy:** *2.1.1 Increase walking/biking: Increase the number of minutes per day adult residents spend walking and/or biking by increasing accessibility and education.* **Intervention Strategy:** *2.1.2 Strong Women, Healthy Hearts Initative: Implement the Strong Women, Healthy Hearts initiative (from Kansas Health Matters).*	**Outcome Measure(s)** • *By 2016, 60% of County adults will participate in recommended levels of physical activity.* • *100% of schools have a healthy vending policy by 2015.* • *Increase minutes per day adult residents spend walking and/or biking for non-leisure, utilitarian trips from 27.6 min./day to 30 min/day (5%) by YE 2017.* • *10% of high-risk women in county participate in Strong Women, Healthy Hearts by 2017.* • *Women enrolled in the Strong Women, Healthy Hearts program walk at least 10,000 steps per day, based on pedometer readings.*
Objective: *2.2 Increase the percentage of children within the County School Districts who score 6 of 6 on the State fitness test by 2017.* **Intervention Strategy:** *2.2.1 Increase the level of physical activity in after school programs.* **Intervention Strategy:** *2.2.2 Increase the amount of physical education for elementary school students.*	**Outcome Measure(s)** • *By 2017 increase percentage who score 6 of 6 to: 25% of 5th graders; 35% of 7th graders; 40% of 9th graders.* • *By 2017, elementary schools increase amount of physical education from 1 hour per week to 2.5 hours per week, on average.*

Worksheet 5. Objectives and Outcome Measures

OBJECTIVE	
What will change?	
By how much?	
For whom?	
By when?	

OUTCOME FOR OBJECTIVE* At the highest level ask: - How will we know we are making a difference in this priority? - What can we track over time to demonstrate progress, and that we are "moving the needle"?	DRAFT OUTCOME MEASURE
Is there a national/regional measure to use?	
Baseline & Target:	
Is this reasonable to measure and how?	
Outcome/Impact vs Activity:	
Timeframe specified/implied:	
Short/Medium/Long-term Success:	

*Note: Each Objective will have one or more Outcomes Measures
Adapted from Michigan Public Health Institute, accessed from NNPHI website:
http://nnphi.org/CMSuploads/CHIPActionPlanningWorkbook_MPHI_201311.docx

Worksheet 6. Addressing Community Assets and Resources

What other efforts, resources, and assets do we have in our community to address strategic issues? (List one per row.)	Organization, Person, or Group	Is this group already working with us?	If not working with, us should they be?	Who can we contact with this agency or group?

Adapted from Michigan Public Health Institute, accessed via NNPHI website:
http://nnphi.org/CMSuploads/CHIPActionPlanningWorkbook_MPHI_201311.docx

Worksheet 7. Identifying Barriers and Solutions

What are potential barriers to this work and how can we overcome them?	
POTENTIAL BARRIER	SOLUTION TO BARRIER

Adapted from Michigan Public Health Institute, accessed via NNPHI website:
http://nnphi.org/CMSuploads/CHIPActionPlanningWorkbook_MPHI_201311.docx

Worksheet 8. CHIP Framework: Action Steps Detail

GOAL:					
OBJECTIVE:					
INTERVENTION STRATEGY:					
Action Steps or Process Measure	Target Date	Lead Person or Organization	Resources Needed	Potential Partners	Process measure met? or Progress Notes
1.					
2.					
3.					
4.					
5.					

Adapted from Connecticut Department of Public Health Guide and Template for Comprehensive Health Improvement Planning, assessed from: http://www.ct.gov/dph/lib/dph/state_health_planning/planning_guide_v2-1_2009.pdf

Worksheet 8 continued. CHIP Framework: Action Steps Detail Example

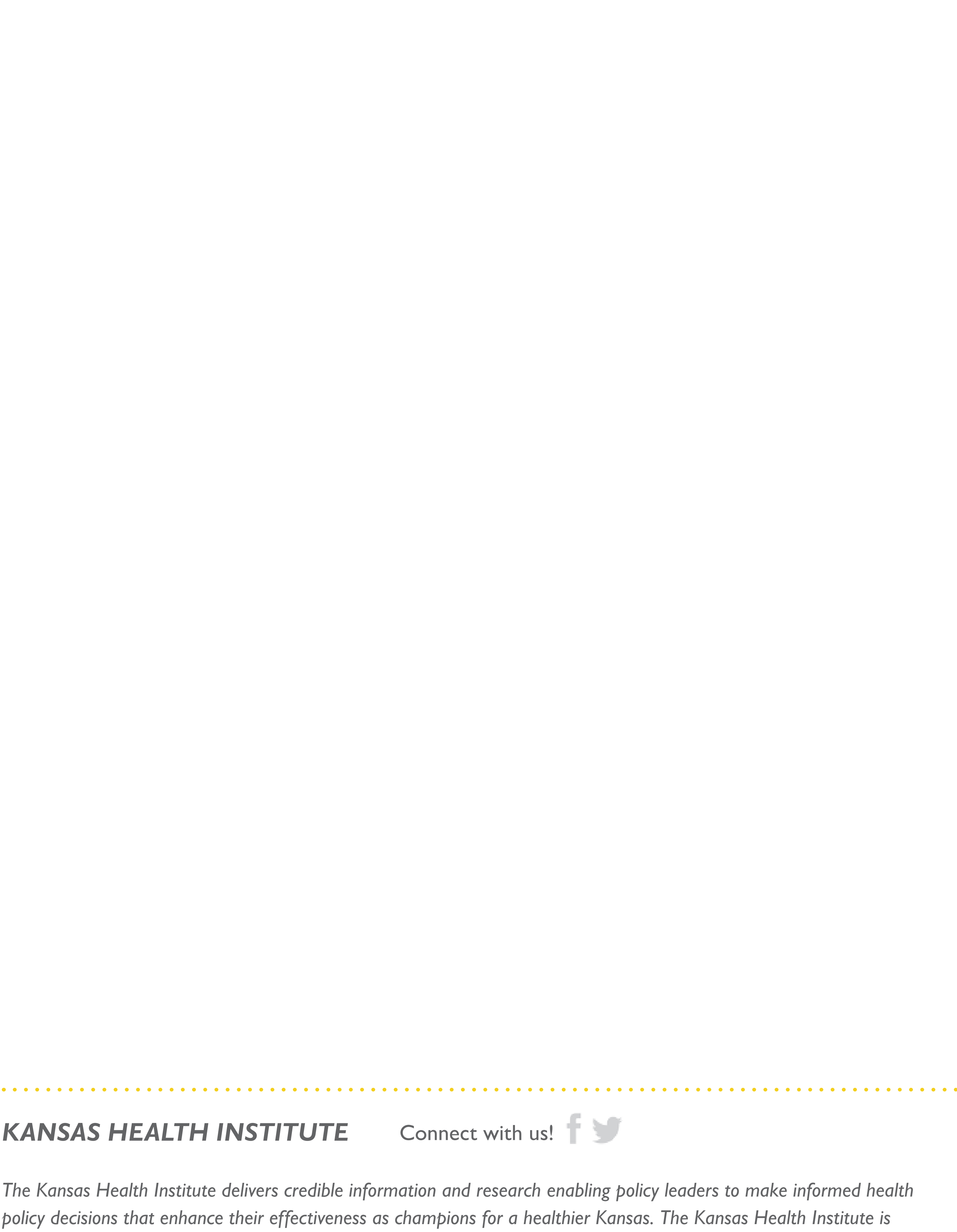
GOAL: *Increase the consumption of healthy foods by County residents.*					
OBJECTIVE: *1.1. Increase the percent of children and teens (ages 2-17) who consume five or more servings of fruits and vegetables daily to 22% by 2017.*					
INTERVENTION STRATEGY: *1.1.1. Work with school board to create and implement healthy vending policy.*					
Action Steps or Process Measure	Target Date	Lead Person or Organization	Resources Needed	Potential Partners	Process measure met? or Progress Notes
1. *Research model policies*	*April-14*	*County Commission*	*PC with internet access (in-kind)*	*KHI*	*Written summary completed*
2. *Adapt policy for our community*	*Jun-14*	*Communications lead*	*10 hours of staff time*	*County Commission, KHI, KDHE*	*Draft policy created*
3. *Set meeting with School Board*	*Sep-14*	*Schools liaison*		*Schools, County Commission, KDOE*	*Meeting set*
4. *Propose policy to school board*	*Oct-14*	*Health Department, County Commission*	*Printing of handouts ($)*		*Policy proposed*
5. *Vote on vending policy*	*Nov-14*	*School Board*			*Vote held*

Worksheet 9. Monitoring and Evaluation Table

PRIORITY AREA:							
GOAL:							
Outcome measure	Baseline	Target	Target Date	Monitoring Organization or Frequency	Data Source	Results	Actions Taken Based upon Results
1.							
2.							
3.							
4.							

Worksheet 9 continued. Monitoring and Evaluation Table Example

PRIORITY AREA: *Obesity*							
GOAL: *1. Increase the consumption of healthy foods by County residents.*							
Outcome Measure	Baseline	Target	Target Date	Monitoring Organization or Frequency	Data Source	Results	Actions Taken Based upon Results
1. By 2017, 22% of youth ages 2-17 consume 5 or more servings of fruit and vegetables	17%	22%	Dec. 2016	Health Department/ yearly	School survey	2014: 18% 2015: 18% 2016: 20%	Consider a healthy lunch policy as well
2. 100% of schools have a healthy vending policy by 2015	2	50 total	Jan. 2015	School Board/ Health Department	School Board policy list	2014: 40% 2015: 80%	Continue working with schools that do not have policy in place
3.							
4.							



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