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CHIP COLLABORATIVE HANDBOOK

Community Health Improvement Planning

Version 2.0
MAY 2014

KANSAS
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Community Health Improvement Planning

MAY 2014

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Prepared for this Collaborative by the Kansas Health Institute.

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Acknowledgements

Parts of this handbook were adapted from the Center for Healthy Communities at the Michigan Public Health Institute.

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What is a Community Health Improvement Plan (CHIP[1])?

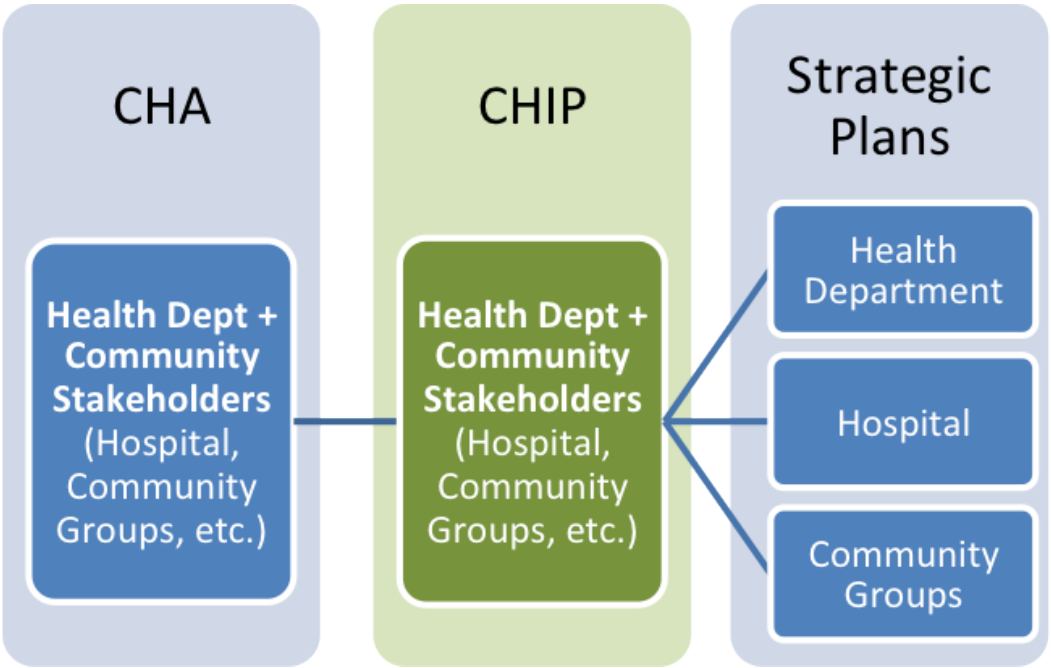
The community health improvement plan is the "roadmap" for improving the performance of the public health system, improving population health, and keeping community health planning visible to local decision-makers and communities. It lays out a long-term, strategic effort to address public health issues based on results of the community health assessment.

The community health improvement plan is developed through a consensus process involving members of the community, partner organizations, and the health department, following the Community Health Assessment (CHA) and the priority-setting process.

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

The development of a community health improvement plan represents a natural output of the community health assessment process. An assessment without an accompanying plan is not very useful. A community health improvement plan describes how community stakeholders will address the health priorities identified through the community health assessment.

The CHIP should address the full range of strengths, weaknesses, challenges, and opportunities that exist in the community. It should look beyond the actions, responsibilities, and performance of only the health department, and look instead to ways many organizations will contribute to the overall health and wellbeing of the community.



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:

- The vision of health for the community
- Description of the community health improvement planning process
  - Participants
  - Community engagement
- Community health priority areas (results from community health assessment data)
- Goals
- Objectives
  - Outcome Measures: How change in behavior, environment, and/or policy will be measured
- Evidence-based Intervention Strategies
  - Specific populations that will 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 of planned follow-up and implementation monitoring and evaluation activities

Definitions

Sometimes, terms are defined differently depending on 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 that was informed by community health assessment data. These are areas that if addressed, could significantly improve community health and wellbeing. A CHIP should include between two or six Priority Areas.

Example Priority Area: "High rates of obesity."

Goals are broad targets that address 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 about what specifically your efforts or actions are intended to attain or accomplish in the community. The objective statement is about your measure of change. It is written in terms of 'what,' 'by whom,' and 'by when.'

Example Objective: "By 2016, 35% 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 you are on the path to meet your goal.

Example Outcome Measure: 100% of schools have a healthy vending policy by 2016

Intervention Strategies These are evidence-based actions or decisions that can be carried out to 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 that are assigned to each organization that is 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.

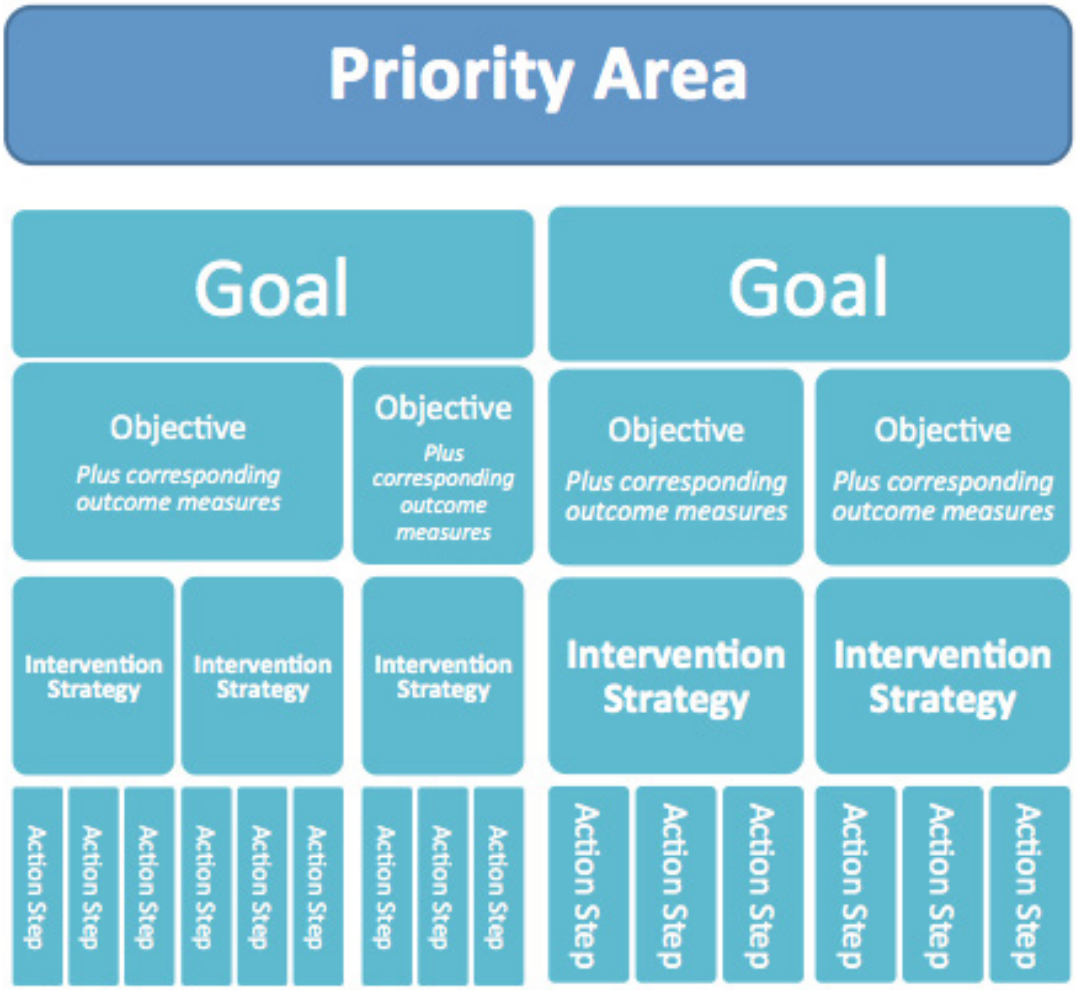
Example Action Step: "Research model policies and prepare written summary by August 2014."

Process Measures are a representation of whether or not the activities in the action plan were carried out, and if they were carried out on time. 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 Your CHIP

This workbook will help your group walk through the steps of developing your CHIP.

STEP 1: SET PRIORITIES

Priority Areas

Priority Areas are broad, health-related areas identified through community health assessment data to be a focus of the community health improvement plan; areas that if addressed, could significantly improve community health and wellbeing.

After reviewing the results of the health assessment, the steering committee/advisory group uses a prioritization process to select and name the specific priorities to be included in the Community Health Improvement Plan. These priorities create the foundation for building a set of action plans to improve community health over the next 3-5 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. We recommend that you include these in at least one of your priority areas.

How to Set Priorities for Health Improvement

Most communities will not have sufficient resources to address all the health issues that are identified. To assure that interventions are selected that meet the needs and wishes of the community, and that resources are concentrated appropriately on those interventions, a priority setting process needs to be put in place. 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 that can be used and adapted in a variety of situations. In this section we provide a quick overview of some important aspects of setting priorities.

Community Involvement

Priorities should not be set by a steering committee/ advisory group alone, but they should be defined with the full participation of stakeholders and community members. Broad community involvement in reviewing the results of the data collection and analysis and deciding what priorities should be pursued is important.

A variety of methods to report the findings of the assessment to the community can be used, such as written reports, oral presentations and public meetings. The use of 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

To prioritize and select community health issues requires a careful consideration of each issue and how the community views that issue. The combination of factors, rather than any single factor, is important in determining whether an issue will become a priority or not.

Factors usually considered in the ranking process are:

- Magnitude: How many people are affected by the issue 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 that are perceived by the community as most severely affecting its health should be taken into account. A high level of concern in the community is also likely to produce a higher level of community engagement in the solution of the issue.
- Feasibility: Also known as "do-ability," places all the community health issues into a broader context that includes 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 and are often helpful in assisting to build consensus and move from a long list of health issues to a shorter list of priorities. Some other tools are brainstorming, affinity diagram, Pareto charts, nominal group, and prioritization matrices. Details about these tools can be found in your "Memory Jogger" booklet and in various forms online. One good resource can be found here: http://www.health.state.mn.us/divs/opi/qi/toolbox/prioritizationmatrix.html. If interested, you can request additional information from the KHI team.

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 varies from community to community, depending on the resources available and the scope of the problems being addressed. Some CHIPs may include as few as two or three priorities, while others may have six or more.

There are many methods for priority setting. Complete Worksheet 1 (page 25) as a priority setting exercise.

STEP 2: SET GOALS

You will set one or more goals for each priority area. A goal statement is used to tell your stakeholders and community what you intend to achieve. It describes the desired change that you are trying to introduce. It identifies in broad terms how your initiative is going to address the health priority that you have identified.

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. A root cause analysis is a tool to dig deeper into problems to see what underlies the issue. This will help you think strategically about the best ways to address the priority in your community, so that you will be addressing the 'root' of the problem, rather than the symptoms. You will conduct a root cause analysis for one or all of the priorities you have set.

Review your community health assessment report and other community data available to describe the priority. What contributes to the issue in your community? What makes your community and residents at a high risk related to this issue? What is causing this problem or making it a bigger issue? The answers to these questions will help you understand what is causing the issue in your community and will help you plan specific actions that will produce improvement.

Complete Worksheet 2 (page26).

Goals

Next, you will write one or more goals for each priority area. Look at the questions in Worksheet 3 (page 27) and use them to write goals into the CHIP Framework on Worksheet 4 (pages 28-9).

Questions to Ask:

- What is the desired state or outcome for this priority area?
- What are we trying to achieve for our county/region/team?
- 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?

Example goals:

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

STEP 3: SET OBJECTIVES AND OUTCOME MEASURES

An objective is a statement about what specifically your efforts or actions are intended to attain or accomplish in the community. The objective statement is about your measure of change. It is written in terms of 'what,' 'for whom (target population),' and 'by when.' When you write objectives you will focus each objective on the outcomes you wish to see happen in the community. Your objectives are the intermediate steps between goals and intervention strategies. Your objectives should describe specifically what change in health status or change in a system you want to see accomplished and how it will be measured. Also, consider aligning objectives with similar efforts happening in the county, state, or federal level (e.g. Healthy Kansans 2020).

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

Reference Worksheet #3 and write your brainstormed objectives in Worksheet 5 (page 30). To meet PHAB standards, plan to have a mix of long- 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 (think big systems, such as social system, health care system, employment system, government system, etc.) are needed?

Example SMART objectives:

- By August 2014, increase the use of the farmers' market among Hispanic/Latinos in [community] from 20% to 60%.
- By August 2016, increase the number of elementary school students in [community] who eat at least 5 servings of fruits and vegetables per day from 30% to 60%.

After brainstorming, finalize one or two SMART objectives for each goal. Write your finalized objectives into the CHIP Framework Grid in Worksheet 4 (pages 28-9).

Outcome Measures

When you write a SMART objective, the highest measure of outcome desired is typically stated within the content of the objective. Accomplishment towards goals and objectives hinges on 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] , but never demonstrating if you are there or not.

Since the outcomes measures section of your plan is one of the most important areas for future focus for reporting progress and success, it is important to ensure that you articulate the specific measure(s) here that serve as evidence of success.

To develop solid outcome measures there are several questions to consider:

- 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"?

Then, also consider:

- Is there a national/regional standard measure here that is commonly used AND reflects your desired outcome for the objective?*
- 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 time frame for attainment specified (or implied)?
- Do we have reasonable outcome measures that reflect short, intermediate, long-term success?

** If your 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 30). Then, write your finalized outcome measures into the CHIP Framework Grid in Worksheet 4 (pages 28-9).

Note: Make sure your outcome measure is a measure of a change in the community that has meaning vs the result of an action step. Action steps and their measures of accomplishment (called Process Measures) belong in the action steps section of the plan.

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

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

The goal is to accomplish the following:

- Identify current efforts in the community to address your priority issues.
- Define existing strengths and community readiness to address the issues that you can build upon.
- Identify any existing (concrete and tangible) assets or resources that may be used to help support your work.

As a team, complete Worksheet 6 (page 31).

STEP 4.1: RE-ENGAGE EXISTING AND NEW PARTNERS

After evaluating your community's assets and resources, there may be additional people or organizations that you will want to engage in the CHIP. Think about the people/organizations that have been involved in your CHA process, and identify any additional individuals that you'll need to engage to address your priority areas.

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

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

- Influential people from all the parts of the community affected by your 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 your community
- People you know who are interested in the problem or issue

For practical ideas and tools for working together with community partners, go to: 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 that you will take to achieve each objective. Intervention strategies are action-oriented programs or areas of policy change that you'll implement to improve health. An objective is WHAT you are going to do, and the intervention strategy is HOW you will do it.

In order to make sure you are choosing effective intervention strategies, you should:

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

Example Intervention Strategies:

- Implement a policy that requires all school districts to serve at least one serving of fresh fruits and vegetables at every meal served 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 that allow the use of athletic facilities and outdoor recreational facilities by the public 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.

PHAB encourages, and sometimes requires evidence-based intervention strategies in the standards and measures. A document available from the Community Guide outlines PHAB standards and provides links to interventions that exist in the Community Guide repository. You can reference the document here: http://www.thecommunityguide.org/uses/Table%202%20Community%20Guide-PHAB%20Crosswalk%20Version%201.pdf.

Using Worksheet 4 (pages 28-9), choose one or more intervention strategies that will help you accomplish each objective. If needed, reference the questions in Worksheet 3 (page 27).

Note: If possible, try to select intervention strategies that have evidence (research and data that prove that this strategy really works) that they can create the change (outcome) you are targeting in your goals and objectives.

STEP 5.1: IDENTIFY BARRIERS AND ADAPT INTERVENTION STRATEGIES

Change is hard. It is not uncommon for people to resist change. While trying to implement your intervention strategies, you will encounter resistance and some barriers.

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

Use Worksheet #7 to identify potential barriers you may face for each of the changes you brainstormed earlier.

Using what you have brainstormed for your barriers and solutions, you will then adapt your intervention strategies to your community to ensure success.

Interventions, strategies, methods, messages, and materials will need to be adapted to the specific characteristics of your community. The process of "cultural tailoring" takes into consideration the beliefs, values, languages, and circumstances of the specific people within your community. It is the process of developing programs in a culturally relevant context.

Ask yourselves if the strategy you are considering for your plan fits with your community's characteristics, size, and culture. If not, develop a list of changes or modifications to the strategy that you would need to make in order to overcome barriers for it to be a good fit.

For each strategy you are thinking about including in your action plan, ask yourselves if there are ways you could 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 your target audience

STEP 6: COMPOSE AN ACTION PLAN

Action Steps

Your action steps help you turn your vision into a reality. These are a way to make sure the work you have completed so far is made concrete and feasible. They describe in detail how your group will implement intervention strategies to meet the objectives. Action steps describe who is going to do what and by when.

There are many good reasons to work out the details of your work in action steps:

- To be sure you don't overlook any of the details
- To understand what is and isn't possible to accomplish
- For efficiency: to save time, energy, and resources in the long run
- For accountability: To increase the chances that people will do what needs to be done
- To lend credibility to your organization. An action plan shows members of the community (including grant makers) that you are well organized and dedicated to getting things done.
- To explicitly clarify specific milestone activities – "process measures" that reflect accomplishment of specific actions that help lead to achievement of the intervention strategies, objectives and outcomes measures.

What are the criteria for good action steps?

The action steps for your CHIP should meet several criteria. Questions you should ask to judge the quality of your action steps include:

Are these steps…

Complete? *Do the steps represent changes to be sought in 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

You will want to be sure that the action steps are being completed according to plan. In order to measure this, you will monitor the process measures for your action steps to determine whether your team is on track.

The process measure answers the question, "Are we doing what we said we were going to do?" Your 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 on time.

Complete the CHIP Framework: Action Steps Detail template Worksheet 8 (pages 33-4) with the information you have gathered thus far. This template will allow you to see all of your ideas in a systematic manner, and prepare for the road ahead.

STEP 7: PRODUCE THE CHIP DOCUMENT

The CHIP document is the compilation of your plan for your team and for the public. This document should be clear, concise and understandable for those who read it.

There are two basic ways of presenting your CHA and CHIP: together or as separate documents. Some communities decide to publish both pieces in one document, while others prefer to publish the documents separately.

How you decide to present the CHIP is up to you, and depends in part on the timing of the completion of the two processes. Regardless of the number of documents, we suggest the following outline:

- **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

We have developed a template CHIP document (attachment) to use and modify when putting together your own CHIP report. There are also several examples of quality CHIP documents from accredited health departments that may provide you with ideas and examples.

STEP 8: RELEASE AND DISSEMINATE THE CHIP

It is important to think about how you will communicate the CHIP to your stakeholders and community members. The CHIP is the planned action that has resulted from the CHA process; one that the community stakeholders likely participated in or heard about. It is important for your community to know that you are taking action on their recommendations.

A communications plan is not a requirement for PHAB, but it is required that you make the document widely available to the public. To accomplish this, it is a good idea to have a coordinated plan that is woven into your entire process.

It will be helpful for you to think about:

WHO *will be reading the document*

WHAT *you will present to whom (i.e. full report or executive summary version)*

WHEN *they need to be updated, and*

HOW *you will get the information to them*

You will probably want a mix of communication methods, for example: a paper copy, an electronic copy of the report, communication via social media, and communication via other media.

We recommend that you assign a lead individual to think about these things as you move through your CHIP process, as you disseminate the final report, and during the implementation phase as well.

STEP 9: IMPLEMENTATION, MONITORING AND EVALUATION

Until you actually start work on your Community Health Improvement Plan, it is still just that—a plan. The implementation of the CHIP is perhaps the most important and most challenging part of the process. Having the plan that you have put together in the previous steps ensures that you are well-prepared to implement the activities that you propose.

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

Monitoring and Evaluation Plan

In order to track your results throughout the implementation of your CHIP, you will want a central place to evaluate the results of the indicators you are monitoring. Worksheet #9 provides a single location to record your outcome measures. It will help you to determine where your data will come from, who will collect it, and at what frequency it will be gathered. The worksheet also has a place for you to record the baseline, target, results and how you will adjust if the results are not in line with what you had envisioned. Finally, you may want to summarize any unanticipated outcomes, lessons learned, and success stories that may influence future actions on your current CHIP and inform upcoming cycles of your CHA, CHIP and Strategic Plan.

Worksheet 9 (pages 35-6) provides a single location to record your outcome measures.

Endnotes

1. Public Health Accreditation Board (2011). Acronyms and Glossary of Terms. Version 1.0. Available online: http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf.

2. http://publichealth.nc.gov/lhd/cha/docs/CHA-GuideBookUpdatedDecember15-2011.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 to guide you through the process of the CHIP with relevant exercises. Please note that these are only a sampling of many resources that can be found online to assist with each of these steps. Also note that the handbook and accompanying exercises are meant as a guide, and can be modified, substituted, or skipped to fit your own process.

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*

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.

Key Health Issues (list below):	Selection Criteria					Total Rating
	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.						

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.

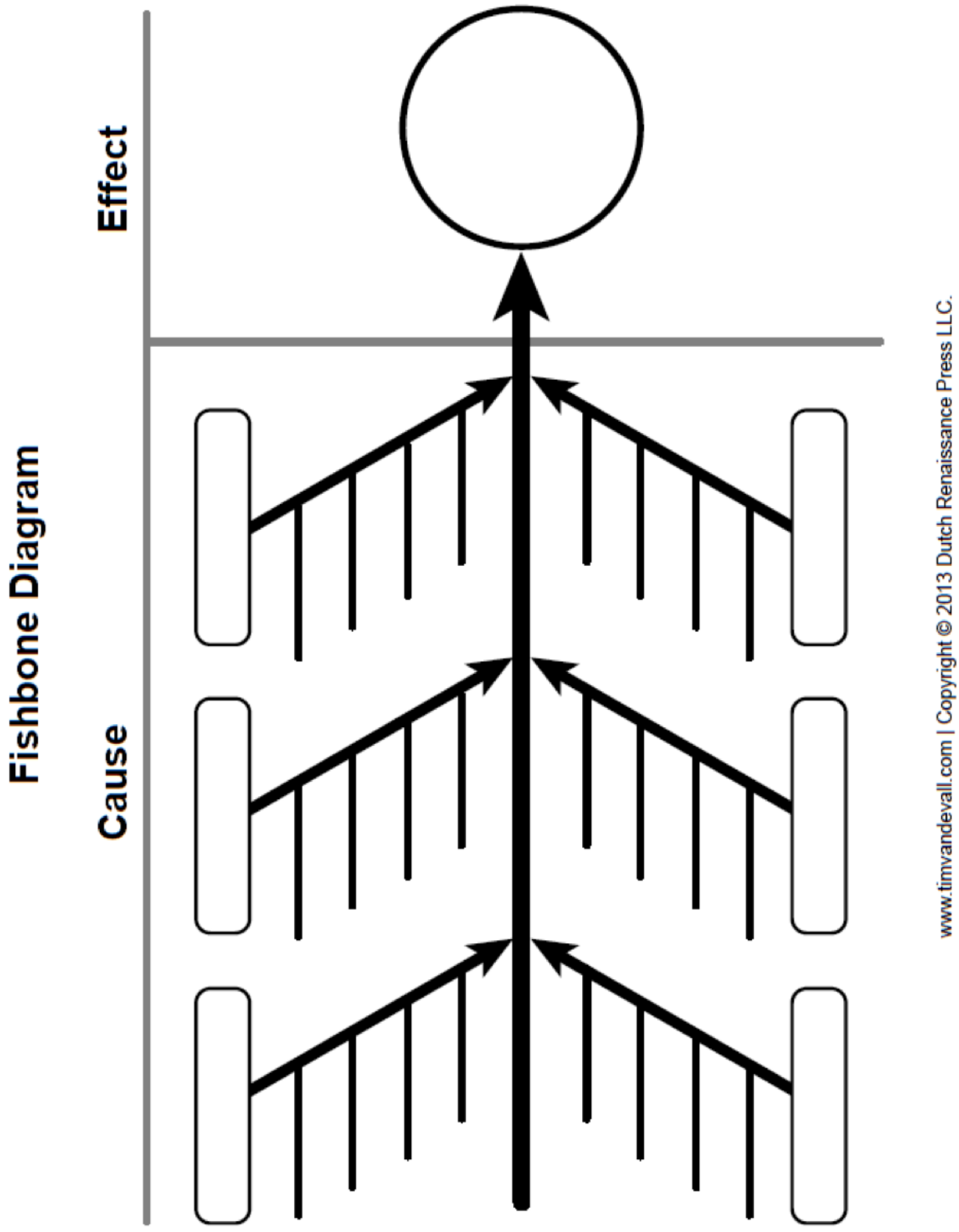
In the case of identical totals, use your best judgment to assign a unique rank number to each health issue to break the tie.

Rank Order of **Health Issues** (use each number only once):

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: Fish Bone 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. •Whereas 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. 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:	
Time frame 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 the potential barriers to this work and how might they be overcome?	
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. 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. 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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