Community Health Needs Assessment & Health Improvement Plan (CHNA & HIP) Guide

Revised August 2018

CHNA & HIP Guide

Iowa Department of Public Health

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CHNA & HIP GUIDE SUMMARY

The following community health needs assessment and health improvement planning (CHNA&HIP) guide consists of basic steps and tools for community assessment and planning. Key elements include an analysis of community health needs and assets and developing a set of priorities and objectives for taking action. The process calls for community-wide participation in shaping decisions about improving the community's health and mobilizing support and resources. The basic steps in the guide are consistent with the assessment and planning requirements in the Public Health Accreditation Board (PHAB) Public Health Standards (Domains 1 and 5) available at www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/ and the Patient Protection and Affordable Care Act for tax-exempt hospitals at https://federalregister.gov/a/2014-30525. **However, additional documentation is required to demonstrate compliance with PHAB and IRS requirements. See the documents referenced above for specific documentation requirements.**

Build the Foundation

Step 1: Adopt a planning structure and identify resources. The planning structure should include a plan development process and staff/technical support plans.

Step 2: Inform the community about the process and its importance; identify and engage stakeholders. From the beginning, stakeholders need to be consulted and actively involved.

Recommended stakeholders include:

- Business/industry representatives
- Civic groups
- Local schools and academic institutions
- Emergency management
- Faith-based organizations
- Members of the general public
- Judicial system
- The local board of health
- Local health care providers (e.g., hospitals, clinics, practitioners, veterinarians)
- Food system stakeholders (e.g., farmers, processors, food assistance providers, food retail, waste management)
- Community not-for-profit organizations
- Departments of government (e.g., housing, planning and zoning, economic development)
- Elected official representation
- EMS
- Fire department
- Human service agencies
- Law enforcement
- Media
- Other public health system agencies (e.g., substance abuse, problem gambling, and mental health providers)
- Foundations and philanthropists
- Planning organizations

Ensure that the interests of such disparate population groups as seniors, ethnic/racial minorities and persons with disabilities are represented.

Step 3: Identify and secure resources. Resources may include financial and non-financial support from groups whose purposes align with creating a healthier community.

Gather Information on Community Health Status Needs & Assets

Step 4: Identify data that describes community health status and needs.

Step 5: Gather and analyze the data and develop a community health needs assessment (CHNA) summary report. Share the report with stakeholders.

A summary report of the needs assessment includes the following:

- Description of the community assessed.
- Description of the assessment process, including how the data were analyzed.
- Summary of the data and analysis/trends.
- Description of identified problems/needs/assets.

Evaluate the Community's Resources and Invite Feedback

Step 6: With stakeholder assistance, review the key factors that are important for health and well-being as part of setting health priorities and objectives.

Step 7: Document key points of the stakeholder discussion. Invite broader community participation and input. Include the feedback in the priority decision-making.

Lay Out the Action, Communication and Evaluation Plans

Step 8: Develop the action plan/health improvement plan (HIP) that includes SMART+C goals, objectives, strategies and indicators.

Step 9: Implement, track progress, and sustain the process. Celebrate the milestones.

Step 10: Establish and implement a plan to communicate health needs and goals to the community.

Step 11: Annually evaluate the goals, objectives, strategies and indicators. Revise and update the needs assessment and health improvement plan.

STEP 1: ADOPT A PLANNING STRUCTURE

Involvement of and support from the community hospital and public health agency administrators, other agency heads, top political leaders, and key policy makers in a community (e.g., county or multi-county area) significantly improves and strengthens the local planning process. Effective leadership is necessary to inspire a shared vision and enlist appropriate partners and staff in the development process. Once leaders' commitments and buy-in are secured, planning structures, resources and other essential elements often fall into place more easily. The suggestions and tools can help you build a strong foundation for planning. Implementation will depend, of course, on the unique characteristics of your community. Examples of planning tools include, but are not limited to the following:

Community Toolbox, University of Kansas	http://ctb.ku.edu/en/table-of-contents
MAP-IT (Healthy People 2020)	https://www.healthypeople.gov/2020/tools-and-resources/Program-Planning
MAPP (Mobilizing for Action through Planning and Partnerships):	http://archived.naccho.org/topics/infrastructure/mapp/
Minnesota Dept. of Health Local Public Health Assessment & Planning Resources	http://www.health.state.mn.us/divs/opi/pm/lphap/community/cha.html
NACCHO: Resource Center for Community Health Assessments and Community Health Improvement Plans	http://www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm
Assessing and Addressing Community Health Needs	https://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf
CDC Community Health Assessment Public Health Professionals Gateway	https://www.cdc.gov/stltpublichealth/cha/index.html
Moving to the Future: Tools for Developing Nutrition and Physical Activity Programs	www.movingtothefuture.org

TIPS

#1: Don't pass GO before gaining leadership support.

Enlisted leaders can:

- Influence public opinion;
- Mobilize support and engage partners;
- Inspire action to get things done;
- Facilitate locating, obtaining, and allotting resources;
- Guide decision making;
- Advocate for the plan's goals and objectives; and
- Set policy and ensure that objectives are monitored and considered in policy matters.

#2: Begin within your own agency:

- Engagement of executive leadership
- Senior staff and program managers

#3: Include local and county elected officials and boards of health:

- Advisory committees
- Political and policy leaders
- Key health supporters, as well as potential adversaries

#4: Enlist heads of other agencies and health providers:

Primary care, oral health, mental health, substance abuse, environmental, social services, children and families, food and nutrition assistance, aging, disabilities, education, agriculture, transportation, and other agencies.

#5: Know the playing field:

- Conduct a SWOT (strengths, weaknesses, opportunities, and threats) analysis;
- Learn from past successes and mistakes; and
- Define how the community plan can support and advance leaders' current policies and priorities;
- Know how your community plan activities will align with other planning and improvement efforts.

#6: Be explicit about what you are requesting from others:

- Identify shared values and common goals;
- Identify specific roles and responsibilities;
- Share responsibilities and decision making; and
- Establish accountability mechanism

STEP 1: ADOPT A PLANNING STRUCTURE

Action Checklist:

- ☐ Secure commitment from senior staff.
- ☐ Identify potential barriers and facilitators to success.
- ☐ Form a preparation team to identify goals and guide early stages of development.
- ☐ Present the plan development process to political leaders for support.
- ☐ Create a planning structure.
- ☐ Examine the policy/political environment.
- ☐ Identify related initiatives to integrate or consider coordination with any other plans.
- ☐ Engage partners early and maintain their involvement.
- ☐ Define functions and composition of an advisory and/or steering group.

Notes:

STEP 2: IDENTIFY AND ENGAGE STAKEHOLDERS AS PARTNERS

The health status of community residents is not the sole responsibility of providers of health services. While providers may bear responsibility for leading community health improvement efforts, their success hinges on their ability to establish and maintain effective partnerships throughout the county or region. The responsible organizations need to identify and work with all entities that influence community health—from other government agencies to businesses to not-for-profit organizations to the general public. Initiatives should begin with a commitment to collaboration among diverse constituencies so that everyone feels a sense of ownership in the plan. By working with partners, initiatives can be developed to address such social determinants as housing, transportation and education that are critical to creating a healthy environment.

TIPS

#1: There is strength in numbers—community input does not burden, but strengthens, the planning process. Community partners can:

- Advocate for the goals and objectives of the plan in the community and recruit other partners;
- Contribute particular skills and talents; and
- Help monitor progress and achieve objectives.

#2: Be inclusive, not exclusive (Don't invite just your friends!).

- Strive for broad representation, and regularly assess gaps.
- Identify individuals and organizations that look at problems and solutions differently.
- Look for partners who have a stake in healthy communities, will contribute to the process and help achieve objectives.

#3: Create and define useful roles for partners by:

- Confirming commitments in writing where possible;
- Giving credit where credit is due; and
- Accepting that some partners will have different levels of commitment.

#4: Don't just meet for the sake of meeting.

- Be clear about the purpose and desired results of meetings.
- Choose an effective facilitator (not always the chair).
- Show respect for other people's time.
- Plan the meeting from the participants' perspective.

#5: Nobody likes to be a rubber stamp.

- Provide a continual feedback mechanism and consider all feedback received.
- Report to partners about how comments were addressed.
- Give people a voice before priorities are set.
- Ensure that groups have options and understand their implications before making big decisions.
- Strive to understand all parties' concerns and perspectives.
- Allow time for meaningful discussion.
- Establish ground rules that are fair to all.
- Establish partners' sense of ownership of the process.

#6: Find creative and flexible ways to engage partners and community members by:

- Considering rotating meeting places and times to accommodate different schedules and give participants a chance to see other communities;
- Offering meeting options that accommodate different preferences and levels of comfort with groups, such as informal discussions, conference calls, anonymous surveys, provider forums, focus groups, independent work groups, and kick-off events or small breakout groups; and using electronic communications, listservs, and websites, when possible.

Action Checklist:

- ☐ Define target audiences
- ☐ Identify key individuals and organizations
- ☐ Design strategies for engaging partners
- ☐ Identify roles for partners and assign responsibilities
- ☐ Develop a communication vehicle to highlight partner activities
- ☐ Establish formal partnership agreements where appropriate
- ☐ Reassess and evaluate partner involvement and satisfaction

Notes:

STAKEHOLDER MEETING RECORD WORKSHEET*

Part 1: A Model Stakeholders' Meeting Record* Instead of taking notes, this meeting record format may be used like a template and a convenient option to meeting minutes. It can be used to document stakeholder input and discussion. Take notes on Part 2, focusing on main ideas with the topics discussed, and then complete 2, 3 and 4 on Part 1.

Meeting: _____ Date: _____ Location: _____

1. Participants and Agency/Organization Represented

_____
_____
_____
_____
_____
_____
_____
_____

2. Agenda: Enter key words indicating the agenda topics. Check off an item when it is completed. Items you do not complete should be carried over to the next meeting.
   (1) Warm-up
   (2) Agenda Review
   (3)
   (4)
   (5) Set Agenda for the Next Meeting
   (6) Meeting Review

3. Brief summary of topics, decisions, or conclusions and next steps.

4. Futures File: items for future consideration but not for the next meeting.

5. Meeting Review

Next Meeting
Date: _____ Time: _____ Location: _____
Note Taker: _____

STAKEHOLDER MEETING RECORD WORKSHEET*

Part 2: A Model Stakeholders' Meeting Record* Take notes during the meeting on a page like this. Summarize the discussion whenever possible and then complete items 2, 3 and 4 in Part 1.

Topic 1: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

Topic 2: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

Topic 3: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

Topic 4: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

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*Adapted from Peter R. Scholtes, *The Team Handbook*

DEVELOP VISION AND MISSION STATEMENTS

It is essential to take time at the outset to clarify purpose and provide a focus for what you want to achieve by developing vision and mission statements. A vision is important to develop early in the CHNA & HIP process. It helps provide focus for the assessment and helps in framing goals, objectives and strategies. The vision is future-focused. It is a statement to inspire the group about its destination, its outcome, its end product, its finish line. A mission statement is present-focused. It sets priorities and clearly describes how the group will reach a destination or achieve the vision. Both statements should be brief enough to remember, captured quickly, and understood by everyone in the community; they should provide in one or two short sentences why the group exists and where it's headed. Sometimes groups spend considerable time "wordsmithing" without realizing that the statements can be changed when needed.

Setting the vision and mission before conducting the assessment and creating the health improvement plan helps ensure you're asking the right questions and are focusing on solutions rather than problems. For example, instead of asking the question "What are the problems/needs we have related to early childhood?" you might ask, "How do we ensure children are ready to succeed in school?" The first question may result in a plan that simply reacts to problems, which may or may not be related to your vision. The second question focuses more on solutions or required action that is essential to achieving your vision.

Some questions worth asking…VISION

- How would you describe your community of the future? Next Year? In 5 Years? What should your community expect?
- What impact and results do you want to be achieving?
- What will success look like?

Some questions worth asking…MISSION

- What will you do to deliver the results and impact you envisioned?
- How will you do it? How will you act? What will your reputation be?
- What do you need to get there? What is preventing you from getting there?

BRAINSTORMING: TWO POSSIBLE APPROACHES

One of the easiest ways to develop vision and mission is through brainstorming—a freewheeling approach that generates participant excitement and involvement. The objective is to collect ideas from everyone without criticism and to encourage everyone to contribute. Discussion will come later. Two possible approaches to brainstorming:

1

- ✓ Give the group a few minutes of quiet, think-time.
- ✓ Invite everyone to call out his or her ideas.
- ✓ The facilitator or another team member should quickly write down the ideas on a flip chart.

Or

2

- ✓ Ask participants to write their ideas down on post-it notes–one idea for each note.
- ✓ Post the notes on a wall.
- ✓ Without discussion, ask participants to group related ideas together to form patterns.
- ✓ Name each group of notes with a descriptive header phrase.
- ✓ If there is a miscellaneous group of notes, decide where the ideas fit or do not fit.

After discussion, the group can finalize the ideas by placing sticky dots on the ones that are of most importance and reaching consensus. The discussion may lead to draft statements, which can be given to a smaller group for refinement.

DEVELOP VISION AND MISSION STATEMENTS

VISION AND MISSION STATEMENT EXAMPLES

Iowa State Association of Counties (ISAC)

Vision: To be the principal, authoritative source of representation, information and services for and about county government in Iowa.

Mission: To promote effective and responsible county government for the people of Iowa.

Iowa Public Health Association (IPHA)

Vision: A healthy and thriving Iowa because of the strong foundation laid by public health.

Mission: Uniting and strengthening the voice for public health in Iowa.

Sioux County Community Health Partners

Vision: Healthy Sioux County residents living in communities that support and promote active and healthy lifestyles.

Mission: Partnering to promote and improve the health of all who live, learn, work, and play in Sioux County.

STEP 3: IDENTIFY AND SECURE RESOURCES

Identifying and securing resources for community health planning is a constant challenge. Funding, shared services and collective action facilitate a successful planning initiative. A helpful strategy is to identify how the goals of the plan may be aligned with the goals of potential resource contributors like businesses and hospitals. In addition, a detailed budget for planning activities facilitates securing both public and private resources. The budget should cover all aspects of the development process, including resources needed to carry out each of the various steps in making an assessment and developing an improvement plan.

TIPS

#1: Ask the right questions early.

- What is the scope of the community health planning process?
- What does the community want to accomplish through this process?
- Why should taxpayers or others fund the development of the plan?
- What will it take to support the planning initiative?

#2: Recognize up front that planning takes money.

- Find examples of what other community initiatives have included and required in funding.
- Develop a plan for supporting the process, identifying both people and dollars.
- Think about developing a separate budget for plan development.
- Be realistic — do not underestimate your costs.

#3: Capitalize on what you have.

- Investigate the uses of available resources.
- Negotiate reallocation of existing agency staff.
- Identify and secure assistance from experts (e.g., grant writers).
- Identify other community-based assessments recently completed that could be integrated into the community health plan.

#4: You can't get it if you don't ask for it.

- Research potential external funding sources, such as the federal government, private and community foundations and other public or private sources whose purposes may be aligned with the plan.
- Ask businesses or community groups to donate services or other non-financial resources.

#5: Don't forget to plan for the future—it's not over when the plan is released.

- Identify resource needs to carry out a five-year plan including monitoring progress, publishing periodic reviews, and sustaining activities.
- Keep a wish list ready for future funding (e.g., resources for a business companion document, a special health disparities consortium or other ideas generated during the planning).

#6: ***Feel free to ask for contributions.***

- Partners may be willing to provide support for meetings, staff and equipment.
- Other kinds of non-financial support include meeting facilitation, meeting space, advertising, web links, expertise in research or data analysis, writing and creating documents, and other promotional activities.

STEP 3: IDENTIFY AND SECURE RESOURCES

Action Checklist:

- ☐ Identify resources needed to develop the plan.
- ☐ Identify existing internal resources.
- ☐ Develop a budget.
- ☐ Identify potential external resources, including potential donated resources.
- ☐ Plan to integrate the plan into budgeting and programming processes.
- ☐ Develop a staff and technical support plan.
- ☐ Secure identified resources and develop alternative resources, if necessary.

Notes:

STEP 3: IDENTIFY AND SECURE RESOURCES

REVIEW PAST ASSESSMENT AND PLANNING EFFORTS

The following worksheet is taken from a literature review of challenges and factors for the success of an assessment and planning process. This list can be used to begin a discussion of past assessment and planning efforts and provide a starting point for building on achievements and anticipating barriers to action.

Factors Affecting Successful Assessment and Planning Efforts

- ✓ Partner collaboration and lack of turf issues
- ✓ The community as a partner
- ✓ Shared decision making
- ✓ Dedicated staff and staffing
- ✓ Commitment to assessment
- ✓ Leadership and vision
- ✓ Interagency cooperation
- ✓ Technical assistance and consultation
- ✓ A history of success in community problem solving
- ✓ Social marketing
- ✓ Limited resources and expertise for data collection and interpretation
- ✓ Too much data
- ✓ Access to data, technology, peer learning
- ✓ Marketing
- ✓ Use of quantitative and qualitative data
- ✓ Finding creative ways to pay for the process
- ✓ Capitalizing on existing community assessments

STEP 4: IDENTIFY INFORMATION/DATA THAT DESCRIBES THE NEEDS OF THE COMMUNITY

There are two kinds of information for developing a profile of the critical health needs of the community--qualitative data or descriptive information and quantitative or numerical data. Both play a role in building a foundation of understanding the strengths and weaknesses as well as the threats and opportunities to improve health.

Partners can provide a rich source of information, based on their experiences and observations in living and working in the community. A simple SWOT (strengths, weaknesses, threats and opportunities) analysis is an exercise that can yield this important background. Another tool that can be used focuses on assessing the direct health services, health education and resources, and ancillary community factors that contribute to the health and wellbeing of everyone in the community.

Quantitative data may be considered more objective and can balance the more subjective SWOT and community asset analysis. Although some communities may choose to conduct a survey to gather primary or first-hand data, Iowa has valid and reliable secondary data published by the US Census Bureau, US Department of Agriculture, other federal agencies, the University of Iowa, the Child and Family Policy Center, and the Iowa Department of Education and the Iowa Department of Public Health. There also are such valuable local sources of data as health care providers, law enforcement, schools, chambers of commerce, food systems groups, Iowa State University Extension and Outreach, and United Way.

Previous needs assessments conducted by local health, education, and human service agencies or food systems groups may contain information that may be useful. These resources may yield data about the health status of disparate groups in the community not covered elsewhere.

Data gathering should include the following:

- Community Demographics
- Socioeconomic Status
- Access to Health Services
- Health Status of the Population and Disparate Groups
- Conditions Related to the Top Causes of Death
- Infectious Diseases
- Food Systems and Food Security
- Natural Environment
- Social Environment
- Resources/Assets*

* These categories should be included in all assessments. See Assessing & Addressing Community Health Needs, p. 54 www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4

Basic County Health Data Sources

Basic County Data sources generally include data for a variety of categories, such as those listed in the *Health Data by What Public Health Does* section below. For that reason, they may not be referenced in the specific topic area below. Users are encouraged to use the basic sources first, then, use the topic-specific sources to find data that may not be included in the basic sources.

CHNA.org A comprehensive mapping, analytic, and reporting tool for socio-economic factors, demographics, physical environment, and health behaviors showing up-to-date county, state, and national comparison data. www.chna.org/
County Health Rankings Measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income, and teen births in nearly every county in America. www.countyhealthrankings.org/
Iowa County Health Snapshots: The snapshots provide an overview of key health indicators about chronic disease, environmental health, oral health, reproductive outcomes and population. https://tracking.idph.iowa.gov/
Iowa Health Fact Book Disease Incidence and Mortality, Health and Social Behaviors, Health Resources, Health Care Providers, and Environmental Factors www.public-health.uiowa.edu/FACTBOOK
Iowa State Data Center US Census Bureau Data organized by a wide array of topic areas and maps. http://data.iowadatacenter.org/browse/counties.html
US Census Bureau Age, Race/Ethnicity, Housing, Income, Business Facts, Social and Economic Characteristics. http://quickfacts.census.gov/qfd/states/19000.html

Health Data by What Public Health Does

PREVENT INJURIES AND VIOLENCE

Falls in Iowa – Death and Hospitalization Rates https://idph.iowa.gov/falls-prevention
Iowa Kids Count: Child Abuse Statistics www.cfpciowa.org/en/data/kids_count/

PREPARE FOR, RESPOND TO, AND RECOVER FROM PUBLIC HEALTH EMERGENCIES

Iowa Health Fact Book: Health Care Providers, Health Care Facilities, Trauma Care Facilities www.public-health.uiowa.edu/FACTBOOK

PREVENT EPIDEMICS AND THE SPREAD OF DISEASE

***Iowa Surveillance of Notifiable and Other Diseases Annual Report*:** Common Notifiable Diseases by County https://idph.iowa.gov/CADE

STRENGTHEN THE HEALTH INFRASTRUCTURE

Find Health Professional Shortage Areas by State & County: Primary Medical Care, Mental Health, and Dental Care. http://hpsafind.hrsa.gov/
Iowa Health Fact Book: Health Care Providers, Health Care Facilities, Trauma Care Facilities. www.public-health.uiowa.edu/FACTBOOK

PROTECT AGAINST ENVIRONMENTAL HAZARDS

Adult Blood Lead Testing Data https://idph.iowa.gov/Environmental-Health-Services/Occupational-Health-and-Safety-Surveillance/Adult-Blood-Lead-Epidemiology
Environmental Health Profile: Air Quality, Climate, Demographics, Home Hazards, Water Quality https://tracking.idph.iowa.gov/Reports/Environmental-Health-Profile
Iowa Daily Erosion Project Daily estimates of rainfall, runoff, and soil erosion down to the township level http://wepp.mesonet.agron.iastate.edu/
Iowa Department of Natural Resources Impaired Waterways Waters impaired by point sources and non-point sources of pollutants. http://www.iowadnr.gov/Environment/WaterQuality/WaterMonitoring/ImpairedWaters.aspx

PROMOTE HEALTHY LIVING

Cancer: State Health Registry of Iowa Cancer incidence and mortality rates by site, sex and race with trend data. www.cancer-rates.info/ia/
Disability and Health Surveillance Age-adjusted county estimates of health status, behavioral risk factors, access to preventive services and care, and socio-economic outcomes. https://idph.iowa.gov/disability-injury-violence-prevention/disability-health/surveillance
Iowa Barriers to Prenatal Care Project Survey data from women delivering babies in Iowa hospitals. https://idph.iowa.gov/family-health/maternal-health/barriers-project
Iowa Kids Count Child and Family Well-Being Indicator Data. www.cfpciowa.org/en/data/kids_count/
Iowa Youth Survey Survey data from students in 6th, 8th, and 11th grades on social competence, risky behavior, safe and supportive community, secure and supportive school climate, success in school, contribution to the community, bullying, etc. www.iowayouthsurvey.iowa.gov/index.html
Map the Meal Gap: Hunger & Food Insecurity in Your Community Food Insecurity, Additional Money Needed to Meet Meal Needs, Average Cost Per Meal http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx
Poverty and Food Needs, Iowa State University Extension and Outreach County poverty and food needs, food and nutrition assistance participation, food-related health and economic measures. www.icip.iastate.edu/special-reports/poverty
Sexual Health County adolescent sexual health fact sheets from Eyes Open Iowa. https://www.eyesopeniowa.org/data/
US Department of Agriculture (USDA): US Agriculture Census State and county profiles on food and farming (e.g., number of farms, acres in fruit and vegetable production, value of ag products sold directly to individuals for human consumption. www.agcensus.usda.gov/index.php
USDA Food Access Research Atlas Food deserts. www.ers.usda.gov/data-products/food-access-research-atlas.aspx#
USDA Food Environment Atlas Provides a wider set of statistics on food choices, health and well-being, and community characteristics for all communities in the United States than the Food Access Research Atlas. www.ers.usda.gov/data-products/food-environment-atlas/.aspx

ANALYZE COMMUNITY HEALTH ASSETS*

The assets categorized as direct health services, health education and information resources, and ancillary community assets represent key community-based factors important for the health and well-being of everyone in your community.

Instructions: Mark the column that best describes your community's situation. If a service is available to a subset of the population only, please indicate that the service is available but fails to meet needs adequately, and be sure to indicate what this subset of the population is in the comments section. This exercise helps local groups set goals and priorities to improve their health infrastructure.

A. Direct Health Services	Available and meets existing needs	Available but fails to meet needs adequately	Not Available	Comments
Access to primary care (doctor, nurse practitioner, physician assistant) within 20 minutes or 30 miles	☐	☐	☐	
Access to mental /behavioral health care within 20 minutes or 30 miles	☐	☐	☐	
Access to dental care within 20 minutes or 30 miles	☐	☐	☐	
Emergency feeding programs, food pantries, soup kitchens, food shelves	☐	☐	☐	
Food and nutrition assistance programs (SNAP, WIC, CACFP, Summer Feeding, WIC Farmers' Market Nutrition Program, Senior Farmers' Market Nutrition Program)	☐	☐	☐	
Weight management services, including physical activity and nutrition education	☐	☐	☐	
Immunizations for Children and Adults	☐	☐	☐	
Cancer prevention, screening & treatment	☐	☐	☐	
Cardiovascular disease prevention, screening & treatment	☐	☐	☐	
Diabetes prevention, screening & treatment	☐	☐	☐	
STD and HIV/AIDS screening and treatment	☐	☐	☐	
Smoking cessation	☐	☐	☐	
Alcohol and drug abuse prevention and treatment- gender specific and allows women to have young children with them	☐	☐	☐	

ANALYZE COMMUNITY HEALTH ASSETS*

A. Direct Health Services	Available and meets existing needs	Available but fails to meet needs adequately	Not Available	Comments
Shelter and services for victims of abuse, violence, and sexual assault	☐	☐	☐	
Violence & Injury prevention programs	☐	☐	☐	
Prenatal, delivery, and postpartum care (and support)	☐	☐	☐	
Family planning	☐	☐	☐	
Child Preventive Services	☐	☐	☐	
Breastfeeding support	☐	☐	☐	
Protection against environmental hazards	☐	☐	☐	
Prevention of epidemics and the spread of disease	☐	☐	☐	
Preparation for public health emergencies	☐	☐	☐	
Responding to public health emergencies	☐	☐	☐	
Recovering from public health emergencies	☐	☐	☐	
Emergency shelters and services for persons with disabilities	☐	☐	☐	

B. Health Education & Information Resources**	Available and meets existing needs	Available but fails to meet needs adequately	Not Available	Comments
Information about how and where to find needed health care services	☐	☐	☐	
Information related to health maintenance and disease prevention	☐	☐	☐	
Facts about specific diseases, disorders, and conditions	☐	☐	☐	
Information about how to access emergency feeding sites or food and nutrition assistance programs	☐	☐	☐	

ANALYZE COMMUNITY HEALTH ASSETS*

B. Health Education & Information Resources**	Available and meets existing needs	Available but fails to meet needs adequately	Not Available	Comments
Comprehensive and reliable health education for adolescents, including STD and pregnancy prevention	☐	☐	☐	
Centralized coordination to help consumers navigate through health care and health information systems.	☐	☐	☐	

**The health information resources listed should be available via health classes, Internet websites, publications available in a variety of languages and reading levels, phone-in Hotlines, health agency staff, newspapers and newsletters, and/or radio and television programs and public service announcements. Local health fairs and health-education programs sponsored by employers, faith- based organizations and non-profit agencies also add information and raise awareness about health issues.

C. Ancillary Community Assets (Additional Support)	Adequate	Needs Improvement	Inadequate	Comments
Child care and elder care services (including caregiver health)	☐	☐	☐	
Public areas accessible by disabled individuals	☐	☐	☐	
Public policies that discourage discrimination based on sexual orientation	☐	☐	☐	
Racially/ethnically diverse healthcare workforce and services (including racial/ethnic diversity and linguistic/translator services)	☐	☐	☐	
Cultural competency training for local healthcare workforce	☐	☐	☐	
Safe recreational areas, exercise facilities, and a walkable environment	☐	☐	☐	
Healthy food access available at farmers' markets, community supported agriculture farms, community gardens, food retail	☐	☐	☐	
Farm production practices that support individual and environmental health	☐	☐	☐	
Local colleges and universities with open-admission policies	☐	☐	☐	
Emergency care centers available 7 days a week, 24 hours a day	☐	☐	☐	
Responsive public officials and justice system	☐	☐	☐	
Air and water quality within safe limits	☐	☐	☐	
Job training opportunities – gender specific	☐	☐	☐	

ANALYZE COMMUNITY HEALTH ASSETS*

C. Ancillary Community Assets (Additional Support)	Adequate	Needs Improvement	Inadequate	Comments
Access to public transportation	☐	☐	☐	
Bike trails and lanes	☐	☐	☐	
Emergency medical services	☐	☐	☐	
Adequate supply of health providers	☐	☐	☐	

D. Community Building Activities	Adequate	Needs Improvement	Inadequate	Comments
Housing	☐	☐	☐	
Economic development	☐	☐	☐	
Income and income distribution	☐	☐	☐	
Food security and healthy food access	☐	☐	☐	
Early child development	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	

*Adapted from *Women's Health Assessment Toolkit,* The Office on Women's Health

SWOT WORKSHEET

SWOT is an examination of a group's internal strengths and weaknesses, as well as the environment's opportunities and threats. It should be used in the beginning stages of decision-making and strategic planning in light of the vision and mission statements that the planning group has established.

Strengths: What are the community's particular strengths? Do you do something particularly unique? What could be an asset in developing objectives for your plan?

Weaknesses: What is your community lacking? What do others seem to accomplish that you cannot? What could limit your community health planning efforts?

Potential Internal Strengths	Potential Internal Weaknesses
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

SWOT WORKSHEET

Opportunities: What is happening in your community that could provide opportunities?

Threats: What is happening that could pose threats to the process or your goals?

Potential External Opportunities	Potential External Threats
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

STEP 5: ANALYZE THE DATA AND DEVELOP A CHNA SUMMARY

In analyzing the data for setting priority needs, it may be helpful to compare one county with another, assess how a county has progressed over time, select indicators related to state and national benchmarks, and pay attention to such influences as race/ethnicity, education, child care, income, and housing. Following are suggested data sources for conducting this analysis:

Comparisons

- *CHNA.org* is designed to assist hospitals, non-profit community-based organizations, and local public health agencies and other key stakeholders in understanding the needs and assets of their communities. County, state and national data are compared for social and economic factors, demographics, the physical environment and health behaviors. Visit www.chna.org/ to learn more.
- In the *County Health Rankings & Roadmaps Report*, counties are ranked by measures reflecting aspects of health that can be improved and are available for all 3,141 counties. The report ranks counties according to their summary measures of health outcomes and health factors. Counties also are ranked by mortality, morbidity, health behaviors, clinical care, social and economic factors, and the physical environment. It should be noted that population size and other characteristics and other socio-economic differences are not considered in the ranking. The report offers an enhanced peer-county comparison tool with a list of counties that are similar in key demographics and social and economic indicators. Visit www.countyhealthrankings.org to learn more.

Trends

- Data sources published regularly can help answer the question about whether or not a county is improving over time.

Examples of data sources that publish the same data for more than one year include:

CHNA.org: www.chna.org/
County Health Rankings: www.countyhealthrankings.org/
Iowa County Health Snapshots: https://tracking.idph.iowa.gov/Reports/Health-Snapshots
Iowa Health Fact Book: www.public-health.uiowa.edu/FACTBOOK

Benchmarks

- Benchmarks are standards against which a county can assess needs requiring improvement. National benchmarks are available in *Healthy People 2020* topics and objectives: www.healthypeople.gov./2020/topicsobjectives2020/default
- *Healthy Iowans: Iowa's Health Improvement Plan 2017-2021* contains baseline data and targets for Iowa's top health issues: https://idph.iowa.gov/healthy-iowans

Socio-Economic Determinants of Health

Efforts to address the socio-economic determinants of health—factors like poverty, education and employment—have a great impact on health (see A Framework for Public Health Action in Step 8 of the complete guide.) Therefore, in making an assessment, it is crucial that quantitative and qualitative data are used in assessing these factors. Qualitative data can be gathered from local sources and community agencies. For quantitative data, see Basic County Health Data Sources in Step 4 of the complete guide.

STEP 5: ANALYZE THE DATA AND DEVELOP A CHNA SUMMARY

Draft a Community Health Status Needs Assessment (CHNA) Summary

A summary report of the needs assessment includes the following:

- ☐ Description of the community being assessed
- ☐ Description of the assessment process, including how the data were analyzed
- ☐ Summary of the data and analysis/trends
- ☐ Description of problems/needs/assets identified

IRS requirements for non-profit 501(c)(3) community hospitals in their written (CHNA) report*

- ☐ A description of the community served by the hospital
- ☐ A description of the process and methods used to conduct the assessment
- ☐ A description of how the hospital took into account input from persons who represent the broad interests of the community served by the hospital including a public health agency and special population groups
- ☐ A prioritized description of all of the community health needs and the process of identifying health priorities
- ☐ A description of the potential resources and measures to address the priorities
- ☐ Wide availability of the report to the public
- ☐ An evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital's prior CHNA(s)

*See IRS Schedule H (Form 990) https://www.irs.gov/pub/irs-pdf/f990sh.pdf

PHAB requirements for accreditation, Measure 1.1.2 T/L, are the following:

- ☐ Data and information from various sources that contributed to the community health assessment and how the data were obtained
- ☐ Demographics of the population
- ☐ Description of health issues and specific descriptions of population groups with particular health issues and inequities
- ☐ Description of factors that contribute to specific populations' health challenges
- ☐ Description of existing Tribal or community or assets or resources to address health issues

STEP 6: REVIEW FACTORS IMPORTANT FOR HEALTH AND WELL-BEING (SETTING PRIORITIES)

Determining health priorities helps direct resources to the areas that matter most to community partners and that will have the greatest impact on community health status. With so many competing needs, selecting priorities and establishing goals and strategies may seem like an arduous task. When well publicized, documented, and endorsed by communities, a sound priority-setting process helps achieve widespread support for the plan.

Understanding the Dimensions of the Problem

Use the following questions to open the discussion of the problem:

- What are the compelling reasons for people to be concerned about the problem?
- How can the problem be documented with supporting data?
- What interventions are effective in solving the problem?
- Why is common action important?
- Who needs to be involved in the action?
- What system do we have in place now to prevent the problem and promote health?
- What stages within the health system need to be mobilized? (For example, health promotion, disease prevention, acute treatment, aftercare)
- What health disparity and quality of life issues need to be considered?
- What will happen if the problem is not addressed? What are the societal costs?

Assessing Needs to Set Priorities

When assessing needs, consider the following:

- Prevalence (the number or proportion of cases or events or conditions in a given population)
- Frequency (the number of times an event occurs within a stated period of time)
- Incidence rate (a measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time)
- Seriousness
- High-risk exposure or environmental conditions
- Urgency
- Survival rate after exposure
- Case fatality rate
- Direct impact on others (likely or not and to what degree)
- Comparative risk information
- Any other information to demonstrate the importance of the problem
- Severity of disability/disease

PRIORITY SETTING WORKSHEET

A tool as simple as a questionnaire completed by partners will help clarify priorities and potential strategies. As an initial step after reviewing needs assessment data, ask members of the planning group to describe the three most important health areas of concern for the community in the next five years. For each issue, list the primary goal and the primary strategy that has been or could be used to approach it. After consensus on the priorities has been achieved, consider this input in ranking potential goals and issues to address.

Issue #1:

Primary Goal:

Strategy:

Issue #2:

Primary Goal:

Strategy:

Issue #3:

Primary Goal:

Strategy:

STEP 7: DOCUMENT KEY POINTS OF STAKEHOLDER DISCUSSION & INVITE BROAD COMMUNITY INPUT

Broad community input is essential to the health assessment process. It can validate the draft needs assessment, strengthen community support or buy-in, and lead to identification of issues unique to special population groups. Community meetings, presentations to organizations, and press releases are standard approaches for engaging the community along with website postings and use of social media. An example of how one community validated its needs assessment process follows:

> St. L hosted a community forum to validate priorities. It identified 12 health problems in the community, based on CDC and county health ranking data. Each problem was listed on a poster board. Forum participants, representing a broad spectrum of the community and health and social service providers were given "sticky notes" on which they wrote their names and contact information.
>
> After a brief presentation about each of the identified problems, there was a general discussion, which resulted in adding two more problems that were also posted. Participants were asked to vote with their sticky notes for community problems they believed were most important.
>
> It soon became clear which problems were priorities for the forum attendees. The hospital also had a list of people and organizations interested in working on priority issues through the contact information on their sticky notes.
>
> --Catholic Health Association of the United States
> *Assessing and Addressing Community Health Needs*
> Discussion Draft: Revised February 2012, p. 71

Conflicting views on what issues are critical to a community's health can be expected to emerge. Although difficult, this situation demonstrates that participants are sufficiently concerned about their community's health to raise questions. Suggestions for managing the conflicts are excerpted from *Assessing and Addressing Community Health Needs* (p. 70) and include:

- Addressing the community's concern first, building trust and buy-in from community members.
- Embarking on an educational campaign to raise awareness of the priority needs.
- Addressing both needs, the problem clearly identified by public health data and the problem identified by community members.
- A skilled facilitator to help participants come to a common understanding and recognize that there may be different priorities, but that all are valid and require different strategies.

STAKEHOLDER MEETING RECORD WORKSHEET*

Part 1: A Model Stakeholders' Meeting Record * Instead of taking notes, this meeting record format may be used like a template and a convenient option to meeting minutes. It can be used to document stakeholder input and discussion. Take notes on Part 2, focusing on main ideas with the topics discussed, and then complete 2, 3 and 4 on Part 1.

Meeting: _____ Date: _____ Location: _____

1. Participants and Agency/Organization Represented

_____

_____

_____

_____

_____

_____

_____

_____

2. Agenda: Enter key words indicating the agenda topics. Check off an item when it is completed. Items you do not complete should be carried over to the next meeting.
   (1) Warm-up
   (2) Agenda Review
   (3)
   (4)
   (5) Set Agenda for the Next Meeting
   (6) Meeting Review

3. Brief summary of topics, decisions, or conclusions and next steps.

4. Futures File: items for future consideration but not for the next meeting.

5. Meeting Review

<u>Next Meeting</u>

Date: _____ Time: _____ Location: _____

Note Taker: _____

STAKEHOLDER MEETING RECORD WORKSHEET*

Part 2: A Model Stakeholders' Meeting Record* Take notes during the meeting on a page like this. Summarize the discussion whenever possible and then complete items 2, 3 and 4 in Part 1.

Topic 1: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

Topic 2: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

Topic 3: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

Topic 4: (brief description) Main Points:

Decisions/Conclusions:

Next Steps:

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*Adapted from Peter R. Scholtes, *The Team Handbook*

STEP 8: DEVELOP THE ACTION PLAN [HEALTH IMPROVEMENT PLAN (HIP)]

COMPONENTS

A written summary of the health improvement plan includes the following:

- ☐ A description of the community
- ☐ Vision and clearly articulated mission to address community needs
- ☐ Leadership commitment to improving community health
- ☐ Target areas and service to vulnerable populations
- ☐ A description of how the plan was developed and adopted
- ☐ What groups were involved in crafting the plan
- ☐ The major health needs and how the priorities were determined
- ☐ What the lead organization and collaborating groups will do to address the community health needs (goals, objectives, strategies, and indicators)
- ☐ The resources, including collaborative efforts, that will be used to implement and sustain the plan
- ☐ How and when the plan will be evaluated

IRS requirements for non-profit 501(c)(3) community hospitals' implementation strategy*

- ☐ A strategy to meet community needs identified in the CHNA and a plan to evaluate impact
- ☐ A description of how the hospital plans to commit programs and resources to address the health need(s)
- ☐ Identified needs that are not addressed and rationale for not addressing them
- ☐ Governing board approval of the implementation strategy
- ☐ Updated implementation strategy based on changes in community health status at least every three years

*A final rule allows an additional 4.5 months after the CHNA is completed for the implementation strategy (to match the due date, without extensions, of the hospital's Form 990. See IRS Schedule H (Form 990) www.irs.gov/pub/irs-pdf/f990sh.pdf.

PHAB requirements in Measure 5.2.2 L for a health improvement plan:

- ☐ Desired measurable outcomes or indicators of health improvement and priorities for action
- ☐ Policy changes needed to accomplish health objectives
- ☐ Individuals and organizations that have accepted responsibility for implementing strategies
- ☐ Consideration of state and national priorities

RESOURCES

- The National Association of City and County Health Officials (NACCHO) has some excellent resources on community health assessment and planning models: www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm
- The Healthy People 2020 website contains Map-It, an easy-to-follow model: www.healthypeople.gov/2020/tools-and-resources/Program-Planning
- A publication especially designed to help hospitals improve the health of their communities through community benefits programs is *Assessing & Addressing Community Health Needs* developed by the Catholic Health Association of the United States in cooperation with VHA Inc. and the Healthy Communities Institute: https://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4

IDENTIFY GOALS, OBJECTIVES, AND STRATEGIES

Goals, objectives and strategies are the outline of what needs to be done to address the needs/problems. In setting goals, objectives, and strategies, consider these questions:

- What are the expected outcomes?
- What are the cost and time to accomplish the goals and take action?
- Is there any research demonstrating that interventions are effective?
- What agency or group is willing to assume responsibility for achieving the goal or taking action?
- Are there baseline data so the goals and strategies can be tracked?
- What kind of communication in social marketing strategies as well as in technology will be needed to reach the goals of taking action?
- To ensure a broad-based document, identify the targeted populations and the channels for reaching them. Are there populations experiencing disparities in health status?

GOALS are the end toward which the efforts are directed. They are to be achieved over a long-term period of years.

OBJECTIVES are short-term goals to describe how much change is sought, of what kind, and by whom. They should fit the following criteria: (S.M.A.R.T.+C)

Specific: Are they specific? What is to be achieved? Who is expected to change, by how much and by when?

Measurable: Can data/information be collected, detected or obtained from records? Is there a baseline indicator?

Achievable: Can they really be met? Are they realistic?

Relevant: Are they relevant to the mission or vision of your group? Do they show what the group hopes to accomplish and why?

Timed/Timely: Do they include a timeline by which they will be achieved?

+Challenging: Do they stretch the group to set its aims on significant improvement of importance to the community?

STRATEGIES/ACTION STEPS provide the details on how to achieve the objectives and answer the questions: How do we get there from here? What agency or group is responsible for carrying out the strategy? A good strategy takes into account existing barriers and resources (e.g., people, money, power, materials).

EXAMPLE 1

Goal: By 2021, reduce bullying among students in county Y.

Objective: Reduce the percentage of county Y students in grades 6, 8 and 11 who have experienced bullying on school property from 50% in 2010 to 40% by 2021.

Strategy: By 2019, develop and enforce a policy that places sanctions on students engaging in bullying.

EXAMPLE 2

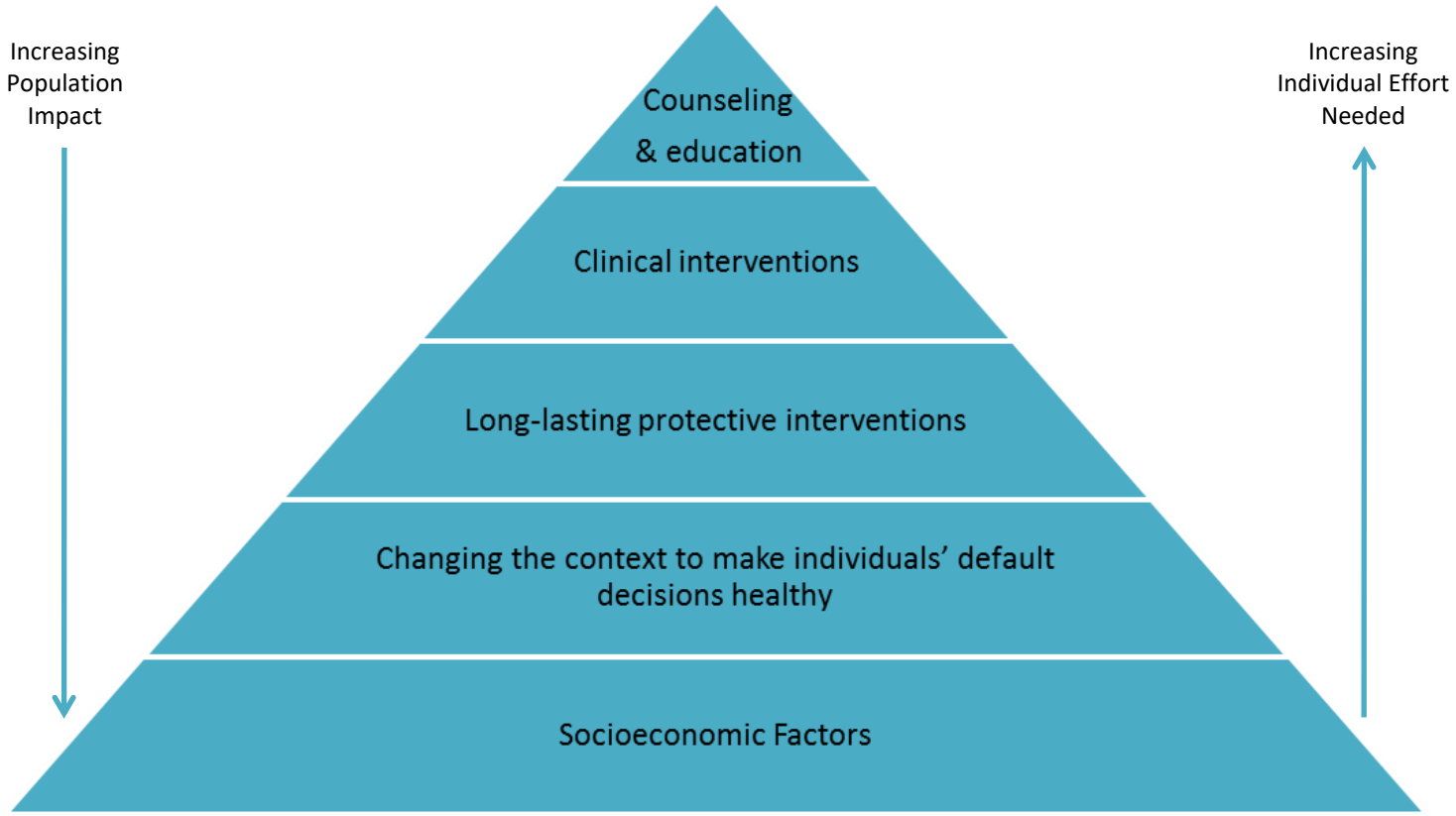
Goal: By 2021, reduce sexual violence among students in county Y.

Objective: By 2021, reduce by 10% the percentage of 11th grade students in county Y who report being physically forced to have sexual intercourse.

Strategy: By 2019, increase by 20% the number of 11th grade students in county Y participating in comprehensive community sexual violence prevention programming.

A Framework for Public Health Action

What efforts have the greatest impact for improving health? A framework for public health action[1] can be depicted by a five-tier pyramid. At the base with the greatest impact are efforts to address socio-economic determinants of health, factors such as education, childcare, income, housing, race/ethnicity and neighborhood conditions. In ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that confer long-term protection, ongoing direct clinical care, and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort. Implementing interventions at each of the levels can achieve the maximum possible sustained public benefit.



[1] Thomas R. Frieden, MD, MPH. A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health.2010; 100: p. 590-595.

Recommended Reading: Cohen L., Swift S. The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1730534/pdf/v005p00203.pdf
This article by Larry Cohen and Susan Swift provides a workable tool for moving beyond an educational approach to achieve goals through strategies that include policy development.

STEP 9: IMPLEMENT, TRACK PROGRESS, & SUSTAIN THE PROCESS

Once the action plan is established, the stakeholders or partners can begin to implement the strategies and action steps set forth in the plan. Everyone who has accepted responsibility for specific tasks will need to complete those tasks in a timely manner, consistent with the schedule agreed upon in the action plan. This part of the process is helped by having a diversified and cooperative group of community leaders who share the same vision. For example, having the school superintendent as an advisor and supporter of the healthy community initiative could make it easier to implement proposed actions in the schools.

Another key to implementation is monitoring or routine tracking of events. For example, if your action plans call for monthly reports to be created by a given group on a set topic, monitoring will let you know that this indeed, is occurring. A good monitoring system will help you understand if the action plan is being implemented as anticipated. Also, remember that it is best to plan how to monitor an initiative before the initiative has begun. Remember, bringing about change may take weeks, months or years.

Tracking is a two-part step. First, you will need to analyze or evaluate the data you have collected. Then you will need to report the progress. As the implementation of your action plan moves forward, it is important to inform the community of the progress being achieved. You can hold meetings or progress reviews to communicate progress being made in your community. Reporting at regular board of health meetings can highlight progress for advancing community health.

Evaluation and tracking are vital to the long-term success of your stakeholders' efforts. If you cannot document the health promotion and disease prevention efforts, you may not be able to determine if the adopted strategies improve your community's health concerns. One convenient way to handle this step is to hold regularly scheduled meetings in which everyone reports on actions taken, no matter how small. This type of ongoing support can keep stakeholders interested and involved in the mission. It is important to celebrate small successes along the way to your goal. Your stakeholders will be more likely to stay involved if they can see that their efforts not only are making a difference, but also are appreciated.

Using the local media—school or community papers, television, radio, websites, newsletters, social media —can be an effective way of letting the community know about your efforts.

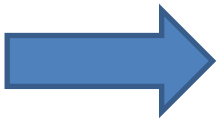
STEP 10: ESTABLISH & IMPLEMENT A COMMUNICATION PLAN

A communication plan clarifies how the community can share the vision with others, promote the **published** needs assessment and health improvement plan, and "make things happen." To develop goals and objectives, planners must determine priority audiences, desired results, key messages, strategies and tactics, and partners.

To identify your PRIORITY AUDIENCES, ask the team…

Whose opinions or actions are most important to the success of the CHNA & HIP process and the implementation of goals and strategies?

Next



Identify potential target audiences and choose two to three of most importance.

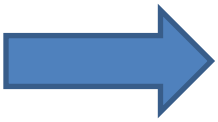
Sample Target Audiences for Communication Plans

- ✓ Policymakers, including elected officials
- ✓ Private sector health organizations, including managed care organizations
- ✓ Private sector employers
- ✓ Medical societies and other health professional associations
- ✓ School and education leaders
- ✓ State voluntary organizations with local affiliates
- ✓ Public health leaders and program managers
- ✓ Front-line public health and hospital staff
- ✓ Grass roots groups with the capacity to address health objectives
- ✓ Potential community advocates for priorities

To determine your DESIRED RESULTS, ask the team…

What do you want each target audience to do or believe?

Then



Be specific! The final plan and marketing materials should be designed, either explicitly or subtly, to achieve the desired outcome.

STEP 10: ESTABLISH & IMPLEMENT A COMMUNICATION PLAN

To identify your KEY MESSAGES, ask the team… For each audience, what are the main messages to communicate?

Things to consider when developing messages…
Perhaps your main message is that this is a "people's plan," a call to action, or a measure of the current path to success. Whatever your message, be sure to identify key words and phrases that support it. If your market research has identified that your target population responds favorably to "milestones," "action plans," and "steps to success" but turns off when they hear "objectives" or "benchmarks" or "social determinants," include the preferred words in your key messages. Remember to be consistent with vocabulary. Key messages should be reinforced in all communications about the plan, including slogans, conference presentations, press releases, and executive summaries.

When developing COMMUNICATION STRATEGIES AND TACTICS, ask the team… How will you reach each audience?

REMEMBER: Strategies describe your general communication approach. For some audiences and purposes, the best strategy may be to blanket the audience with messages about the plan in a short time period. For others, your strategy might be to selectively promote the plan in connection with timely events (e.g., budget hearings) over several years. Assess the communication environment of the target audience. The way to reach policy makers may be through their staff or targeted newsletters, whereas the way to reach leadership may be through an annual conference or posters at work. List the marketing strategies with a budget in mind. However, a longer menu of marketing options can help identify communication opportunities and resources in the future.

Finally, when identifying your COMMUNICATION PARTNERS, ask the team… Who can help us reach our audience?

Tip:
General media, special interest media, advocacy organizations, public relations offices, health education units, graphics departments, private health care organizations and professional organizations with newsletters or web sites may be excellent partners.

STEP 11: EVALUATE GOALS, OBJECTIVES, STRATEGIES & THE COMMUNICATION PLAN

An annual evaluation of your goals and strategies is an essential part of the needs assessment and health improvement planning process. The final IRS regulations for tax-exempt hospitals require an evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital's prior CHNA(s).

Using an established method for evaluating your goals and strategies with additional data, you can track the progress in improving the health status of everyone in your county. **The evaluation does not have to be complex**; it can be as simple as asking a few basic process and outcome questions. The questions can be used to guide your annual evaluation of the public health goals your community selected as a priority.

PROCESS

- Did we implement the strategies identified in our health improvement plan as we intended (as outlined in our plan) during the year?
- If not, what strategies were used that were different from the original plan?
- Why were different strategies used from those identified in the original plan?
- Are there additional data available to describe the health of the community as well as special population groups? (See PHAB Measure 1.1.2 T/L required documentation #3).

OUTCOME

- Formative or Process Evaluation: What progress has been made this year to help reach the long-term goal(s)? Are there any changes/revisions needed to the plan?
- Long-Term Impact: What overall progress has been made to reach the long-term goal(s)? What was the baseline at the start of the timeframe (baseline data)? What are the data at the end of the most current year?

CHANGES/REVISIONS

- Is the logic behind our plan sound or does it need to be revisited?
- What strategies could be implemented to help meet our long-term goals?
- What other changes need to be made to help meet our goals?

RESOURCES

For more detailed information on evaluation, see

- *Community Toolbox*, University of Kansas, Chapter 36: Introduction to Evaluation at http://ctb.ku.edu/en/table-of-contents/evaluate/evaluation
- *Principles of Community Engagement*, Second Edition, Chapter 7: Program Evaluation and Evaluating Community Engagement at www.atsdr.cdc.gov/communityengagement/pce_program_background.html