IPLAN Workbook

Illinois Project for Local Assessments of Needs (IPLAN)

A Workbook for Local Public Health Department
Administrators, IPLAN Leaders, and Community Participants

IDPH
Illinois Department of Public Health

Illinois
Public Health
Institute

Table of Contents

How to Use This Workbook

About This Workbook

This workbook serves as an update to the original Illinois Project for Local Assessment of Needs (IPLAN) Workbook developed in 2006. This online version is reorganized according to the IPLAN requirements, with links to tools and resources that may be periodically updated as new resources become available.

Understanding IPLAN

The workbook begins with an overview of IPLAN based on the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards and a brief history of the evolution of IPLAN.

Resources & Compliance Tools

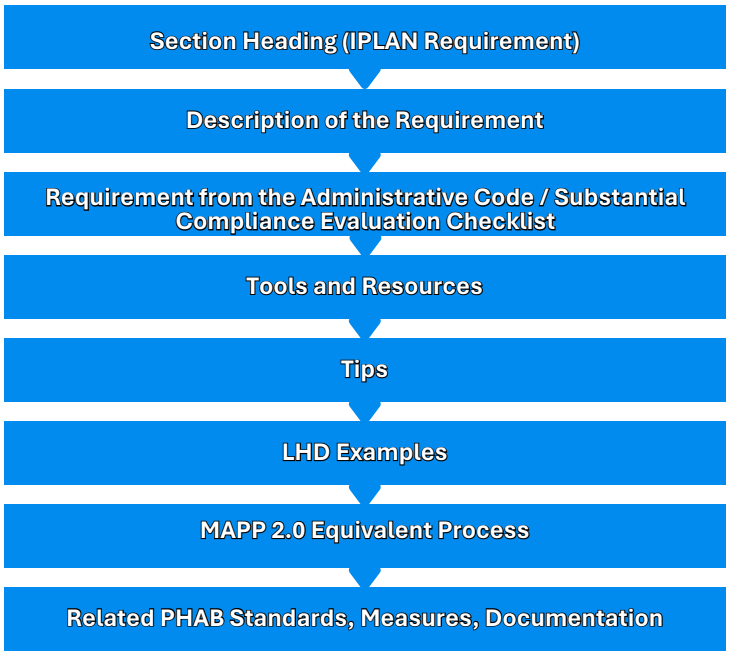
The Illinois Department of Public Health has developed a variety of resources to support local health departments with the IPLAN process on both the IPLAN and IQuery websites. The Substantial Compliance Evaluation is a tool LHDs should use to ensure that their IPLAN includes all of the required components.

Workbook Structure

This workbook is organized by the IPLAN requirements and the Substantial Compliance Evaluation with content from the Assessment Protocol for Excellence in Public Health (APEX-PH), which the IPLAN process was based on, and a variety of other tools and resources commonly used when conducting community health assessment and improvement planning. Relevant APEX-PH content and guidance is included in the workbook, and relevant worksheets are replicated in the Appendix for LHD use. The Appendix includes many useful resources, worksheets, and reference documents, including an acronym list in Appendix A and a glossary of terms found in the workbook in Appendix B.

Section Navigation

Each section in this workbook corresponds to a required IPLAN component and includes content on "how" to meet the requirement, tools and resources to use, LHD examples, and tips. In addition, each section also provides a brief explanation of the MAPP 2.0 equivalent and any related Public Health Accreditation Board (PHAB) requirements. See the site map to the right for the layout of each section.



We hope LHDs find this workbook helpful in conducting the IPLAN process, and we welcome feedback to help us continually improve the resource. Feedback may be submitted to dph.iplan@illinois.gov.

IPLAN Overview

The Illinois Project for Local Assessment of Needs (IPLAN) is a Community Health Needs Assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. Based on the Assessment Protocol for Excellence in Public Health (APEX-PH) model, IPLAN is grounded in the core functions of public health and addresses public health practice standards. The completion of IPLAN fulfills most of the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards.

See the full Administrative Code.

The essential elements of IPLAN are:

- **an organizational capacity assessment**
- **a Community Health Needs Assessment**
- **a Community Health Plan, focusing on a minimum of three priority health problems**

Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards requires local health departments (LHDs) to complete the three components of IPLAN every five years. LHDs are required to submit the Community Health Needs Assessment (CHNA) and Community Health Plan to the Illinois Department of Public Health (IDPH). Submission of the organizational capacity assessment to IDPH is optional but highly recommended. The LHD administrator must provide documentation that the assessment or an organizational strategic plan has been completed and reviewed by the LHD governing body.

History of IPLAN

IPLAN was developed in 1992 by IDPH, in collaboration with LHDs and other Illinois public health system partners, to meet the requirements set forth in the Illinois Administrative Code, Section 600 - Certified Local Health Department Code.

Certification characterizes local health departments as performing core functions of public health, assessment, policy development, and assurance within their jurisdiction. The certification serves as a differentiation between local health departments and other public health providers in the area. It is a unique qualification in Illinois, allowing for public health services to be administered by a local health department, which is in the best interest of the public.

According to the Centers for Disease Control and Prevention, “benefits [of completing a CHA/CHIP] include:

- Improved organizational and community coordination and collaboration
- Increased knowledge about public health and the interconnectedness of activities
- Strengthened partnerships within state and local public health systems
- Identified strengths and weaknesses to address in quality improvement efforts
- Baselines on performance to use in preparing for accreditation
- Benchmarks for public health practice improvements

(CDC - CHA/CHIP Benefits, 2025)”

IPLAN Overview

History of IPLAN (Continued)

All of the benefits described on page 2, including IDPH certification and PHAB accreditation, translate to the scale of national public health.

IDPH certification demonstrates the LHD's commitment to providing core public health functions. Certification is also a requirement for Local Health Protection Grant funding.

IPLAN is a series of planning activities conducted within the LHD jurisdiction. This workbook is dedicated to defining the series of planning activities, which include a Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP), and an organizational self-assessment.

Certified LHDs in Illinois have engaged in this planning process every five years since 1994. In 2002, a work group of LHD representatives and IDPH staff recommended staggering recertification dates for the current and future cycles of IPLAN. The IDPH IPLAN Administrator maintains the schedule for the IPLAN cycles. For more information, please see the section on the IPLAN application on page 6 and in Appendix C.

APEX-PH Introduction and Evolution of the Work

The IPLAN process is fundamentally based on the Assessment Protocol for Excellence in Public Health (APEX-PH). APEX-PH has been a widely used planning process for LHDs that desire to assess and enhance their organizational capacity and strengthen their leadership role in the community. Developed through a collaborative effort involving the American Public Health Association (APHA), the Association of Schools of Public Health, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the CDC, it was released by NACCHO and the CDC in 1991. While the APEX-PH model is no longer supported online, the process and its components still provide a foundation to conduct a Community Health Needs Assessment, Community Health Improvement Plan, and organizational capacity assessment.

Many local health departments in Illinois use the IPLAN (APEX-PH-based) process. However, according to Section 600.410 (b) of the Certified Local Health Department Code, an "equivalent" process for recertification that meets other code requirements may be used by the LHD. Upon written request from IDPH, processes like Mobilizing for Action through Planning and Partnership (MAPP, NACCHO) may be considered equivalent to the IPLAN process. For more information on the equivalent planning processes, such as MAPP, please refer to page 9.

The Public Health Accreditation Board (PHAB) is the accrediting body to advance "standards of excellence and accountability for the systems that promote and protect the health of all people." (PHAB, 2022) PHAB serves as the initial accreditation and reaccreditation body for governmental public health across the country. Local health departments can pursue PHAB accreditation, but they must meet the initial requirements to do so. PHAB-accredited LHDs are also required to complete a CHNA/CHIP process and organizational strategic plan every five years. PHAB accreditation is optional. LHDs may choose to pursue PHAB accreditation in addition to maintaining their Illinois Local Health Department Certification through the IDPH. See Appendix D for more information on PHAB standards and measures related to the CHA and CHIP, similar to IPLAN.

In April 2024, IDPH Director Dr. Sameer Vohra announced an initiative aimed to strengthen the state's public health system and address complex health challenges during the Illinois Public Health Workforce Transformation Initiative Kick-Off Meeting. The initiative, funded by the CDC Public Health Infrastructure Grant, is being led by IDPH, the University of Illinois Chicago School of Public Health, local health department associations, and the Illinois Public Health Association.

Illinois Public Health Practice Standards

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER I: LOCAL HEALTH DEPARTMENTS
PART 600 CERTIFIED LOCAL HEALTH DEPARTMENT CODE
SECTION 600.400 PUBLIC HEALTH PRACTICE STANDARDS

Section 600.400 of the Certified Local Health Department Code provides in detail the Public Health Practice Standards for certified health departments. This section of the code begins to describe what is required for the successful completion of an IPLAN process. The following points summarize the Public Health Practice Standards embedded in the Illinois Administrative Code:

a) Assess the health needs of the community

b) Investigate the occurrence of adverse health effects

c) Advocate for public health

d) Develop plans and policies to address priority health needs

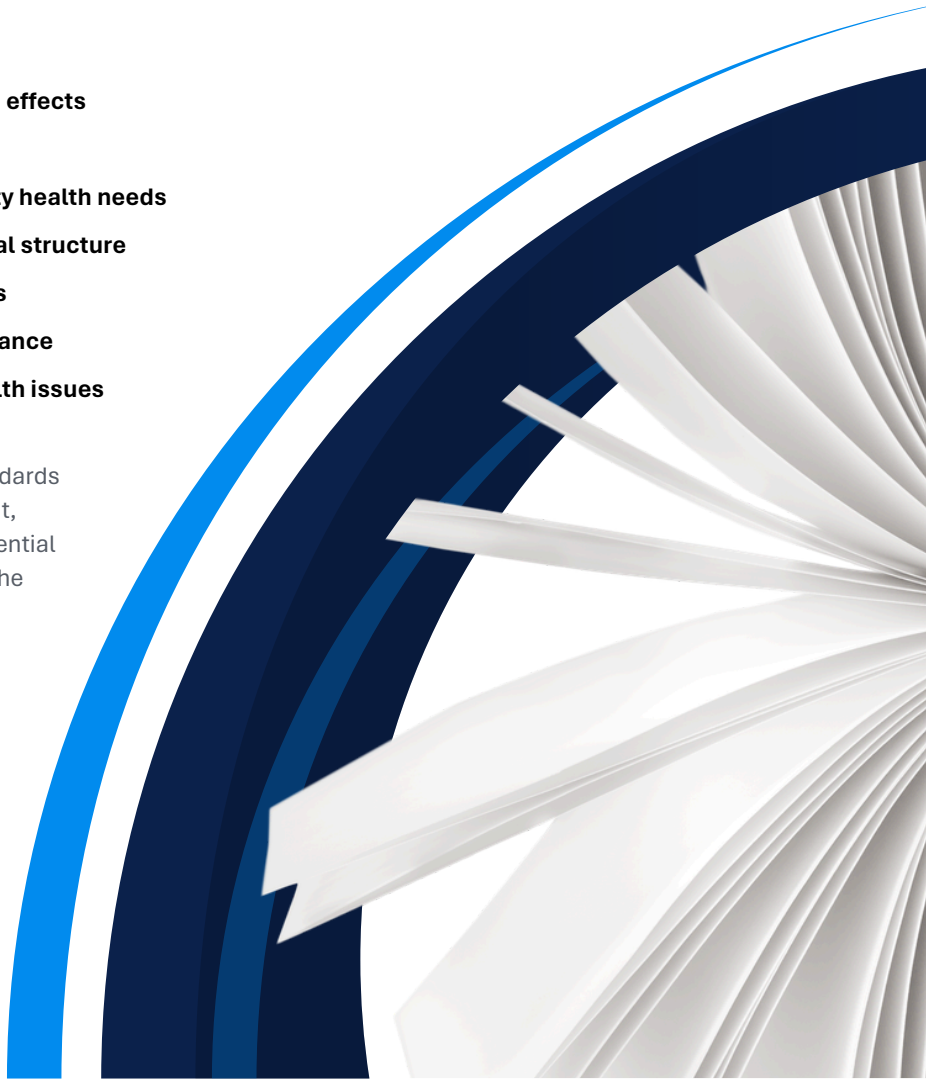
e) Manage resources and develop organizational structure

f) Implement programs and other arrangements

g) Evaluate programs and provide quality assurance

h) Inform and educate the public on public health issues

Please note the similarities of these practice standards to the core functions of public health (Assessment, Policy Development, and Assurance) and the Essential Public Health Services Framework described on the following page.



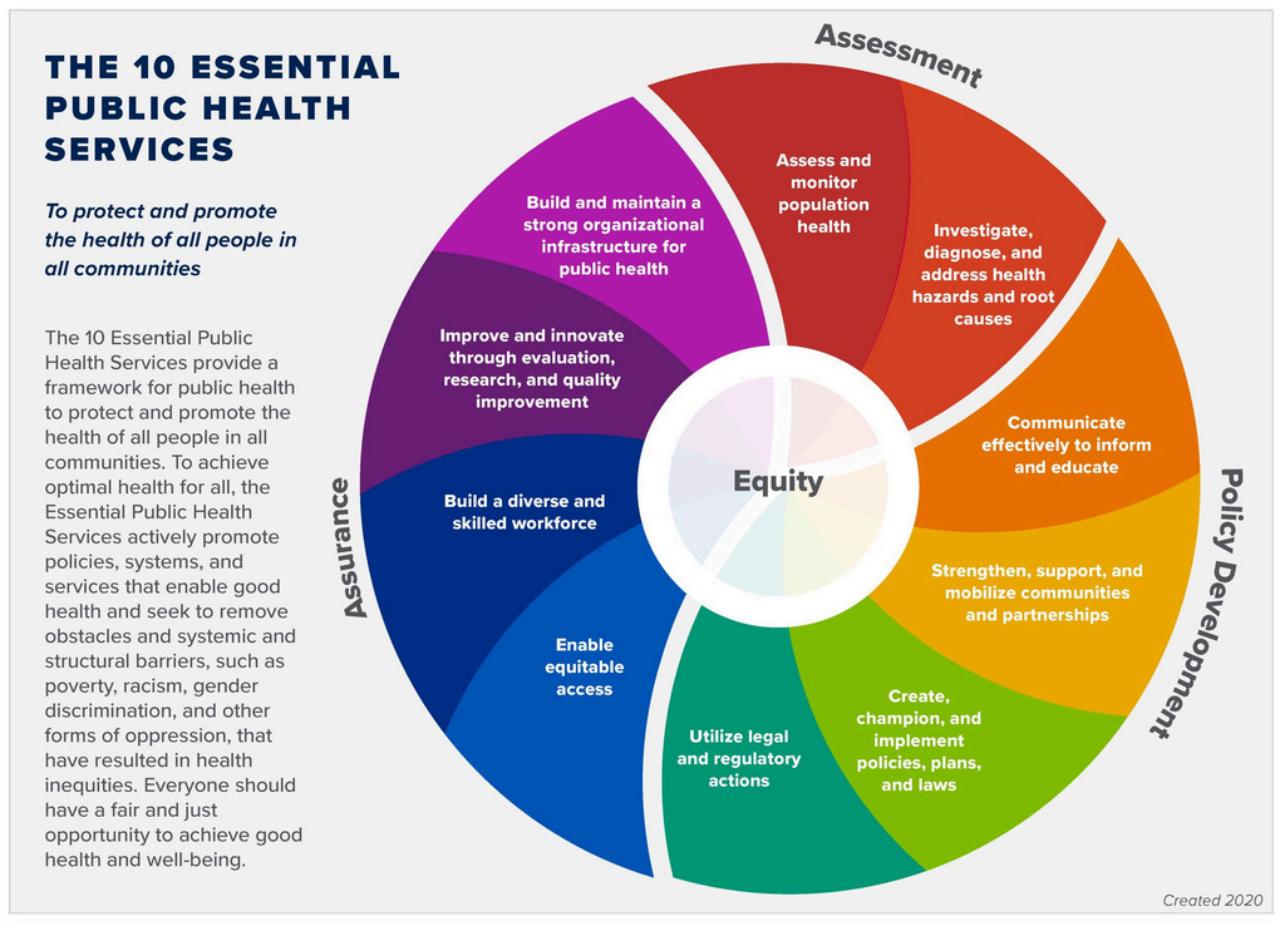
Illinois Public Health Practice Standards

The 10 Essential Public Health Services

The 10 Essential Public Health Services (EPHS) describe the public health activities that all communities should undertake. Originally released in 1994, the framework is well-recognized for describing the mission of public health with services related to the core functions of public health.

The EPHS, created by the public health field and for the field, were updated and released in 2020 by the de Beaumont Foundation, PHAB, and a task force of public health experts. The revised version centers equity and is intended to align with current and future public health practice.

To achieve equity, the EPHS actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. (Public Health Infrastructure Center, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/infrastructure/index.html)



IDPH Certification Requirements

Local health departments (LHDs) shall recertify every five years.

Applications shall be made 60 days prior to expiration.

Per 600.210(c)(1), Submission of Recertification Application (IPLAN) is requested from IDPH at least 60 days prior to the LHD's certification date. There are two important dates for the LHD to keep in mind:

1. Submission of Recertification Application (Appendix C) - 60 calendar days before the certification expiration date.
2. Certification expiration date (Found on your current certificate)

Examples of dates for IPLAN certification:

Current Certification Period	IPLAN Due Date	Certification Expiration Date
2/26/2022 – 2/25/2027	12/27/2026	2/25/2027
7/1/2023 – 6/30/2028	5/1/2028	6/30/2028
10/28/2024 – 10/27/2029	8/28/2029	10/27/2029

Above are three examples of a current certification period and the expiration date (which is the last date of the current period). No matter the date within the month of the certification period, the submission needs to be 60 calendar days before the certification expiration date.

If there is uncertainty of the IPLAN due date, please contact DPH.IPLAN@illinois.gov

IDPH grants LHD certification for a period of five years. Some conditions or circumstances beyond the control of a local health LHD may delay the successful completion of an IPLAN process.

Per 600.210(d) of the Certified Local Health Department Code, if a delay in the process is needed, a LHD may request a temporary waiver of six months and up to three extensions of six months each to extend certification.

If an extension is needed, LHD administrators should send a formal notice on LHD letterhead stating the reason(s) a request is necessary to DPH.IPLAN@Illinois.gov. The notice should be dated, addressed to the IDPH IPLAN Administrator, and signed by the LHD Public Health Administrator.

IDPH Certification Requirements

IPLAN Submission Requirements

LHDs are required to include the following IPLAN submission checklist to be submitted to IPLAN Administrator at DPH.IPLAN@Illinois.gov.

1. Certification Application via LHD Certification Application (also see Appendix C)
2. Electronic version of IPLAN (Community Health Needs Assessment and Community Health Improvement Plan)
    a. IPLAN must include page numbers and table of contents
    b. Board of Health (BOH) approval letter, signed and dated by a BOH president or representative, of:
        i. The IPLAN approval (see Appendix E for example)
        ii. A letter stating that the BOH has seen the Organizational Self-Assessment Plan
        iii. Both of these BOH approval documents can be combined in one letter.
    c. LHDs should keep the organizational Self-Assessment Plan for their records, IDPH does not require a copy
3. IPLAN substantial compliance evaluation (also see Appendix G)
    a. LHD completes
        i. LHD Name (on first page)
        ii. Health Priorities (on first and as applicable for pages 3-6)
        iii. Page numbers for substantial compliance review (if there is something missing, LHD will provide comments to explain, for example, data is not available)
4. Applicable new Personnel Information Form (PIF) i.e., change in personnel (also see Appendix J)
5. Any applicable LHD change requests to the LHD directory, such as name changes, contact information, or updates. LHDs should send a formal notice, with justification for the need, written on official letterhead, signed, dated, and addressed to IPLAN Administrator at DPH.IPLAN@Illinois.gov.

LHDs can also find an introduction to the Regional Health Officers in Appendix I.

IDPH Certification Requirements

Documents Needed for IPLAN Application

The application for recertification includes the documents prepared by the local health department (LHD), based on their completion of the IPLAN process.

1. Community Health Needs Assessment (CHNA)
2. Community Health Plan or Community Health Improvement Plan (CHIP)
3. Organizational Capacity Self-Assessment or Organizational Strategic Plan. See below for more information.

In accordance with Subpart B and Subpart D of the Certified Local Health Department Code, a letter from the LHD administrator attesting to the completion and board review of the organizational capacity assessment may be completed in the following ways:

A. Organizational Capacity Self-Assessment (using the APEX-PH assessment tool provided in Appendix M)

or B. Documentation of organizational strategic planning process

The LHD may choose either method to complete the requirement. The organizational capacity assessment or strategic plan does not need to be submitted to IDPH. Per 600.400(i), a copy of this document should be kept on file for Regional Health Officer (RHO) review. A letter from the LHD administrator attesting to the completion and board review of this assessment is required. See Appendix E and Appendix F for sample letters.

IPLAN Components and Equivalent Processes

The IPLAN process is fundamentally based on the Assessment Protocol for Excellence in Public Health (APEX-PH). APEX-PH has been a widely used planning process for local health departments that desire to assess and enhance their organizational capacity and strengthen their leadership role in the community. It was developed through a collaborative effort involving the American Public Health Association (APHA), the Association of Schools of Public Health, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the Centers for Disease Control and Prevention (CDC).

Many LHDs in Illinois use the IPLAN (APEX-PH-based) process to complete their IPLAN. However, according to Section 600.410 (b) of the Certified Local Health Department Code, a LHD may use an "equivalent" process for recertification that meets other requirements of the code. Many local health departments use MAPP 2.0 as that equivalent process. Upon written request from IDPH, the following processes on page 10 may be considered equivalent to the IPLAN process.

See Appendix H for the IDPH Substantial Compliance Evaluation for required components of the IPLAN, as described by the Administrative Code.

IDPH Certification Requirements

Comparing IPLAN and MAPP 2.0 Community Health Planning Frameworks

A crosswalk of the IPLAN process and MAPP 2.0 can be found in Appendix L, with a brief visual comparison below.

IPLAN Process	MAPP 2.0 Process
Organizational self-assessment	No perfect equivalent from MAPP
Statement of purpose	Phase I - Developing the community vision
Description of the community participation process	All Phases - Developing the community partner groups
Description of the health status and health problems by 7 data groupings	Phase II - Do the assessments
Description of the process and outcomes of setting priorities	Phase III - Prioritize issues for the CHIP
Alignment of the community priorities and SHIP priorities	No perfect equivalent from MAPP
Description of the action plan cycle	Phase III - Continuously improve the community
Community Health Plan with measurable outcomes and impact objectives and strategies	Phase III - Continuously improve the community

IDPH Certification Requirements

IPLAN Components and Equivalent Processes (continued)

A APEX-PH

APEX-PH is a three-part process, as described below.

1. "Part I, the Organizational Capacity Assessment, calls for an internal review of a local health department. It provides for an assessment of a health department's basic administrative capacity and of its capacity to undertake Part II. It is conducted by the health department director and a team of key staff members.

2. Part II, The Community Process, is intended to be a more public endeavor, involving key members of a community as well as department staff in assessing the health of the community and identifying the role of the health department in relation to community strengths and health problems. It provides for the use of both objective health data and the community's perceptions of community health problems. This is also known as the Community Health Needs Assessment (CHNA).

   The focus is on strengthening the partnerships between the local health department and community partners. The benefit of the APEX-PH Community Process is that it mobilizes community resources in pursuit of locally relevant public health objectives. It also lays the groundwork for local adoption of the Healthy People objectives and other national or state objectives.

3. Part Ill, Completing the Cycle, integrates the plans developed during the Organizational Capacity Assessment and The Community Process into the ongoing activities of a health department and the community it serves. It discusses policy development, assurance, monitoring, and evaluation of plans developed in conducting Parts I and II. This is also known as the Community Health Improvement Plan (CHIP)."

IDPH Certification Requirements

IPLAN Components and Equivalent Processes (continued)

B MAPP 2.0

MAPP is another common planning process used by some Illinois LHDs for IPLAN recertification. It is fully recognized by IDPH as an "equivalent" process.

Since 2001, MAPP has been a widely used resource for Community Health Improvement (CHI). MAPP was originally developed in response to a need for a CHNA/CHIP framework that engages the community. It has since been an effective framework for starting cross-sectoral partnerships, gathering community input, meeting accreditation requirements, and more.

MAPP is based on other frameworks from the Institute of Medicine and Assessment Protocol for Excellence in Public Health (APEX-PH) and has been updated over the years as public health has policy evolved, e.g., the Affordable Care Act, the Public Health Accreditation Board launch, updates to essential public health services, etc.

During the 2019 MAPP evaluation, the results revealed a need to embed health equity more intentionally throughout and to revise the framework to be more adaptable and responsive to community needs. This new version is known as MAPP 2.0.

Major updates for MAPP 2.0 include:

- Redesign with three phases
- Addition of the Starting Point Assessment to reflect on historical MAPP cycles
- Reduction of the assessment processes to three, eliminating the local public health system assessment
- Addition of the Power Primer
- Addition of editable spreadsheets and documents
- Emphasis on advancing health equity and community engagement

MAPP is a community-driven strategic planning process to improve public health and achieve health equity by:

- Addressing the power imbalances rooted in white supremacy
- Recognizing and identifying how white supremacy has created historic and current injustices, which has led
- to inequities
- Breaking down these structures and creating new ones rooted in equity, community power, and community strengths and assets

For more information on the equivalent MAPP process, documents like the MAPP 2.0/IPLAN Crosswalk are in Appendix L of this document.

Organizational Capacity Self-Assessment

To satisfy this requirement, the Certified Local Health Department must either complete an Organizational Capacity Self-Assessment or develop a strategic plan.

Steps in the Organizational Capacity Self-Assessment

Step 1: Prepare for the Organizational Capacity Assessment

The first part of preparing for the assessment from APEX-PH is to evaluate the capacity of the health department based on the time and commitment required to conduct the assessment as well as to implement the findings from the assessment. Senior leadership must also spend time orienting the staff to commit to work for the success of the project. Regular communication with staff helps keep them informed of the process and how they may contribute to implementing the outcomes. Forming an organizational capacity assessment team is another important part of preparing for the assessment.

Forming an Organizational Capacity Assessment Team

An organizational capacity assessment team is responsible for carrying out the APEX-PH process. It is made up of staff from within the health department.

The team provides the core information and data for the assessment. Members must achieve consensus on organizational problems and action plan priorities; they must also coordinate the roles of the various organizational units, helping to ensure that limited resources are used effectively. The team is critical to the assessment's success and possibly to the development and implementation of the subsequent action plan for improving the capacity of the health department.

Step 2: Score Indicators for Importance and Current Status

In this step, an assessment team applies APEX-PH organizational capacity indicators to assess the organizational capacity of the health department. Capacity Assessment Worksheets are provided in Appendix M of this workbook from the APEX-PH manual.

Step 3: Identify Strengths and Weaknesses

To identify a health department's major strengths and weaknesses, an assessment team compares the *importance rating* with the *current status rating* assigned to each indicator in Step 2. The correlation of the two ratings may indicate a strength or a weakness.

Organizational Capacity Self-Assessment

To satisfy this requirement, the Certified Local Health Department must either complete an Organizational Capacity Self-Assessment or develop a strategic plan.

Organizational Capacity Assessment Process

Step 4: Analyze and Report Strengths

In this step, an assessment team identifies areas in which the health department is doing well and the factors that contribute to that success. The results may have the following benefits: (1) the factors that contribute to the strengths may be applicable to solving problems that will be identified when weaknesses are analyzed, and (2) the morale of the assessment team and the health department staff in general may be boosted by knowledge of departmental successes.

Step 5: Analyzing Weaknesses

The purpose of this step is to prepare for correcting problems by identifying the causes of the health department's major weaknesses.

Defining Problems

An assessment team can define problems at one of three levels: (1) for weaknesses on individual indicators, (2) for weaknesses within principal sections, or (3) for cross-section clusters of weaknesses.

Identifying Related Factors

Related factors are the source of a problem, resources that are available for addressing a problem/correcting a weakness, and barriers that may make correcting a problem difficult.

- **Sources** are all factors that cause a problem; for example, they may include inadequate funding, inadequate staffing levels or a lack of personnel with specific skills, inadequate data, a lack of other needed resources, or an inadequate authority to act.
- **Resources** for addressing a problem may be powers or authorities, specific persons who would support or act, or available funding. Strengths of the health department will often be resources for problem-solving and may be recognized as such in this step. For example, if one of the health department's identified strengths is that the policy board is active and supportive, this support can be identified here as a resource that can be used when correcting a weakness.
- **Barriers** are factors that perpetuate a problem; for example, they may include a lack of power or authority, persons who would oppose an action, a lack of needed funds, an insufficient number of staff, a lack of knowledge, or competing agendas. They can be the same factors listed above as sources but considered barriers here because they tend to persist, despite remedial efforts.

Organizational Capacity Self-Assessment

To satisfy this requirement, the Certified Local Health Department must either complete an Organizational Capacity Self-Assessment or develop a strategic plan.

Organizational Capacity Assessment Process

Step 6. Rank Problems in Order of Priority

In this step, the senior management component of an assessment team reviews the problems that were defined in Step 5 and assigns a priority ranking of I, II, or III to each. Problems assigned a rank of I would be those that could—or should—be corrected immediately.

The process should begin with: (1) deciding what approach to take when assigning priority ranks to the problems, (2) assigning priority ranks to the problems using the chosen approach, and (3), if more than five problems receive a priority rank of I, reevaluating the ratings.

Step 7: Develop and Implement Action Plans

In this step, an assessment team plans how to address the problems with a priority of I, with a goal of substantially strengthening the health department's status on the related indicators within 12 months.

An assessment team develops a separate action plan for each problem. Each action plan describes the goals and objectives for correcting the problem, who is responsible for implementing the plan, what methods will be used to correct the problem, and when it will be corrected.

Implementing Action Plans

As action plans are implemented, they should come under the regular managerial structure of a health department. The person or team responsible for implementing each plan will develop more detailed plans for conducting the activities called for by the particular plan. Documenting activities and results for management review and evaluation is crucial.

Step 8: Institutionalize the Assessment Process

Evaluating the achievements of an organizational action plan begins a continuing cycle of improvement in the health department. The results of these evaluations should inform the planning phase for the next cycle of organizational improvement. This cycle is similar in many ways to The Community Process, to be introduced in the next section of this workbook. Further recommendations for incorporating assessment into the broader functions of a health department are made in Part III, Completing the Cycle.

Organizational Capacity Self-Assessment

To satisfy this requirement, the Certified Local Health Department must either complete an Organizational Capacity Self-Assessment or develop a strategic plan.

Organizational Strategic Plan

Strategic planning is a process for defining and determining an organization's roles, priorities, and direction over a minimum of three to five years. A strategic plan sets forth what a group or an organization plans to achieve, how it will achieve it, and how it will know if it has achieved it. A strategic plan provides a guide for making decisions on allocating resources and for taking action to pursue strategies and priorities. (PHAB, 2025). Note that the strategic planning process is not a linear process.

Road Map for the Future: An Local Health Department (LHD) strategic plan may serve as a roadmap to the future by addressing two very important pieces:

- How the organization will be strengthened or improved in the future
- How the community will be improved in the future as a result of the organization

(Illinois Public Health Institute, 2023)

Organizational Capacity Self-Assessment

To satisfy this requirement, the Certified Local Health Department must either complete an Organizational Capacity Self-Assessment or develop a strategic plan.

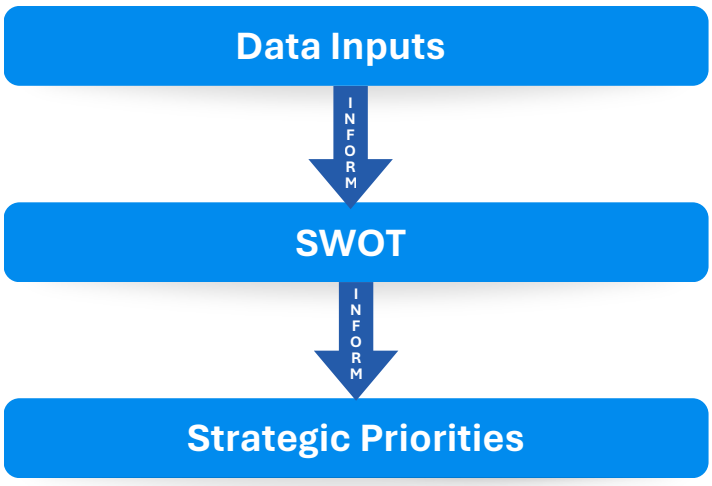
Organizational Strategic Plan

Components of a Strategic Plan

- **Strategic Planning Committee** – Commonly consists of LHD governing body members, LHD leadership, and other staff who lead the planning and will be involved with implementation.
- **Mission, Vision, Values or Guiding Principles** – Statement of purpose for the LHD; description of the desired future state; and core beliefs, values, and principles to guide the work and decision-making of the LHD.
- **Environmental Scan Summary** – Key findings from primary data collection (surveys, focus groups, key informant interviews, etc.) and a review of secondary data (internal and external) that describes how the LHD is functioning as well as the needs and opportunities in the community.
- **SWOT Analysis Summary** – Summary of the overall internal strengths and weaknesses and external opportunities and threats (see below), based on the environmental scan and analysis of data and discussions.
- **Strategic Priorities** – List of strategic priorities the organization plans to address over the next 3-5 years.
- **Goals and Objectives** - (1) For each strategic priority, 1-2 goals; (2) for each goal, 3-5 objectives with strategies to achieve the objectives, and (3) for each objective, proven intervention strategies.

SWOT Analysis

Part of the strategic planning process includes a SWOT Analysis. SWOT, as mentioned above, includes the identification and analysis of key findings from the environmental scan. These findings inform a set of themes describing the LHD's internal strengths and weaknesses and external opportunities and threats for the LHD and community. The themes from the SWOT analysis inform the priorities the organization considers addressing.



(Illinois Public Health Institute, 2023)

Organizational Capacity Self-Assessment

Tips for Organizational Capacity Assessment

Utilize NACCHO's Developing a Local Health Department Strategic Plan: A How-To Guide and PHAB's Strategic Plan Template and Strategic Plan Development Workshop as tools and resources to guide the strategic planning process.

Determine available time and resources for conducting an organizational strategic plan or conducting the Organizational Capacity Assessment before starting. This will allow for realistic planning related to data collection, engagement, and prioritization of the plan.

Form a committee of LHD leadership, governing body members, and other stakeholders interested in participating in the Organizational Capacity Assessment or serving on the strategic planning committee.

Community Health Needs Assessment

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
600.400.2.a. A statement of purpose of the Community Health Needs Assessment that includes a description of how the assessment will be used to improve health in the community.	600.400.a.2.A	The statement of purpose includes a description of how the community's health will be improved.
600.400.2.b. A description of the community participation process, a list of community groups involved in the process, and method for establishing priorities.	600.400.a.1.C 600.400.a.1.D 600.410.a.1 600.400.a.2.B 600.400.a.2.D	Community participation is used to both identify problems and set priorities. All parts are described clearly and in detail.
600.400.2.c. A description of the health status and health problems most meaningful for the community in the data groupings designated by the Department, which are: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic disease; infectious disease; environmental/occupational/injury control; and sentinel events.	600.400.a.1.B 600.410.a.2 600.400.a.2.C	Each grouping includes a description of the relevant data in IQuery. Each grouping includes a description of the issues of most concern to the community.
600.400.2.d. A description of the process and outcomes of setting priorities.	600.400.a.1.D 600.400.a.2.D 600.410.a.3	Three priority health needs are identified.
600.400.2.e. A statement that the State Health Improvement Plan (SHIP) was reviewed, including a description of the alignment or nonalignment between the priority health needs of the applicable local public health jurisdiction, as identified by the local health department, and the priorities to improve the public health system, as set forth by the SHIP.	600.400.a.2.E 600.410.a.4	The Community Health Needs Assessment describes how the priorities are similar to and different from the SHIP .

Community Health Needs Assessment

Community Health Needs Assessment (CHNA) Requirements

Local health departments (LHDs) are required by the Administrative Code to assess the health needs of the community by establishing a systematic needs assessment process, which periodically provides information on the health status and health needs of the community.

A Community Health Needs Assessment should describe the prevailing health status and health needs of the population within the LHD's jurisdiction and shall be conducted at least once every five years. **A Community Health Needs Assessment is one of the core IPLAN requirements**. The administrative code clearly defines what is expected of the LHD to meet the standards of this requirement but does not prescribe the exact methodology used to conduct the assessment. The LHD can use a variety of methods and tools for this assessment, as long as the process is described and the relevant practice standards defined in the code are maintained. The Community Health Needs Assessment should be conducted through completion of IPLAN or equivalent process identified on page 8.

The assessment shall, at a minimum, include:

1. An analysis and description of data in groupings by the seven data groupings identified by IDPH:
    - Demographic and Socioeconomic Characteristics
    - General Health and Access to Care
    - Maternal and Child Health
    - Chronic Disease
    - Infectious Disease
    - Environmental/Occupational/Injury Control
    - Sentinel Events

2. An analysis and description of the health problems most meaningful for the community in the seven data groupings designated by IDPH (see above)

3. Community participation in the assessment process to facilitate the identification of community health problems and to set priorities from among those health problems

4. Identification of at least three priority health needs based on the analysis of data in the Community Health Needs Assessment and on the judgment of the community participants

Some LHDs in Illinois will use a health needs assessment tool similar to the one developed in Part II of the APEX-PH process, or the slightly modified version of APEX-PH that is available on the IPLAN website. Other LHDs may use the MAPP 2.0 tools for completing the Community Health Needs Assessment requirement. The process, regardless of which is used, should be structured to ultimately yield a set of at least three health priorities and a Community Health Plan for addressing those priorities. In addition, the required components for the Community Health Needs Assessment report based on the IDPH IPLAN substantial compliance checklist include:

- A statement of purpose for the Community Health Needs Assessment that includes a description of how the assessment will be used to improve health in the community
- A description of the community participation process, a list of community groups involved in the process, and a method for establishing priorities
- A description of the health status and of data from IQuery by the seven data groupings
- A description of the health problems most meaningful for the community in the seven data groupings designated by IDPH
- A description of the process and outcomes of setting priorities
- A statement that the SHIP was reviewed, including (1) a description of the alignment or nonalignment between the priority health needs of the applicable local public health jurisdiction, as identified by the local health department, and (2) the priorities to improve the public health system, as set forth by the SHIP

Each of these components must be included in the Community Health Needs Assessment submitted to IDPH as part of the IPLAN, regardless of the process used to complete the IPLAN. The substantial compliance evaluation must be completed and reference the page numbers from the LHD's IPLAN document for each component. Each of the required components are described in this workbook.

Statement of Purpose

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
600.400.2.a. A statement of purpose of the Community Health Needs Assessment (CHNA) that includes a description of how the assessment will be used to improve health in the community.	600.400.a.2.A	The statement of purpose includes a description of how the community's health will be improved.

Describing the Statement of Purpose

IDPH requires that all submitted IPLANs include a statement of purpose for the community needs assessment portion of the IPLAN document. The statement of purpose should describe how the assessment will be used to improve health in the community. While a clear statement of purpose may be simple, it can serve as a foundational step—an opportunity to engage the community in defining a mission for convening and assessing the community's health needs and articulating a vision or desired future state. APEX-PH does not have a defined process for accomplishing this requirement. However, there are many tools and guidance documents for creating a mission and vision as part of the CHNA process. Guiding principles may also be defined as part of this collaborative process. They can help establish the way the organization and collaborative work together and with the community, support the approaches used, and steer decision-making.

Mission Statement

A mission statement describes the core purpose and the reasons why the organization or group is leading the IPLAN process. A mission statement describes what the group plans to accomplish in the present to serve the community, focusing on the specific functions and activities.

Vision Statement

A vision statement describes the desired future state and is often an aspirational declaration of what the community should look like in the future. For CHNA, the vision statement describes the ideal future state of an equitable and healthy community and inspires long-term related goals.

Guiding Principles

Guiding principles describe the core values and principles for the group working together on the CHNA. The principles are foundational to the way the group works together and with the community and include shared beliefs and commitments that guide behavior and decisions and support mission and vision.

Statement of Purpose

Describing the Statement of Purpose (Continued)

Steps to develop the mission, vision, and guiding principles include the following:

1 Form a committee to lead the development

This step is critical to ensure the engagement of diverse voices representative of the community being assessed. This group may include representatives of the LHD and other partner organizations, governing bodies, local public health experts, and community members representing population groups impacted by inequities, etc.

2 Brainstorm and draft statements with the committee by asking guiding questions

Mission Statement Questions:

1. What is our purpose for coming together to assess the needs of the community?
2. Why are we conducting an assessment?
3. What are the intended benefits?
4. How do we intend to conduct and use the assessment?
5. How will the assessment improve the health and well-being of the community?

Vision Statement Questions:

1. As a result of conducting an assessment and addressing priorities to improve the community, what does the ideal future state include?
2. What does a healthy community look like in the future (e.g., in five years)?
3. What is the ideal impact we want to have on the community?
4. What do we hope the community will look, feel, and sound like in the future?

Guiding Principles Questions:

1. What are our common beliefs about our community and the health of our community?
2. What values or principles should guide the way we work, make decisions, and act together?
3. What are important declarations about who we are and what we are do that should be defined?

3 Draft and refine statements based on the responses to the questions

LHDs should be as concise as possible while being thorough and clear. It is important to use simple and direct language and avoid jargon.

Example mission format:

"The mission of [collaborative name/project name] is to [what you plan to do] for [whom] by [how] in order to [why]".

Example vision format:

"We envision a [descriptive statement] community where [desired future state]".

Example guiding principles format:

“We believe [core values and beliefs]. We strive to or we conduct ourselves according to [desired behavior or function].”

4 Integrate the statements and align them with the CHNA.

Once finalized, the mission, vision, and guiding principles become the foundation for all subsequent steps in the CHNA process. For example, they can be used to frame the data analysis and inform prioritization criteria and process. It is important to regularly communicate the mission and vision publicly to keep community members and other stakeholders informed and engaged and, as much as possible, focused on common goals.

Statement of Purpose

Tips for Statement of Purpose

Include the community widely in the visioning and the statement of purpose, so the process is led by the community.

Have a plan but remain open to changing the activities if energy is low or the activity is not resonating with the group.

LHD Examples

The DeKalb County Health Department conducted their 2022-2027 IPLAN process in collaboration with Northwestern Medicine. The IPLAN report included the following statement of purpose for the Community Health Needs Assessment. "This CHNA aims to identify prevalent health needs among residents in DeKalb County, illuminating health disparities that particularly affect medically underserved, low-income, and uninsured populations. CHNA insights will inform the development of new strategies with the goal of advancing public health and well-being within our communities." (See page 4 of the IPLAN report at https://health.dekalbcounty.org/iplan-community-health-needs-assessment/.)

The Will County Health Department completed their fifth iteration of a collaborative MAPP process with the Will County MAPP Collaborative, governed by the MAPP Executive Committee. The group established a vision, a mission which defines their statement of purpose, and a set of values statements to guide their work. The following statements are excerpted from their 2022 CHNA report.

- **Vision Statement**: Achieving equitable and optimal health in body and mind for all Will County residents
- **Mission Statement**: The Will County MAPP Collaborative will assess the health needs of the community and develop, implement, and evaluate initiatives to promote the highest quality of life for all residents.
- **Value Statements**
  - Health Equity: All individuals have the opportunity to realize their full potential and to achieve the highest quality of life.
  - Collective Impact: We strive to be a progressive community that maximizes the use of community partnerships and collaboration among all sectors to ensure, enhance, and promote comprehensive, quality and equitable education, healthcare, and social services.
  - Respect: Every life has value.
  - Communication: We commit to sharing our data, assessments, and plans to educate and engage
  - the community.
  - Quality: We believe in evaluation, continuous improvement, and innovation.
  - Inclusiveness: We are a community rich in diversity, where involvement and commitment have deep roots among our residents.

(See page 3 of the 2022 Will County Community Health Needs Assessment report, found at https://the-will-county-mapp-collaborative-willcountygis.hub.arcgis.com/.)

Statement of Purpose

MAPP 2.0 Framework

The information below describes the equivalent processes in MAPP 2.0 from Phase I – Building the Community Health Improvement Foundation.

It is important to establish a vision for the MAPP process because it provides an opportunity for LHD community partners to define what "community" means to them and to define their long-term, aspirational vision for the community. The vision is the north star of the IPLAN process and will guide the rest of the process—the vision is how LHDs will measure progress during the process. For many, this may be the first time an LHD will convene the community, so this step is an opportunity to get the community excited and motivated for MAPP implementation.

The purpose of this step is to facilitate a launch or "visioning" event for MAPP in which the community defines what community means to them and their long-term aspiration vision for the community.

The goals of the visioning process are:

- Define "the community"
- Develop an aspirational vision for the community
- Build relationships among the individuals and groups involved in and affected by MAPP
- Increase community awareness of, enthusiasm for, and engagement in MAPP

Page 51 of the MAPP 2.0 handbook describes the different activities that can be done to conduct this visioning process.

Community Participation Process

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
a.1.C. The assessment shall include community participation in the Community Health Needs Assessment (CHNA) process in order to facilitate the identification of community health problems and the setting of priorities from among those health problems.	600.400.a.1.C	Community participation is used to both identify problems and set priorities.
a.1.D. Community health needs shall be identified during the Community Health Needs Assessment process, based on the analysis of data describing the health of the population and on the judgment of the community participants concerning the seriousness of the health problems and needs.	600.400.a.1.D	
a.1. The process shall involve community participation in the identification of community health problems, priority-setting, and completion of the Community Health Needs Assessment and Community Health Plan.	600.410.a.1	
a.2.B. A description of the community participation process, a list of community groups involved in the process, and a method for establishing priorities.	600.400.a.2.B	All parts are described clearly and in detail.
d.3. The local health department shall utilize community participation to assist in the development of the Community Health Plan. a.1. The process shall involve community participation in the identification of community health problems, priority-setting, and completion of the Community Health Needs Assessment and Community Health Plan.	600.400.d.3 600.410.a.1	Community participation is utilized in the setting of objectives.

Community Participation Process

Describing the Community Participation Process

An important first step, as recommended in the APEX-PH guide, is to build a Community Health Committee for those who play a role in the local public health system. Potential participants would include individuals and organizations who are involved in the delivery of Essential Public Health Services (see page 5 of this workbook for a list of these services). The committee should also be representative of the overall community. A broad cross-section of residents and organizations is needed for members to truly represent the perceptions, interests, and needs of the entire community. Other criteria could include expertise in specific areas of health and community well-being, access to key assets and resources, and the need for diversity and inclusiveness.

Convening a group of stakeholders and partners is essential to a comprehensive IPLAN process. This group can help inform the process, share data, engage other community partners, and ensure that community issues and voices are brought to the forefront of any assessment and planning process. As shown in the table on page 24, describing community participation is a required element of both the assessment and planning processes. See the glossary in Appendix B for the Administrative Code definition of "community participation".

When identifying a group to lead and support the CHNA work, LHDs should engage partners and community members from across their local public health system. These partners bring valuable perspectives, influence, and resources that can strengthen the process. Their relationships, especially with people experiencing inequities, are essential for ensuring that the assessment is inclusive and reflective of the community's needs.

According to American Hospital Association Community Health Improvement (ACHI) Community Health Assessment Toolkit, a committee would work best with partners who:

- come from different interests and sectors
- are open to consensus-oriented approaches
- represent a variety of community voices
- bring different strengths and/or resources to support the process
- are energetic, committed, and willing to collaborate

A multi-sector local public health system representation could include the organizations below:

Source: (NACCHO, 2023)

Community Participation Process

Describing the Community Participation Process (Continued)

The Community Health Committee is an initial demonstration of the local health department (LHD)'s willingness to engage the community in the collaborative IPLAN process. It serves several purposes, including broadening the perspective of the IPLAN process by engaging representatives from a variety of other sectors in the community. The committee can also help increase awareness of the process and build strategic alliances that may be needed to address the IPLAN priorities.

LHDs should consider the size and scope of the committee, as well as clearly define the roles and responsibilities of both committee members and staff. The role and formation of subcommittees should also be considered. For example, the CHNA phase may benefit from a subcommittee composed of participants with expertise and access to health data sources.

The APEX-PH framework recommends that the Community Health Committee serves in an advisory role to the local board of health. It further suggests that the committee include 12 to 15 members who collectively reflect the diversity of the community's population and institutions. Membership should represent individuals and organizations involved in delivering essential public health services (see page 4 of this workbook for a list of these services), as well as a broad cross-section of residents and community-based entities.

To ensure that the committee reflects the perceptions, interests, and needs of the entire community, selection criteria might include expertise in specific areas of health and community well-being, access to key assets and resources, and a commitment to equity.

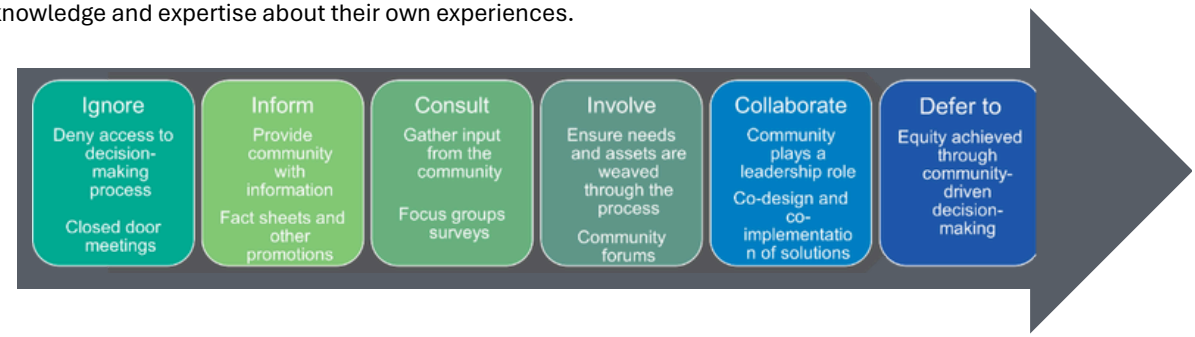
Tools to Engage Partners and Communities

It is important for LHDs to engage with partners by moving at the speed of trust, ensuring accountability and transparency, and promoting a space where all perspectives are heard. One of the ways this can be accomplished is through a shared vision and group agreements that the group develops by consensus and follows in their behaviors and actions. This collective understanding is especially important if the local health department engages community members with lived experience in the IPLAN process.

To effectively engage their communities, LHDs must first understand what community means within their jurisdiction. Defining community should be a collaborative effort developed with partners and community members. Community can take many forms and look different to different people. It may be defined by geography, shared identity, common interests, or local networks. Taking the time to clearly define what community means, beyond geographic boundaries, is essential for guiding and strengthening the IPLAN process.

One of the frameworks for engaging people with lived experience in the process focuses on how to move towards shared decision-making with the health department. Below is a description of this framework, The Spectrum of Community Engagement to Ownership. LHDs can also learn more about this framework and tools in the IPLAN Training Series on the IPLAN Website.

The Spectrum of Community Engagement is a visual tool that can help LHDs identify opportunities to deepen community engagement by moving towards power-sharing practices. Power-sharing is the intentional effort to distribute decision-making power to the community. That means recognizing that community members have valuable knowledge and expertise about their own experiences.



Source: (Community Commons, 2020)

Community Participation Process

Tips for the Community Participation Process

Develop and sustain effective vehicles of communication with the Community Health Committee to build and maintain transparency and trust.

Develop a set of group agreements with the committee or group to ensure values and processes are aligned.

- LHDs can also use Memorandums of Understanding (MOUs) to ensure accountability among people participating in the process.

Summarize or provide minutes after each meeting for transparency and to keep members on the same page.

Encourage participation and leadership of everyone on the committee.

Consider a multi-sector composition of a committee from across the local public health system assessment for different perspectives during the process.

Consider financial stipends when engaging people with lived experience, to compensate for people's time and expertise during the community participation process.

Community Toolbox resources and toolkits:

- **Toolkit for increasing community participation in the process**
- **Tips for conducting effective meetings with community partners**

Community Participation Process

LHD Examples

The Boone County Health Department describes a high level of community participation in their 2023-2027 IPLAN. The health department used the MAPP 2.0 framework and started by completing the "Whose Voices are Included?" worksheet to include groups experiencing inequities, to bring in "views and expertise vital to improving the functioning, impact, and outcomes of systems and services provided. More than 290 community partners were included in MAPP. These partners included voices from across sectors, which represent the diversity of the community. Extra consideration was taken to include voices from disparately impacted populations, such as but not limited to, racial and ethnic minority communities and LGBTQIA+ community action agencies. Leaders from businesses, faith-based organizations, healthcare organizations, community organizations, and city/county officials were also included in MAPP. On January 24, 2023, more than 70 people attended a three-hour MAPP kickoff meeting. At this meeting, partners were educated on MAPP and informed of the yearlong process. Representatives from these MAPP partners were invited to participate in the MAPP Steering Committee. Partners interested in joining the MAPP Steering Committee met on May 10, 2023, and signed a charter, pledging their commitment and support to the MAPP process." The IPLAN report also includes a copy of the completed "Whose Voices are Included?" worksheet, a full list of MAPP partners, and the list of MAPP Steering Committee members. (See page 11-12, Appendix A and C at https://www.boonecountyil.gov/government/departments/health_department/iplan.php.)

The Hancock County Health Department has collaborated with their local non-profit hospital, Memorial Hospital, to conduct the IPLAN process for the past four cycles. "Key individuals, agencies, and organizations who helped in the formulation of the previous health needs assessment, as well as its implementation, were retained as part of the committee for the current Community Health Needs Assessment. The broad representation of the county was also ensured [through a community survey]. In March 2016, Memorial Hospital and the Hancock County Health Department merged about 30 regional agencies and organizations to form the Agency Collaboration Team (ACT). The ACT group meets monthly and is used to articulate the survey tools, pilot the survey, distribute the survey, and identify the priority areas for the health needs assessment." The IPLAN report includes a list of 45 organizations, coalitions, and other groups with individual representatives' names ranging from one per entity to up to as many as 18. (See pages 13-17 at https://www.hancockcountyhealthdepartment.org/iplan.html.)

Community Participation Process

MAPP 2.0 Framework

MAPP 2.0 has guidance and tools throughout the three phases that can be utilized to engage partners and community members in the IPLAN process. Below are short descriptions of the guidance and tools identified in MAPP 2.0.

Guidance:

Before starting Phase I, LHDs can identify the following types of groups to get an idea of the different ways people can become formally involved in MAPP:

- **Core Group:** Two to three people lay the groundwork for MAPP by devoting initial resources such as staff time or funding. They regularly support and lead MAPP to ensure it moves forward. This is likely the group of people involved in MAPP from the beginning.
- **Steering Committee:** A broad group of 10 to 12 stakeholders directs MAPP. The stakeholders represent the community's populations and organizations. The steering committee includes people with resources, community members, and critical public health sectors.
- **CHI Infrastructure Workgroups:** Three to four groups lead strategic projects to improve MAPP. They are established at the end of Phase I, and their focus areas are based on the results of the Starting Point Assessment. Topics might shift after Phase II.

In MAPP 2.0 Phase II, the group responsible for supporting the three assessments is called the Assessment Design Team (ADT). This group is most similar to the Community Health Committee identified in APEX-PH. In Phase II, the ADT leads the implementation of the three assessments. The ADT might dissolve after this phase.

- Leads the design, implementation, and analysis of the three assessments
- Conducts assessment process
- Leads data triangulation
- Facilitates root cause analysis
- Shares assessment findings

In Phase III, priority issue subcommittees oversee the implementation of each priority in the CHIP. LHDs should revisit the stakeholder analysis, past subcommittees, CPA, and the power analysis to help determine who should be on each subcommittee. Consider including the following:

Stakeholder Analysis: The Stakeholder Analysis helps identify key partners and assess their interests, influence, and involvement in community health improvement efforts. Local health departments will use this information to build relationships and engage stakeholders in the MAPP process.

Power Analysis: The Power Analysis classifies stakeholders according to their power over the MAPP process and their interest in MAPP, highlights decision-makers with power to impact the community both positively and negatively, and determines the focus of an engagement plan. Power Analysis and mapping is a working session with tools, such as a power matrix, to determine who has the power to make decisions, push and stop efforts, and ultimately influence steps in MAPP. It produces an accurate picture of current power relations for a given community and a given struggle.

MAPP 2.0 Power Primer: See Step 4—Cultivate Relationships with Communities and Partners—for more information on relationship building.

Community Participation Process

PHAB Standards and Measures

Measure 1.1.1.A

Required Elements:

A list of participating partners involved in the CHA process. Participation must include:

- At least two organizations representing sectors other than governmental public health
- At least two community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes

Documentation Examples:

The intent of required elements a and b is to describe who is involved in the collaborative process to assess the health of the community and how they are involved. This could be included within, for example, the health assessment, an appendix, a partnership charter, or provided as a memo. It is not necessary for the process description to be within the health assessment document itself.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

Description of Health Data

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
a.1.B The assessment shall, at a minimum, include an analysis of data in groupings designated by the Department, which are: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic disease; infectious disease; environmental/occupational/injury control; and sentinel events.	600.400.a.1.B	Each grouping includes a description of the relevant data in IQuery.
a.2. The list of community health indicators published on the IQuery web site shall be utilized to structure the minimal content of the assessment. A local health department may use in its assessment IQuery data and additional data available that describes the health of its population, including natality, mortality, morbidity, and risk factors for illness in its jurisdiction.	600.410.a.2	

Description of Health Data

Data Collection

Both primary and secondary data help us create a comprehensive picture of communities, jurisdictions, and the dynamics within them. Data describes the health of the community at large as well as the health of various subpopulations within the community, especially those disproportionately impacted by health disparities. Data also helps inform priorities and actionable strategies for health improvement and increased equity.

The following sections describe the two IPLAN data collection requirements and use the specific terms to highlight the differences between them. IQuery is Illinois Query, a web-based data query system for collecting and disseminating public health data.

Primary Data	• Data for which collection is conducted, contracted, or overseen by the health department • Examples include data collected from community members via survey, focus groups, listening sessions, town halls, interviews, photo voice, or other methods
Secondary Data	• Data collected by others outside of the health department • Examples include data published on IQuery and other data sites
Qualitative Data	• Data concerning information that is difficult to measure, count, or express in numerical terms • Examples include transcripts from conversations, interviews, focus groups, photographs, responses to open-ended questions, etc.
Quantitative Data	• Data concerning information that can be expressed in numerical terms, counted, or compared on a scale • Examples include demographics, health status, and other data that can be used for statistical analysis

(Definitions from PHAB, 2024)

There are two separate requirements related to data analysis and descriptions that require both quantitative and qualitative data. According to the Administrative Code, the two requirements include:

- **Analysis and description of the health data by groupings in the seven data categories (quantitative data)**
- **Analysis and description of the health problems most meaningful for the community (qualitative data)**

Illinois Department of Public Health (IDPH) differentiates these two requirements by the type and source of the data. For the analysis and description of health data by groupings in the seven required data categories, quantitative data found in IQuery and other credible data sources is used. For the analysis and description of the health problems most meaningful for the community, qualitative data collected by the health department and its community health partners is required.

Description of Health Data

Analysis/Description of Health Data by Groupings

The Administrative Code requires LHDs to analyze data from the IPLAN Data System—IQuery—for the Community Health Needs Assessment, with IDPH's IQuery serving as the primary and minimum data source for the required data categories. According to the Administrative Code, the following are the seven **required** data groupings:

- **Demographic and Socioeconomic Characteristics**
- **General Health and Access to Care**
- **Maternal and Child Health**
- **Chronic Disease**
- **Infectious Disease**
- **Environmental/ Occupational/ Injury Control**
- **Sentinel Events -** any unanticipated event resulting in death or serious physical or psychological injury that could have been prevented or managed by the health care system (Administrative Code 600.110 Definitions)

Most Community Health Assessment frameworks, including APEX-PH, recommend using data from a variety of community health indicators.

IQuery and Secondary Data Collection

IDPH **requires** use of IQuery to collect data for the seven required data groupings.

The IQuery website includes the following pages to help guide LHDs in their data collection:

- **IQuery Dashboard** – includes IPLAN data for the community health indicators and LHD county and state trend comparisons
- **Related Data** – page for data sources that can also be used for data collection
- **Indicator Metadata** – full explanation of each health indicator
- **Frequently Asked Questions** – answers most commonly asked questions related to IQuery and data collection
- **Training** – information for training and technical assistance related to IQuery
- **SHARE** – dashboard for sharing the health assessment results from Illinois LHDs for each round of IPLAN
- **IPLAN** – link to the IPLAN website

Currently, logging in to the IQuery dashboard requires access to an Illinois.gov account. To request access, contact DPH.IQuery@Illinois.gov. Include your name, phone number, email address, and local health department.

LHDs may also use additional data sources, many of which are outlined in the Related Data tab of the IQuery website, to fill gaps in data collection from the IQuery website.

Data acquisition may also involve working with the state health department, the Centers for Disease Control and Prevention (CDC), or with other local, state, federal, or private agencies. LHDs should also compare their local data to the regional, state, and/or national data to understand the benchmarks and where their communities fall in comparison to the larger populations. The most recent community-specific data available should be used, along with any available older data, which can be obtained and organized to show how the data on the community has changed over time.

Description of Health Data

Analysis/Description of Health Data by Groupings

IQuery and Secondary Data Collection (Continued)

While analyzing data, when possible, LHDs should compare data by age, gender, race/ethnicity, and other demographic characteristics to understand differences in their population groups by health status. This analysis will help them understand the health inequities and disparities existing in their communities and where to target their interventions from an equity perspective. Qualitative data from community members will also help fill gaps in understanding of the problems most concerning to the different population groups.

Tips for Description of Health Data

Visit the IQuery website FAQ, which includes examples of the community health indicators based on the IPLAN categories. View the page here.

Watch the IQuery Technical Assistance Training Session for more information on how to access and utilize IQuery. View the session here.

Consider collaborating with local non-profit hospitals and/or FQHCs in the community for data collection and analysis.

When data is not available for a rural, sub-county, or Tribal community, consider using county-level data to help understand the community health problems.

LHD Examples

The Southern 7 Health Department published their 2025-2030 IPLAN report in June 2025. This report is the result of partnership with the Healthy Southern 7 Region Coalition based on a modified version of the APEX-PH Part II. The LHD formed a Community Health Committee from the larger coalition and met with the health department's leadership team to review data and information on Illinois's seven southernmost counties (Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union), including demographic and socioeconomic characteristics (educational attainment, employment status, median household income, family and social support, and community safety), general health and access to care, chronic disease, infectious disease, maternal and child health, environmental, occupational, and injury control, and sentinel events. Data sources included the Illinois Department of Public Health IQuery; the United States Census Bureau; National Center for Health Statistics; Illinois Center for Health Statistics, a division of the Illinois Department of Public Health; Illinois Department of Employment Security; County Health Rankings; the Illinois Behavioral Risk Factor Surveillance System (ICBRFS); and more. For each of the seven required data categories, the LHD defined the category, noted any barriers or lack of data and the rationale, differentiated between data by county or geographic area when possible, summarized key findings including trends in each direction, and provided visual charts and graphs of the data. (See pages 12-48 of the 2025-2030 Southern Seven Health Department Community Needs Assessment and Improvement Plan at https://southern7.org/_downloads/SouthernSeven_IPLAN_2025-2030%206.5.25.pdf?_t=1753716751.)

Description of Health Data

Analysis/Description of Health Data by Groupings

LHD Examples (Continued)

The Oak Park and River Forest IPLAN: Community Health Assessment and Improvement Plan 2022-2027 was conducted by an IPLAN Core Team and a consulting firm using the Mobilizing Action Through Planning and Partnerships framework, which includes four types of assessment.

The analysis and description of health data by grouping was completed in part through the Community Health Status Assessment (CHSA). "Data was collected using the most recently available data sets as of April 2022 from the American Community Survey (ACS) 2016–2020 five-year estimates; CDC Wonder, the Behavioral Risk Factor Surveillance System (BRFSS); Youth Risk Behavior Survey (YRBS); Data Resource Center for Child and Adolescent Health; UDS Mapper: Policy Map; CDC PLACES; and other publicly available online sources. At times, the best data was only available at county or state levels rather than zip-code level. In these cases, a standard extrapolation methodology was used to estimate the percent of a population with a certain disease or condition in each zip code. This methodology allows health data only available at the state or county level to be reliably extrapolated down to a smaller geography, such as zip code, using data breakouts available by race and ethnicity or age. Extrapolations were either provided by CDC PLACES or conducted by [the consultant]."

"The analysis covered zip codes 60301, 60302, 60304 (Oak Park), and 60305 (River Forest) and compared to relevant benchmarks such as Cook County, Illinois, or national averages as appropriate. Data is also occasionally shown by municipality or census tract if that is the most current and relevant data available." The data is displayed using maps, bar charts, and tables, with detailed narratives describing the findings. Data is organized "around the five key areas of social determinants of health (SDOH) identified by Healthy People 2030. These five key determinants are:

1. Social and Community Context
2. Economic Stability
3. Education Access and Quality
4. Neighborhood and Built Environment
5. Health Care Access, Quality, and Disparities"

The IDPH data groupings are incorporated into the five areas plus demographic information. For more information, see the summary of the CHSA on pages 14-33 of the Oak Park and River Forest IPLAN at https://www.oak-park.us/Public-Safety/Public-Health/Leadership-Administration/Community-Health-Strategic-Plan. These data were supplemented by primary data collected for the Community Themes and Strengths Assessment (CTSA), via a community survey and online public comments.

Description of Health Data

MAPP 2.0 Framework

There are three assessments for MAPP 2.0:

- **Community Partner Assessment**
- **Community Status Assessment**
- **Community Context Assessment**

The Community Status Assessment (CSA) includes the compilation of secondary and quantitative data, where LHDs collect data on health status by the seven groupings.

Community Status Assessment

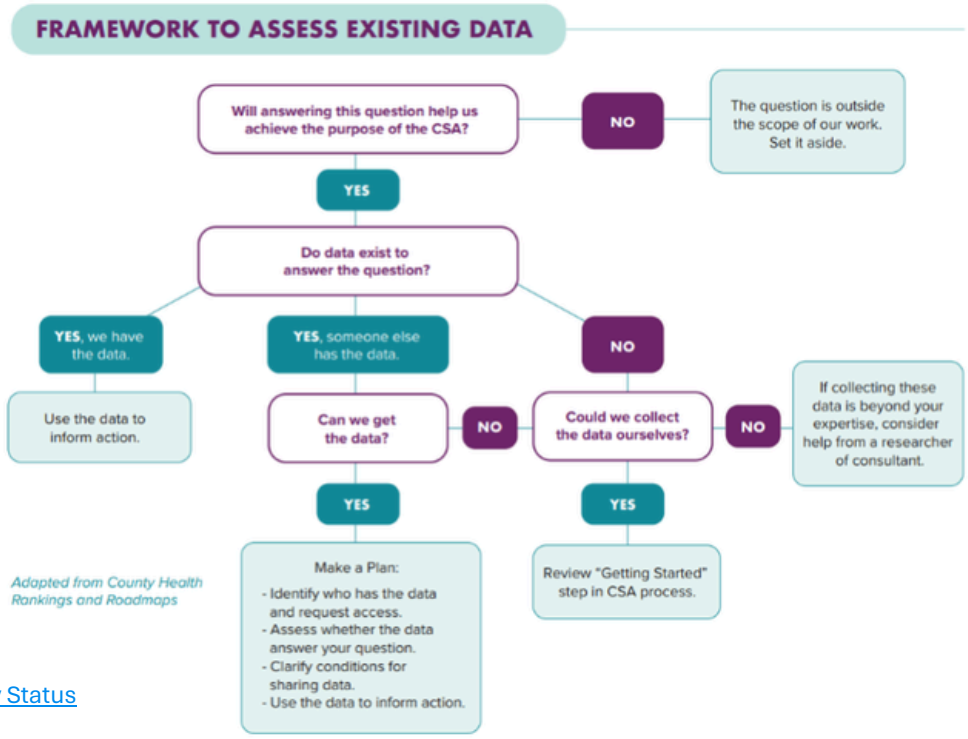
The CSA is a community-driven assessment to help tell the story of the community. The CSA informs MAPP and collects quantitative, community-related data such as demographics, health status, and health inequities. This is the equivalent of collecting the required seven data categories.

As emphasized throughout MAPP, LHDs must engage the community to be successful. These assessments should reflect the community's unique characteristics and members. By including community members and organizations that work with historically marginalized communities and people experiencing inequities, LHDs can help ensure the data reflects all voices.

The CSA recommends utilizing existing data first. MAPP 2.0 provides questions for LHDs to evaluate the data they have and understand what additional data they may need to collect.

- Do the data represent the status of the entire community as you have defined it?
- Do the data include the local public and Tribal health system (e.g., school, economic development, transportation, law enforcement, mental health, physical health)? Data should reflect all sectors in the local public health system to support a full understanding of issues that impact your community.
- Have the data been used strategically to inform improvements?
- Do the data show how different populations are impacted by social determinants of health, disparities, and inequities?
- Do the data reflect systems of privilege, power, and oppression that impact your community?
- What population(s) in your community or the local public health system are missing?
- What is the quality of the data (e.g., reliability, validity, accuracy)?

MAPP 2.0 has a decision chart to help LHDs identify when to use existing secondary data or collect primary data.



(NACCHO Community Status Assessment, 2023)

Description of Health Data

PHAB Standards and Measures

For Public Health Accreditation, there are a few more requirements. Among the most notable: 1) an emphasis on examining disparities among subpopulations or sub-geographic areas and other important local jurisdiction characteristics and 2) a description of inequities in the factors that contribute to health challenges, which must include SDOH or built environment.

Standard 1.3 (see all measures):

Analyze public health data, share findings, and use results to improve population health

Required Element 1.3.1

Analyze public health data (quantitative and qualitative), share findings, and use results to improve population health

Required Element 1.3.2

Share and review public health findings with stakeholders and the public (includes data visualization)

Required Element 1.3.3

Use data to recommend and inform public health actions (policies, processes, programs, or interventions designed to improve the health of the population)

Documentation Examples 1.3.1

Documentation could be, for example, a memo, report section, presentation, or excerpts from the state/Tribal/community health assessment

Documentation Examples 1.3.2

Documentation could be materials that present public health data findings like infographics, webpages, or data visualization. Documentation of distribution could include, for example, a presentation discussing sharing of data findings, an email to partners informing them of the availability of findings on the health department's website, or a social media post informing followers how to access a data visualization platform.

Documentation Examples 1.3.3

Documentation could be, for example, submitted grant applications or program revisions or expansions. Documentation could also be Tribal Council resolutions and Health Oversight Committee meeting minutes, which demonstrate that data were used to inform policy, processes, programs, or interventions.

Measure 5.2.1

Required Elements:

- Engage partners and members of the community in a Community Health Improvement Plan (CHIP).
- Review of the causes of disproportionate health risks or health outcomes of specific populations.

Documentation Examples

Documentation could be, for example, an executive summary outlining the process and participants, a participant roster with meeting minutes or summaries of discussion, a memo describing the process, or an excerpt from the CHIP.

Analysis/Description of Health Problems Most Meaningful for the Community

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
a.2.C. A description of the health status and health problems most meaningful for the community in the data groupings designated by the Department, which are: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic disease; infectious disease; environmental/occupational/injury control; and sentinel events.	600.400.a.2.C	Each grouping includes a description of the issues of most concern to the community.

Analysis/Description of Health Problems Most Meaningful for the Community

Along with compiling and analyzing secondary data, identifying gaps in knowledge about community health issues and understanding what matters to the community it is vital. Primary data collection is one of the most effective ways to address these gaps and understand community perspectives.

Primary data is collected by LHDs and their community health partners, while secondary data is collected by others and used by the health department. Primary data can include community health partners who are collaborating with the health department as part of the IPLAN process to collect data. Qualitative data is most often open-ended questions and data that is not numerical, while quantitative data is numerical. The most commonly used method to collect primary data is through qualitative data.

The "description of health problems most meaningful for the community," as outlined in substantial compliance requirements, is met through a LHD's collection of qualitative and primary data.

Primary Data Collection

LHDs are required to utilize primary and/or qualitative data to supplement secondary data, providing deeper insight into the health conditions reflected in existing data sources (secondary data). Primary data should help explain underlying factors, including how people are experiencing life in their communities.

According to the Public Health Accreditation Board, primary data can be used to understand the health issues of the population served, which may include exploration of health disparities or contributing factors or causes of health challenges. Health departments may require additional data to supplement findings from existing data sets to better understand specific situations, issues, and potential solutions. Collection of primary data does not need to be complicated or costly. Rather, it is intended to enhance knowledge and understanding of the population served by the health department. These data may address social conditions or social determinants of health (SDOH) that have an impact on the health of the population served, e.g., unemployment, poverty, lack of accessible facilities for physical activity, housing, transportation, and lack of access to fresh foods. Health departments need to demonstrate capacity to collect primary data or ensure they have access to another entity that can collect primary data on their behalf.

Examples of primary data collection are listed below:

Analysis/Description of Health Problems Most Meaningful for the Community

Primary Data Collection (Continued)

- **Surveys:** "A survey is a method of gathering information intended to reflect the views of an entire community or group of interest. The questions are asked in a uniform manner to ensure the responses are influenced primarily by the respondents' experiences and not by the interviewer's phrasing. Surveys are typically written but can also be conducted verbally, and distributed via mail, fax, email, web page, phone, or in person." (Community Toolbox, 2025).
- **Interviews:** "There are a number of qualitative methods that can be used in assessment of issues or community needs. We'll list the major ones here and look at them in more detail later in the section.
    - **Individual interviews:** These may be structured interviews, where the questions are determined beforehand, or unstructured conversations that are allowed to range wherever the interviewee wants to go in relation to the general topic. Even in structured interviews, there may be room for both interviewers and interviewees to pursue topics that don't relate directly to answering the original questions. The difference, however, is that in a structured interview, all those questions are formally asked, and the interviewer does their best to make sure they're answered.
    - **Group interviews:** These are similar to individual interviews, but involve two or more interviewees at a time, rather than one. (Sometimes, these are unexpected—[for example] the interviewee's mother and sister are present and insist on being part of the conversation.) Group interviews have some advantages, in that interviewees can act as a check on one another (saying, for example, "I remember that happening in a different way…") and stimulate one another's thinking. At the same time, the interviewer has to be somewhat of a facilitator, making sure that no one person dominates, and that everyone gets a reasonable chance to speak." (Community Toolbox, 2025)
- **Asset Mapping:** "Asset mapping focuses on the strengths of the community rather than the areas that need improvement. Focusing on assets gives the power back to the community members that directly experience the problem and already have the resources to change the status quo. If the changes are made by the community and for the community, it builds a sense of cohesiveness and commitment that makes initiatives easier to sustain." (Community Toolbox, 2025)
- **Photo Voice:** "Photo voice is a process in which people—usually those with limited power due to poverty, language barriers, race, class, ethnicity, gender, culture, or other circumstances—use video and/or photo images to capture aspects of their environment and experiences and share them with others. The pictures can then be used, usually with captions composed by the photographers, to bring the realities of the photographers' lives home to the public and policymakers and to spur change." (Community Toolbox, 2025)
- **Focus Groups/Listening Sessions:** "This is a group of about 6-10 people, led by a trained facilitator, assembled to answer a specific question or questions. An effort is sometimes made to make sure that group members don't know one another, so that social pressures won't influence them. If trained facilitators are available, focus groups can be a good way to get accurate information about an issue." (Community Toolbox, 2025)
- **Community Forums/Town Halls:** "These meetings allow a range of people a chance to express their opinions and react to others'. They can draw on a large pool of opinions and knowledge at one time and uncover disagreements or differences that can then be discussed." (Community Toolbox, 2025)

Analysis/Description of Health Problems Most Meaningful for the Community

IPLAN Requirements

IDPH requires demonstration of the collection of qualitative data by each of the seven data groupings:

- Demographic and Socioeconomic Characteristics
- General Health and Access to Care
- Maternal and Child Health
- Chronic Disease
- Infectious Disease
- Environmental/Occupational/Injury Control
- Sentinel Events

IDPH requires LHDs to document in the Community Health Needs Assessment report that they sought or obtained evidence from **all** data groupings during their qualitative data collection and analysis.

Decide of your sources of information

For the same reason LHDs put together a planning group that represents all the different sectors of the community concerned or involved with the assessment, they should also try to get information from as broad a range of people and groups as possible. The greater the variety of people that supply the data, the better perspective they'll have on the real nature, needs, and resources of the community. One of the most important groups to reach are community members, specifically those who are directly impacted by health inequities.

According to the Spectrum of Community Engagement to Ownership,

"Communities must be informed, consulted, and involved; but through deeper collaboration we can unleash unprecedented capacity to develop and implement the solutions to today's biggest crises [...]" (Facilitating Power, n.d.)

Finally, it's important to note that the analysis of the data from the seven data categories are essential for the next steps in the Community Health Needs Assessment process, including the identification and prioritization of health problems and the analysis of the prioritized health problems in order to identify the risk factors and the direct and indirect contributing factors.

Share findings with community and partners

Once all the required data is collected, LHDs must summarize and present the summarized data to the Community Health Committee. This step in the process is crucial for identifying the top three health priorities. Best practices also include sharing the findings from the CHNA with community members, especially those who participated through community input, and utilizing data visualization to ensure the data is easily accessible.

Data visualization summarize the important and interesting findings. It helps to identify partners, enhance comprehension, and broaden communication for big takeaways. Data visualizations remove the barriers of inaccessibility to ensure all receiving the information can understand what is happening in their communities. The visualizations should be understandable and direct, ensure retention, communicate stores, and evoke emotional reactions better than text. Additionally, jargon and technical language are neither understandable to audiences who don't specialize in that type of research, nor are they likely enticing for most readers.

Analysis/Description of Health Problems Most Meaningful for the Community

Tips for Analysis/Description

- Consider collaborating with local non-profit hospitals and/or FQHCs in the community for data collection and analysis.
- Find tips on data collection methods on the AHA Community Health Improvement site.
- See the Community Toolbox for suggestions on which primary data collection methods are best to use and in what cases.
- Watch the IDPH IPLAN 2025 Training Session, Turning Data into Information, for more information on data analysis, visualization, and narratives.
- Utilize tools to ensure the data visualizations are accessible and are clear to the reader: Data Visualizations, Charts, and Graphs | Digital Accessibility and Dos and Don'ts of Data Visualization —European Environment Agency.

LHD Examples

The McLean County Health Department conducted a joint Community Health Needs Assessment and improvement plan from 2023-2025 with OSF HealthCare St. Joseph Medical Center, Carle BroMenn Medical Center, and Chestnut Family Health Center. To understand what was most meaningful for the community and supplement other data for a better picture of health in McLean County, they developed and administered a community survey with questions related to the following areas:

1. Ratings of health issues in the community—to assess the importance of various community health concerns. Survey items included assessments of topics such as cancer, diabetes, viruses (including COVID-19), and obesity.
2. Ratings of unhealthy behaviors in the community—to assess the importance of various unhealthy behaviors. Survey items included assessments of topics such as violence, drug abuse, and smoking.
3. Ratings of issues concerning well-being—to assess the importance of various issues relating to well-being in the community. Survey items included assessments of topics such as access to healthcare, safer neighborhoods, and effective public transportation.
4. Accessibility to healthcare—to assess the degree to which residents could access healthcare when needed. Survey items included assessments of topics such as access to medical, dental, and mental healthcare, as well as access to prescription medications.
5. Healthy behaviors—to assess the degree to which residents exhibited healthy behaviors. The survey items included assessments of topics such as exercise, healthy eating habits, and cancer screenings.

Analysis/Description of Health Problems Most Meaningful for the Community

LHD Examples (Continued)

6. Behavioral health—to assess community issues related to health issues such as anxiety and depression.
7. Food security—to assess access to healthy food alternatives.
8. Social determinants of health—to assess the impact that social determinants may have on the above-mentioned areas. Finally, demographic information was collected to assess background information necessary to segment markets in terms of the eight categories discussed above.

The 2024 McLean County Community Health Survey was designed using validated and reliable items, with a sample size calculated to achieve a 95 percent confidence interval. Surveys were offered in English and Spanish, both online and on paper, targeting both the general and at-risk populations—defined as individuals eligible for Medicaid. Data were collected through stratified sampling at community locations such as shelters and food pantries and compared with a hospital control sample to assess potential bias. Rigorous data validation and statistical analyses, including correlations and chi-square tests, ensured data integrity and allowed for comparison with the 2021 survey results. (See page 28 of the McLean County Illinois Community Health Needs Assessment report and Appendix 4 found at https://health.mcleancountyil.gov/1656/Community-Health-Needs-Assessment-Health.)

The Kendall County Health Department's Community Health Improvement Plan 2021-2026 describes the community input gathered as "a vital part of the IPLAN process," aimed at collecting data on Kendall County residents' quality of life, assets, and priorities through their lived experiences. A cross-disciplinary team of Health Department staff was trained in ethnographic interviewing techniques and asking reliable, open-ended questions. The staff engaged community members in semi-private interviews conducted in various community settings including local businesses, the health department, laundromats, retail establishments, senior centers, school cafeterias, and the county jail. All interviewees were over the age of 18, and some interviews were conducted in Spanish.

Interviewees included a diverse group of residents who shared information related to socioeconomic well-being, environmental health, mental health, physical health, and community resilience. Although the COVID-19 pandemic reduced the number of planned interviews, 21 were completed, analyzed, and discussed in a follow-up virtual focus group, in order to identify key community themes and strengths. The findings were published on the health department's website to inform the public and to supplement the other data collected to inform the selection of health priorities. (See pages 19-21 of the Kendall County Health Department Community Health Improvement Plan 2021-2025 found at https://www.kendallhealth.org/wp-content/uploads/2022/04/ad-2021-2026-IPLAN-04-2022-3.pdf.)

Analysis/Description of Health Problems Most Meaningful for the Community

MAPP 2.0 Framework

The Community Partner and Context Assessments collect primary and qualitative data.

Community Partner Assessment

The Community Partner Assessment (CPA) is conducted to understand partners' individual systems, processes, and capacities, as well as the network of community partners' collective capacity to address health inequities. This assessment replaced the local public health system assessment (LPHSA).

This assessment includes an orientation to the assessment, the Community Partner Assessment survey, and follow-up discussions to analyze the partner survey results. The CPA Survey takes 30 to 45 minutes and includes the following topics:

- About the organization
- Interest in participating in and supporting MAPP
- Demographics and characteristics of clients or members served/engaged
- Topic area focus(es)
- Organizational commitment to equity
- Whom the organization is accountable to
- Organizational capacities related to the 10 Essential Public Health Services (EPHS)
- General capacities and strategies
- Data access and systems
- Community-engagement practices
- Policy, advocacy, and communication

Community Context Assessment

The Community Context Assessment is conducted to collect qualitative data on the insights, expertise, and views of people and communities affected by social systems to understand the community's strengths, assets, and culture. The CCA centers on people and communities with lived experiences and lived expertise. Core activities are conducting interviews and focus groups, and communicating with the community.

CCA can help fill in data gaps with the CSA. It also intersects with the CPA to highlight how community and partners can work together on solutions. See the primary data collection section on pages 19-21 of the Community Context Assessment MAPP 2.0 Handbook to learn what methods to use for the CCA. This assessment is similar to the IPLAN requirement of conducting analysis on health problems most meaningful to the community.

Analysis/Description of Health Problems Most Meaningful for the Community

PHAB Standards and Measures

For Public Health Accreditation, there are a few more requirements. Among the most notable: 1) an emphasis on examining disparities among subpopulations or sub-geographic areas and other important local jurisdiction characteristics and 2) a description of inequities in the factors that contribute to health challenges, which must include SDOH or built environment.

Standard 1.3 (see all measures):

Analyze public health data, share findings, and use results to improve population health

Required Element 1.3.1

Analyze public health data (quantitative and qualitative), share findings, and use results to improve population health

Required Element 1.3.2

Share and review public health findings with stakeholders and the public (includes data visualization)

Required Element 1.3.3

Use data to recommend and inform public health actions (policies, processes, programs, or interventions designed to improve the health of the population)

Documentation Examples 1.3.1

Documentation could be, for example, a memo, report section, presentation, or excerpts from the state/Tribal/community health assessment

Documentation Examples 1.3.2

Documentation could be materials that present public health data findings like infographics, webpages, or data visualization. Documentation of distribution could include, for example, a presentation discussing sharing of data findings, an email to partners informing them of the availability of findings on the health department's website, or a social media post informing followers how to access a data visualization platform.

Documentation Examples 1.3.3

Documentation could be, for example, submitted grant applications or program revisions or expansions. Documentation could also be Tribal Council resolutions and Health Oversight Committee meeting minutes, which demonstrate that data were used to inform policy, processes, programs, or interventions.

Measure 5.2.1

Required Elements:

- Engage partners and members of the community in a community health improvement process
- Review of the causes of disproportionate health risks or health outcomes of specific populations

Documentation Examples

Documentation could be, for example, an executive summary outlining the process and participants, a participant roster with meeting minutes or summaries of discussion, a memo describing the process, or an excerpt from the CHIP.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

Prioritization Setting

Requirements from Admin Code/Substantial Compliance Checklist

<table>
<tr><th rowspan="2">Admin Code 600.400</th><th colspan="2">Substantial Compliance</th></tr>
<tr><th>Admin Code:</th><th>In Compliance:</th></tr>
<tr><td rowspan="3">a.1.D. Community health needs shall be identified during the Community Health Needs Assessment process based on the analysis of data describing the health of the population and on the judgment of the community participants concerning the seriousness of the health problems and needs. Prioritization shall result in the establishment of at least three priority health needs.

a.2.D. A description of the process and outcomes of setting priorities.

a.2.E. A statement that the SHIP was reviewed, including a description of the alignment or nonalignment between the priority health needs of the applicable local public health jurisdiction, as identified by the local health department, and the priorities to improve the public health system, as set forth by the SHIP.</td><td>600.400.a.1.D</td><td rowspan="2">Three Priority Health Needs are identified.</td></tr>
<tr><td>600.400.a.2.D</td></tr>
<tr><td>600.400.a.2.E</td><td>The Community Health Needs Assessment describes how the priorities are similar to and different from the SHIP.</td></tr>
</table>

Prioritization Setting

The Prioritization Process

In this step of the Community Health Needs Assessment process, the Community Health Committee prioritizes health problems (needs). Local Health Department certification requires at least three health priorities. To accomplish this prioritization of at least three health priorities, LHDs should:

1. Analyze both the data from the health status by seven groupings (required data categories) and the health problems most meaningful to the community by seven groupings (required data categories). This means both the qualitative and quantitative data.
2. Summarize and present the summarized data to the Community Health Committee to explore the data and identify themes to inform a set of health problems emerging from the data.
3. From there, the Community Health Committee and LHD will use that list of themes to narrow down to at least three health priorities through a prioritization process.

There are several methods for prioritizing health problems or community health issues. Regardless of the method selected, the result should be a consensus-based list of priorities grounded in data and input from partners and community. The prioritization process should be transparent, reasonable, and easy to understand, incorporating objective criteria as well as an analysis of available data and community perspectives.

According to the APEX-PH Manual,

"Because resources may not be available to address all of a community's major health problems simultaneously, choices must be made on how the resources will be used. It is important that community opinion be reflected in how health problems are prioritized for the allotment of resources. A principal purpose of a Community Health Committee is to provide the community view on health priorities."

Below are examples of commonly used prioritization processes:

Multi-Voting Technique

The multi-voting technique is typically used when a long list of health problems or issues must be narrowed down to a top few issues.

Strategy Grids

Strategy grids are particularly useful when agencies are limited in capacity and want to focus on areas that will yield the greatest results.

Nominal Group Technique

The nominal group technique is useful in the early phases of prioritization, when there is a need to generate many ideas in a short amount of time and when input from multiple individuals must be considered.

The Hanlon Method

The Hanlon Method is used when the desired outcome is an objective list of health priorities based on baseline data and numerical values.

Prioritization Matrix

The prioritization matrix is helpful when health problems are considered against a large number of criteria or when an agency is restricted to focusing on only one priority health issue.

Prioritization Setting

The Prioritization Process (Continued)

Review the NACCHO Guide to Prioritization Techniques for more information: https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf.

All health problems should be evaluated using a consistent prioritization method. LHDs, and any partners in the assessment process, should carefully consider and select the approach that best fits their community and context, ensuring the process is both appropriate and effective.

LHDs should utilize a set of prioritization criteria to guide their prioritization process along with their selected method. Below are examples of prioritization criteria that LHDs may consider to guide their process:

- Potential severity of consequences for not addressing the issue
- Potential impact: disparities, large number of people impacted and large geographic reach
- Importance to the community
- Complexity of the issue—requires a strategic, collaborative approach including policy, systems, and environmental change strategies
- Alignment with SHIP
- Community strengths and assets to leverage

Tips for Prioritization Setting

Documentation of committee members engaged in the prioritization process and meeting minutes, including the results of the process, should be maintained and summarized in the final Community Health Needs Assessment report.

The prioritization process can be done in many ways. There's no right or wrong method, but there are pros and cons to each. Some important considerations include the number of issues to be prioritized, the number of people participating in the process, and the prioritization criteria to be considered.

The Community Toolbox recommends that LHDs begin to think about the prioritization method and criteria at the beginning of the CHNA.

Prioritization Setting

LHD Examples

The Boone County Health Department used a health equity lens framework based on the World Health Organization's definition of social determinants of health (SDOH) as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." The Boone County Health Department IPLAN 2024 report notes that public health has shifted from focusing mainly on clinical care to addressing the root causes of poor health through collaboration, strategy, and systems-level change. Studies show that social determinants can influence 30 to 55 percent of health outcomes, often more than healthcare or lifestyle factors. Key determinants include income, education, employment, food and housing security, discrimination, early childhood conditions, and access to quality care.

Poor health and inequities often stem from decades of neglecting these determinants. Public health applies an equity and resilience lens to understand how poverty, violence, discrimination, and trauma affect well-being. Community resilience is both an outcome and a process for withstanding and adapting to a range of individual and community adversities.

The Boone County IPLAN report states that a health equity lens aims to reduce preventable disparities by improving access to care, addressing barriers like language and transportation, and promoting trauma-informed approaches. The framework distinguishes:

- Reality: Unequal distribution of resources
- Equality: Same support for all
- Equity: Support based on need
- Justice: Removing the root causes of inequity

The health equity lens was applied by comparing local data to state metrics and gathering community feedback to identify key health priorities and disparities. Community members and partners ranked six emerging health themes using the Full Analytical Criteria Method, a Lean Six Sigma tool that prioritizes issues by comparing them against each other by "more important," "equally important," or 'less important," along with the use of weighting factors. Unlike their 2018 assessment, the 2023 process did not use weighting factors, and responses marked "equally important" were excluded, highlighting that many view all issues as interconnected. Due to resource and staffing challenges post-COVID, the Boone County Steering Committee emphasized leveraging existing committees and coalitions to address these overlapping priorities efficiently.

Prioritization Setting

LHD Examples (Continued)

Peoria County, Tazewell County, and Woodford County Health Departments partner on a Community Health Needs Assessment using the MAPP 2.0 framework to systematically assess and prioritize community health issues in the Tri-County region. The process included the following steps led by the Partnership for a Health Community (PFHC).

1. Assessment and Alignment

- **Assess Health Issues**: PFHC reviewed quantitative and qualitative data to identify major community health concerns.
- **Align Resources**: Cross-sector partners discussed available resources and capacities to address these issues.
- **Strategic Action**: The group analyzed relationships among issues and developed strategies to improve regional health outcomes.

2. Identifying Issue Statements

- The PFHC Board led structured sessions to review data and identify key health issues.
- The Hanlon Method for Prioritizing Health Problems was used to guide the process.
- A PEARL screening (Propriety, Economics, Acceptability, Resources, Legality) was applied to eliminate issues not feasible for public health intervention.
- Four main domains were considered: food insecurity, behavioral health, healthcare access and quality, and preventive care.
- The process resulted in 10 actionable issue statements for prioritization.

3. Collaborative Scoring and Prioritization

- Seven key entities (including health departments, hospitals, and PFHC partners) participated in meetings, scoring each of the 10 issues using the Hanlon scoring method (Size, Seriousness, Effectiveness; each rated 1-10).
- Scores were averaged across entities, and outliers were removed to ensure balanced results.
- During final review, two Issue statements were merged due to overlap and shared significance.

4. Final Priority Areas

- After reviewing aggregated scores and group discussions, the PFHC identified three top priority areas for the Tri-County region. For more information, see pages 216-221 of the 2025 Tri-County Community Health Needs Assessment, found at **https://www.pcchd.org/DocumentCenter/View/3613/2025-Tri-County-Community-Health-Needs-Assessment-PDF-.**

Prioritization Setting

MAPP 2.0 Framework

In order to help Local Health Departments understand the a community's most important health priorities, the MAPP 2.0 process takes the steps of prioritization in three parts: Triangulate Data, Identify Themes, and Develop Issue Statements. See pages 104-126 of the MAPP 2.0 Handbook.

1 LHDs should first work with the Assessment Design Team (ADT) to identify how to engage community partners and members. The handbook has questions to work through with the ADT for this step.

---

2 Take the raw data and answer the guiding questions from each assessment to summarize the data. (Questions can be found in the handbook).

Then, think about where the data fit along the Health Equity Action Spectrum, which can be found in the MAPP 2.0 Handbook and depict the linkages between root causes and health outcomes, showcasing the social determinants of health as a key mediator of this connection.

---

3 Once data from each of the assessments has been summarized, identify cross-cutting themes.

Since an LHD already will have been thinking about how data from each of the individual assessments fit along the Health Equity Action Spectrum, highlighting cross-cutting themes related to the following should be a straightforward process. These themes include;

1. Systems of power, privilege, and oppression,
2. Social determinants of health, and
3. Health behaviors and health outcomes.

Data should also inform themes within community strengths and organizational capacity. LHDs should also be referring to the guiding questions developed at the beginning of Phase II to identify cross-cutting themes.

---

4 Create issue statements from the cross-cutting themes that will identify and summarize why and how the issue occurs, how serious it is, and its outcomes and impacts.

Conducting a root cause analysis of each issue will help LHDs to build out the components of the issue profile. The purpose of a root cause analysis is to understand the cause-and-effect relationships for health issues; moreover, it can help reveal the systems of power, privilege, and oppression that might be impacting health outcomes in the community.

---

5 Finally, share the CHNA findings with the community.

At the end of Phase II, the community developed a set of strategic issues based on CHNA findings. The next step is to prioritize these issues. Continue to the next page to review the steps for prioritizing issues for CHIP.

Prioritization Setting

MAPP 2.0 Framework (Continued)

At the end of Phase II, the community developed a set of strategic issues based on CHNA findings. The next step is to prioritize these issues. Prioritization allows the community to narrow down the issues to a manageable number, so it can target resources, use existing efforts, and develop achievable goals and strategies to address community needs. Prioritization can be reviewed on pages 134-136 of the MAPP 2.0 Handbook. The following are the steps for prioritizing issues for the CHIP:

1

Step 1.1: Review issue profiles and determine whom to involve

Ensure that all involved (core group, steering committee, ADT, workgroups, and other community members) understand the goals and process of prioritization. Once all are oriented to the process, review and reflect on the issue profiles from Phase II.

Based on the topics of the issues, consider other partners, stakeholders, and community members to invite into the prioritization process, including people most impacted by the decisions to follow and people from communities whose voices need to be represented.

2

Step 1.2: Determine criteria for prioritization

The group will use a set of criteria to select priority issues. These criteria should be relevant to the community and agreed upon by the group. Although all findings from the assessments are important, the CHIP will focus on a few prioritized issues over the next three to five years.

Here are some commonly used criteria:

- Relevance of the issue to community members
- Magnitude/severity of the issue
- Urgency to solve the issue
- Impact of the issue on communities impacted by inequities
- Availability and feasibility of solutions and strategies to address the issue
- Trending health concerns (e.g., COVID-19, mental health, obesity, access to healthcare)
- Availability of resources (e.g., time, funding, staffing, equipment) to address the issue
- Opportunity to apply upstream strategies to address the issue
- Social, political, historical, and cultural context of the issue

---

3

Step 1.3: Determine prioritization methods

Each prioritization method has its own benefits and drawbacks. LHDs should base their selected method on what is right for their community. See page 47 in the process section for more information on potential methods.

4

Step 1.4: Validate priorities

Finalize priorities by discussing and confirming with the partners working on IPLAN.

5

Step 1.5: Share results

Finally, share the results of the prioritization with the community. Share the three to five priority issues with everyone who participated in MAPP and with the community at large. Create opportunities for people to learn more about the process and to get involved in future MAPP activities. At this stage, the LHD is on their way to developing the CHIP.

Prioritization Setting

PHAB Standards and Measures

Please note: In 2022 PHAB Standards and Measures, PHAB considers the prioritization process as part of the Community Health Improvement Plan (CHIP).

Measure 5.2.1.A

Required Element: Process used by participants to select priorities

The intent of this required element is to describe the steps or tools used in the prioritization process. If the MAPP process is used, the description will include the specific steps and tools utilized. Tools to prioritize health issues could include, for example, nominal group or multi-voting techniques, affinity diagrams, or prioritization matrices.

Documentation Examples:

Documentation could be, for example, an executive summary outlining the process and participants, a participant roster with meeting minutes or summaries of discussion, a memo describing the process, or an excerpt from the Community Health Improvement Plan.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

SHIP Alignment

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
600.400.2.e. A statement that the SHIP was reviewed, including a description of the alignment or nonalignment between the priority health needs of the applicable local public health jurisdiction, as identified by the local health department, and the priorities to improve the public health system, as set forth by the SHIP. 600.410.a.4 The process shall include a review of the SHIP by the local health department and a description of the alignment or nonalignment between the priority health needs for the applicable local public health jurisdiction, as identified by the local health department, and the priorities to improve the public health system set forth by the SHIP.	600.400.a.2.E 600.410.a.4	The Community Needs Assessment describes how the priorities are similar to and different from the SHIP.

Alignment with the State Health Improvement Plan: Healthy Illinois

The Illinois Department of Public Health (IDPH) is required to complete a State Health Assessment (SHA) and develop a State Health Improvement Plan (SHIP) every five years. IDPH refers to the SHA and SHIP as Healthy Illinois. As part of the assessment, IDPH reviews the priorities selected by each certified local health department in their IPLAN and incorporates this information as key data inputs. In turn, LHDs are expected to review the current SHIP during their IPLAN process, examining the state's priorities and the way local priorities do or do not align with those at the state level. LHDs can review the SHA and SHIP on the IDPH Healthy Illinois 2028 website to compare local priorities with those of the state. As part of this process, LHDs should note areas of alignment as well as areas of divergence, and should also note the rationale for differences, in the Community Health Needs Assessment report.

SHIP Alignment

PHAB Standards and Measures

PHAB infers but does not provide specific guidance on how LHDs should use the State Health Improvement Plan (SHIP). It mentions that LHDs may use the SHIP as a model or resource for their own community health improvement planning processes. The SHIP can serve as a reference for identifying health priorities, strategies, and activities that align with state-level goals. LHDs are encouraged to ensure their Community Health Improvement Plans address the specific needs of the residents within their jurisdiction while considering the broader priorities outlined in the SHIP.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

LHD Examples

The Iroquois County Public Health Department demonstrated their review of the SHIP by listing the five SHIP priorities and noting the relationship to Iroquois County and by referencing local data and similarity between intended state and local goals. For example, the Iroquois County IPLAN report noted chronic disease as a SHIP priority and explained, “Cancer and other chronic diseases ranked 4th in Iroquois Counties Community Themes and Strengths Assessment. Combating chronic disease with education, community clinical-linkages, and the promotion of healthy lifestyle choices is a main priority for Iroquois County.” For a full list of SHIP priorities and their alignment with Iroquois County, see page 33 of the Iroquois County Illinois 2024-2029 Community Health Improvement Plan.

The 2022-2027 Skokie Community Health Improvement Plan included the following statement to demonstrate review and alignment of the SHIP with their local plan. “Skokie's Health and Human Services CHIP shows alignment with two of the priorities outlined in the State Health Improvement Plan (SHIP) of Illinois. Specifically, both plans share a focus on addressing behavioral health as a key area of concern, and their respective goals complement each other in this regard. Additionally, maternal and child health emerges as another priority where the two plans align. The SHIP aims to support healthy pregnancies and improve birth and infant outcomes, which nicely complements Skokie's goal of reducing the percentage of pregnant women who do not receive timely prenatal care. Furthermore, while Skokie's plan emphasizes enhancing access to healthcare services, the SHIP's other priority revolves around tackling chronic diseases. Overall, the congruence between Skokie's Health and Human Services CHIP and the State Health Improvement Plan signifies a concerted effort to address critical health needs in the region, fostering a more comprehensive and effective approach to improving the well-being of the community.” Find the 2022-2027 Skokie Community Health Improvement Plan at https://www.skokie.org/DocumentCenter/View/9974/2022-2027-Skokie-Community-Health-Improvement-Plan.

Community Health Improvement Plan (CHIP)

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
d.5.A A statement of purpose of the Community Health Plan that includes how the plan will be used to improve the health of the community	600.400.d.5.A	The statement of purpose includes a description of how the community's health will be improved.
d.5.B A description of the process used to develop the Community Health Plan	600.400.d.5.B	Each step in the process is clearly described.
d.3 Community participation is utilized in the development of the Community Health Plan	600.400.d.3 600.410.a.1	Community participation is utilized in setting objectives.
d.4 The Community Health Plan has been adopted by the board of health	600.400.d.4	The health plan has been adopted.
d.5.C A description of each priority, including the importance of the priority health need, summarized data and information on which the priority is based, the relationship of the priority to Healthy People national health objectives, and factors influencing the level of the problem (e.g., risk factors, contributing and indirect contributing factors)	600.400.d.5.C 600.400.d.5.C 600.410.a.2 600.400.d.5.C 600.400.d.5.C 600.400.d.1	Community participation is utilized in the setting of objectives. All relevant data is included. The description includes how the priority is similar to or different from the national health objectives. The factors influencing the problem are derived from data or published studies.
d.5.D At least one measurable outcome objective covering a three or more year time frame related to each priority health need	600.400.d.2 600.400.d.5.D 600.410.a.5	The outcome objective is measurable and appropriate for the time frame.
d.5.E At least one measurable impact objective related to each outcome objective	600.400.d.2 600.400.d.5.E 600.410.a.5	The impact objective is measurable and appropriate for the time frame.

Community Health Improvement Plan (CHIP)

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
d.5.F At least one proven intervention strategy to address each impact objective.	600.400.d.2 600.400.d.5.F 600.410.a.5	There is a proven intervention strategy for each impact objective.
g.2 Includes a plan to monitor programs to assess progress towards meeting community health objectives as stated in the Community Health Plan	600.400.g.2	A plan for monitoring the intervention strategies is included in the Community Health Plan.
h. Includes a plan to promote awareness about the public health services availability and health education initiatives	600.400.h	A plan for communicating health initiatives and services with the public is included.

Community Health Improvement Plan Requirements

Developing a Community Health Plan completes the process known as IPLAN, which certified LHDs are required to complete every five years The plan must include the analysis of each health problem (priority) and associated risk, and contributing factors, as well as measurable objectives addressing each priority. Section 600.400 (a)(2)(d) of the code begins to describe the context for creating the Community Health Plan.

The administrative code states that LHDs need to:

"Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved through a systematic course of action that focuses on local community needs and equitable distribution of resources, and involves the participation of constituents and other related governmental agencies."

The following components are required to be included in the Community Health Plan report that is submitted to IDPH:

- Statement of purpose
- Description of the planning process
- Description of each priority
- One measurable outcome objective (for each priority)
- One measurable impact objective (for each outcome objective)
- One proven intervention strategy (for each impact objective)
- Incorporation of Healthy People
- Evaluation plan*

*Though not required in the Community Health Plan, this section of the code does state "The local health department shall conduct monitoring of programs to assess achievement of mandated programs and progress towards meeting community health objectives as stated in the Community Health Plan." Section 600.400 (a)(2)(g)(2)

Community Health Improvement Plan (CHIP)

CHIP Report Introduction

In the introduction of the CHIP, LHDs should include:

- Statement of purpose
- A description of the process
- A list of the community participants and how they participated
- Adoption by the board of health

The statement of purpose should describe how the **plan** will be used to improve health in the community. While this step may be as simple as articulating a clear statement of purpose of the Community Health Plan, it can serve as a foundational opportunity to engage the community in defining a mission for coming together and addressing the community health needs of the jurisdiction and defining a vision, or desired future state, for the community. APEX-PH does not have a defined process for accomplishing this requirement. However, LHDs can still utilize the methods for developing the statement of purpose with the developed mission, vision, and guiding principles from the CHNA statement of purpose section of the workbook (see page 20).

The administrative code also requires the plan to include a description of the process used to develop the Community Health Plan. For compliance, each step of the process should be clearly described. This includes detailing how goals, objectives, and strategies were developed and how the community participated in the development of the plan, specifically for setting objectives.

Finally, the plan must be adopted by the board of health. LHDs must describe the process of adoption and provide evidence of that adoption by the board of health.

Community Health Improvement Plan (CHIP)

LHD Examples

Greene County Health Department utilized an Executive Summary section to describe the process and the way the community participated. In the Statement of Purpose, Greene County also included information about the adoption of the plan by the Board of Health. Below are paragraphs pulled from these sections. To see both sections in their entirety, see pages 7-9 of the Greene County IPLAN document.

Statement of Purpose

Greene County Health Department's mission is to assure access to resources with a focus on prevention, health education, home health, and resource support to tirelessly serve Greene County, Illinois, residents. To accomplish this mission, we must balance three public health functions: assessment of community health status and resources, development of policies and programs, and assurance of equality and effective services.

Through the IPLAN process, we can assess current or emerging trends that the community identifies through surveys, focus groups, and organizational assessments. By utilizing our community to help determine public health focus, we can better impact the long-term health of the residents in Greene County. IPLAN focuses on community input to determine valuable and actionable health needs.

Description of the Process and Community Participation

Health data were collected using national, state, and county-level statistical information, to capture the current status of seven specific health indicators groupings reflective of a format to acquire input indirectly from both citizens of Greene County and community stakeholders. In the process of developing the Community Health Plan, Greene County Health Department stressed that the Plan is a community plan. The priorities were selected based on statistical significance and frequency of community concern.

Greene County continues, in the Executive Summary, to describe in high-level detail that process of establishing priorities, developing objectives and strategies, and conducting an organizational capacity and self-assessment.

Adoption by the Board of Health

Greene County Board of Health reviews the proposed health priorities and Community Health Plan for approval of implementation. Upon approval, the IPLAN document is submitted to the Illinois Department of Public Health (IDPH) for review and approval as part of the local health department's recertification package.

Greene County Health Department also provided evidence of the approval with a letter from the board of health on page 52 of their IPLAN.

Community Health Improvement Plan (CHIP)

LHD Examples (Continued)

The Ford County Health Department provided an introduction to their Community Health Improvement Plan as summarized below.

Statement of Purpose

By completing reviews of relevant data, collecting opinions of community participants, and discussing information with community health partners, the Community Health Needs Assessment was completed for Ford County. The document presented provides guidance and structure to improve the overall health and well-being of the Ford County residents over the next five years. Priorities with achievable goals and measurable outcomes provide this guidance and structure to continue the work with community partners.

Description of the Process and Community Participation

Facing staffing challenges, the department partnered with organizations that had more resources and broader community reach to better coordinate healthcare strategies. Invitations were extended to representatives from mental health, education, hospitals, care coordination, emergency management, and local government to participate in the county's IPLAN process.

At meetings in April and May 2024, participants reviewed community survey data, assessed prevalent health issues, and discussed how health needs were interconnected. Partners worked closely with Gibson Area Hospital to integrate findings from multiple community engagement efforts and align them with statewide and national health improvement plans, such as Healthy Illinois 2028 and Healthy People 2030. Ultimately, they agreed to adopt the same priority concerns identified in Gibson Area Hospital's Community Needs Assessment.

Adoption by the Board of Health

The finalized IPLAN was then reviewed, revised based on feedback, and approved by the Ford County Board of Health. The health department provided a copy of the letter from the Board of Health as well.

For more information, see pages 24-26 of the Ford County Public Health Department 2024-2029 IPLAN, found at https://fordcountyphd.org/file/749/Russell%20-%20IPLAN%20-%2024%20Final%20Draft.pdf.

Community Health Improvement Plan (CHIP)

PHAB Standards and Measures

Measure 5.2.1.A

Required Elements

- A list of participating partners involved in the CHIP process.
- Review of information from the Community Health Assessment.
- Review of the causes of disproportionate health risks or health outcomes of specific populations.
- Process used by participants to select priorities.

Documentation Examples:

Documentation could be, for example, an executive summary outlining the process and participants, a participant roster with meeting minutes or summaries of discussion, a memo describing the process, or an excerpt from the CHIP.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

Description of the Priority

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
d.5.C A description of each priority, including the importance of the priority health need, summarized data and information on which the priority is based, the relationship of the priority to Healthy People national health objectives, and factors influencing the level of the problem (e.g., risk factors, contributing and indirect contributing factors)	600.400.d.5.C	The description includes a discussion of why the problem is important to the community. All relevant data is included.
	600.410.a.2	The description includes how the priority is similar to or different from the national health objectives.
	600.410.a.2	The factors influencing the problem are derived from data or published studies.

Description of the Priority

The description of the priority health need in the community improvement plan includes:

- A description of the importance of the priority health need
- Summarized data and information on which the priority is based
- The relationship of the priority to **Healthy People** national health objectives
- Factors influencing the level of the problem (risk factors, direct contributing and indirect contributing factors, population groups at risk)

LHDs should include in the Community Health Plan their rationale for selecting their three health priorities, based on a thorough review of all compiled data. The justification should include a clear description of why these priorities were chosen by the community, partners, and the LHD, and why each issue is considered important to the community. It should also include a concise, high-level summary of the supporting data, which demonstrates the significance of each selected health priority.

This section should also describe how the selected priorities align or differ from the national health objectives outlined in Healthy People—a valuable resource for setting objectives that can be tailored to meet local needs. Because Healthy People emphasizes the social determinants of health, there are many objectives that directly address these factors in relation to local health problems. LHDs are encouraged to adapt these objectives to reflect their community's unique context and needs.

Factors Influencing the Problem

Finally, this section must describe the factors influencing the level of the problem for each of the selected priorities.

The IPLAN process requires an analysis of both risk factors and the direct and indirect contributing factors associated with each identified health priority.

For this analysis, refer to the following terms and definitions:

- **Risk factor:** A scientifically established factor (determinant) that relates directly to the level of a health problem. A health problem may have any number of risk factors identified.
    - For example, obesity is a risk factor for diabetes. This is true because obesity directly relates to the health problem of diabetes.
- **Direct contributing factor:** A scientifically established factor that directly affects the level of a risk factor.
    - For example, poor diet is a direct contributing factor because it affects obesity.
- **Indirect contributing factor:** A community-specific factor that directly affects the level of the direct contributing factors. These factors can vary greatly from community to community.
    - For example, lack of grocery stores that carry fresh vegetables and fruits are indirect contributing factors because they affect poor diet and may be specific to the local community context.

Identifying the risk factor(s) and the contributing factors are steps in the health problem analysis, which is designed to examine the various factors that may cause or contribute to a selected health priority. Using the Health Problem Analysis worksheet may be useful. APEX-PH created a worksheet that can be found in Appendix N.

From there, the community health plan worksheet asks LHDs to identify:

- Objectives – impact and outcome
- Resources needed
- Barriers that exist
- Corrective actions to reduce the level of the indirect contributing factors
- Proposed community organization(s)to provide and coordinate the activities
- Evaluation plan to measure progress towards reaching objectives

The information LHDs include in the health problem analysis worksheet from APEX-PH is also a requirement to be included in an IPLAN submission.

Description of the Priority

Tips for Description of the Priority

Use the Health Problem Analysis and Community Health Plan Worksheets in Appendix N, Appendix O, and Appendix P, which IDPH highly recommends, regardless of the process used to develop the Community Health Improvement Plan. One worksheet should be used for each priority.

Review Healthy People national objectives to inform the selection and development of objectives at the local jurisdiction level.

Review IDPH's online subject matter expert (SME) list, which is organized by health problems. Individuals listed as SMEs may be contacted to provide guidance on selecting objectives, identifying risk factors, and contributing factors, and, in the next steps in the Community Health Improvement Planning process, selecting evidence based strategies to address the objectives. Find the Subject Matter Expert list by topic area on the IDPH IPLAN website.

LHD Examples

The Southern Seven Health Department Community Needs Assessment and Improvement Plan for 2025-2030 provides examples of using the Health Problem Analysis Worksheet to define the risk factors and the direct and indirect contributing factors for each of the priorities. The Health Problem Analysis Worksheet includes a summary of data related to the priority, an outcome and impact objective, proven intervention strategies, resources and proposed community organizations to coordinate activities, barriers, corrective actions to reduce the level of the indirect contributing factors, and an evaluation plan to measure progress towards reaching objectives. See pages 51-82 of the report at https://southern7.org/_downloads/SouthernSeven_IPLAN_2025-2030%206.5.25.pdf?_t=1753716751

Description of the Priority

LHD Examples (Continued)

The Winnebago County Health Department used the MAPP 2.0 Framework to complete their 2025-2030 IPLAN process. One tool in the MAPP 2.0 process helps develop Problem or Issue Statements for each priority. (This is similar to the IPLAN requirement for describing the health priority.) The health department provides a summary of data and findings that demonstrate the rationale for the health problem or issue specific to the jurisdiction. Next, the health department applies the summary responses to the 5 Whys tool and conducts a root cause analysis on each of their selected priorities. The Root Cause Analysis tool helps them understand the underlying risk factors and direct and indirect contributing factors. Using it helps inform the next steps in implementation plan development, by articulating the types of improvements needed to make an impact in the local community. A template for the 5 Whys tool is provided below. For more information, see pages 158-166 of the Winnebago County Health Department IPLAN 2025-2030, found at https://publichealth.wincoil.gov/wp-content/uploads/2025/06/IPLAN-2025-2030_FINAL_3.17.2025-TableOfContents.pdf.

Root Cause Analysis Tool

Problem or Issue Statement:		
5 Whys	**Answer**	**Assessment(s) or underlying factors supporting answer**
Why is the above problem happening?		
Why is the above problem happening?		
Why is the above problem happening?		
Why is the above problem happening?		
Why is the above problem happening?		
Why is the above problem happening?		
ROOT CAUSE:		

Description of the Priority

MAPP 2.0 Framework

MAPP 2.0 users can utilize Issue Profiles (MAPP 2.0 handbook, page 124) while developing their description of the priority. Issue profiles consist of the following items, which would fall under the requirements of this section of the Community Health Plan.

1

Issue Topic

MAPP 2.0 users should begin with the issue topic, otherwise known as the health priority. This would be an overarching public health topic, like chronic diseases or mental health.

2

Issue Statement

From there, MAPP 2.0 users should utilize the issue statements developed in Phase II, Step 4.4: Develop Issue Statements. Issue statements are one- to two-sentence statements that identify and summarize how and why the health priority occurs, the severity of the issue in the community, and its outcomes and impacts.

3

Description of the Issue

A description identifies why the issue is important in the LHD's community, while specifically noting the root causes of the issue. It would arise from a root cause analysis through the use of tools like the 5 Whys or Fishbone diagrams.

The MAPP 2.0 handbook notes that root cause analysis "is an opportunity to talk about how root causes, or structural determinants, and SDOH uniquely influence this issue in your community." (MAPP 2.0 Handbook, page 124)

4

Priority Community Indicators

MAPP 2.0 users should review the summary data from the assessments LHDs included to support the topic, including which indicators were highlighted, how they are represented in the root cause analysis, and how they bring together upstream and downstream metrics. They should highlight both qualitative and quantitative data related to the indicators that proved the importance of the health priority.

Description of the Priority

PHAB Standards and Measures

Measure 5.2.1.A

Required Elements:

- Review of information from the Community Health Assessment.
- Review of the causes of disproportionate health risks or health outcomes of specific populations. This includes a review of the social and structural determinants of health.

Documentation Examples:

- This could include, for example, meeting minutes demonstrating that the state/Tribal/Community Health Assessment was reviewed by the CHIP partnership, or another description of how the health assessment findings were used in the health improvement planning process.

- Documentation demonstrating review of these determinants, could be, for example, a summary of partnership discussions or meeting minutes.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

Objectives and Strategies

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
d.5.D At least one measurable outcome objective covering a three-or-more year time frame related to each priority health need	600.400.d.2 600.400.d.5.D 600.410.a.5	The outcome objective is measurable and appropriate for the time frame.
d.5.E At least one measurable impact objective related to each outcome objective	600.400.d.2 600.400.d.5.E 600.410.a.5	The impact objective is measurable and appropriate for the time frame.
d.5.F At least one proven intervention strategy to address each impact objective	600.400.d.2 600.400.d.5.F 600.410.a.5	The impact objective is measurable and appropriate for the time frame.

Objectives and Strategies

Objectives

Objectives are essential components of any planning process, including the IPLAN. Objectives represent the operational core of the Community Health Plan, providing clear direction and defining measurable progress toward desired outcomes. Well-crafted objectives define what is to be accomplished and provide the foundation for strategies and interventions. When written, objectives should be concise, actionable statements that clearly guide the planning and implementation process. IPLAN requires at least one outcome objective, one impact objective, and one proven intervention strategy for each priority.

The IPLAN process requires specific types of objectives for the Community Health Plan—outcome and impact objectives—and defines them as follows.

Outcome Objectives

This objective is a measurable statement indicating the desired level of change in a health problem or condition. This is a long-term objective with a five-year timeframe.

Impact Objectives

This objective is a measurable statement indicating the desired level of change in a risk factor. Impact objectives are intermediate in time with a two-to-three-year timeline.

Outcome Objective Examples

Reduce the percentage of XYZ County high school students reporting consumption of alcohol within the past 30 days from 30% to 20% by 2030, as reported in the Illinois Youth Survey.

Impact Objective Examples

Reduce the percentage of XYZ County high school students reporting that it would be "very" or "sort of easy" to obtain alcohol from 63% to 50% by 2028, as reported in the Illinois Youth Survey.

Intervention Strategies and Process Objectives

LHDs should provide at least one proven Intervention Strategy to address each written impact objective. The description should include the community resources that will contribute to implementation, estimated funding needed for implementation, and anticipated sources of funding.

Here is an example of a process measure:

By December 2030, X% reduction of XYZ County of underage alcohol sales.

Here is an example of an intervention strategy:

Partner with youth and law enforcement to conduct alcohol sale compliance checks.

The APEX-PH manual and the IPLAN website provide worksheets for organizing these objectives and intervention strategies. These worksheets are provided in Appendix O and Appendix P.

Where can objectives come from?

- **Funding sources (expectations)**
- Administrative dictates and policies
- Administrative protocols and priorities
- Community Health Needs Assessment
- Partnership agreements and other external relationships
- Recognized state and/or national public health agendas
- Advocacy groups and associations

Objectives and Strategies

Intervention Strategies

LHDs should choose intervention strategies that focus on direct community health needs as well as strategies that address social determinants of health. A comprehensive Community Health Plan requires both downstream and upstream strategies. Upstream strategies focus on social determinants of health and social and structural inequities, while downstream strategies focus more on risk behaviors, disease and injury, and mortality. For more information on upstream and downstream frameworks, see the BARHII framework. **Please note, the administrative code requires at least one proven intervention strategy for each impact objective.**

The AHA Community Health Improvement (ACHI) toolkit describes ways in which LHDs can identify the different levels of intervention strategies by asking the following questions:

- "What level of intervention is the Community Health Plan targeting, based on aim and strategy?
- What type of interventions are being proposed?
  - The **CDC's 6|18 Initiative** identifies three types of interventions—
    - Traditional clinical prevention, such as vaccination and screening
    - Innovative clinical preventive interventions, such as working with community health workers
    - Total population or community-wide interventions, such as policy change
- How many facets of the prioritized need does the strategy address?
  - This is where the LHD considers the priority from a 'big picture' perspective to understand the health department's role in addressing it."

SMARTIE Method

LHDs should also utilize the SMARTIE method when developing objectives and strategies. The CDC describes the SMARTIE Method below.

S	SPECIFIC	The objective should focus on a goal of the program and can be based on partner input
M	MEASURABLE	The objective should include a standard or benchmark to assess progress
A	ACHIEVABLE	The objective should be attainable based on the program's capacity, while also being meaningful
R	REALISTIC	The objective should be relevant and based on the program's plan
T	TIME-BOUND	The objective should include a clear timeline
I	INCLUSIVE	Is "an opportunity to bring traditionally excluded individuals and groups into processes, activities, decisions, and policy making in a way that shares power"
E	EQUITABLE	Means "including an element of fairness or justice to address systemic injustice, inequity, or oppression"

(CDC From SMART to SMARTIE Objectives, 2023)

In recent years, the method has been updated to include inclusivity and equity. This is a result of a shift to focus more on health disparities and communities disproportionately impact by health inequities. Utilizing the SMARTIE method during the planning process demonstrates LHD knowledge of and commitment to addressing health problems in the community, as well as addressing existing institutional and structural barriers to achieving health equity through a lens of social and structural determinants of health and their root causes.

Objectives and Strategies

Tips for Objectives and Strategies

When developing new strategies, think about past strategies, new realizations, what worked, and what didn't work.

Develop and reference a logic model when creating SMARTIE objectives, which makes the process easier. MAPP 2.0 has a process for developing logic models on page 160 of the MAPP 2.0 Handbook.

Review IDPH's online subject matter expert (SME) list, which is organized by health problems. Individuals listed as SMEs may be contacted to provide guidance on selecting objectives, identifying risk factors, and contributing factors, and in the next steps in the Community Health Improvement Planning process, selecting evidence-based strategies to address the objectives. Find the Subject Matter Expert list by topic area on the IDPH IPLAN website.

For more information on the community action plan, watch the IPLAN training, Managing the Community Action Plan Cycle, on the IPLAN training website.

To support the development of proven intervention strategies, LHDs can utilize these existing sources:

- County Health Rankings and Roadmaps—What Works for Health: http://countyhealthrankings.org/strategies-and-solutions/what-works-for-health
- Healthy People—Evidence-Based Resources: https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources
- CDC The Community Guide: https://www.thecommunityguide.org/pages/about-community-guide.html
- CDC Community Health Improvement Navigator: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/chinav/index.html
- SAMHSA Evidence-Based Practices Resource Center: https://www.samhsa.gov/libraries/evidence-based-practices-resource-center
- Rural Health Information Hub—Evidence-based Toolkits for Rural Community Health: https://www.ruralhealthinfo.org/toolkits

Objectives and Strategies

LHD Examples

The Boone County Health Department provides a robust description of each priority health issue selected for their Community Health Improvement Plan. Following the summary of data and information describing the issue and the analysis of local relevant data to substantiate the priority (including interconnected health issues, root causes and contributing factors), the health department defines the vision for each priority, as well as a measurable outcome objective, related impact objectives, and planned intervention strategies. For each outcome objective listed, a set of shorter-term impact objectives and intervention strategies are defined. Following the objectives, a list of organizations and individuals responsible for implementation is provided. Listed below is a sample of one outcome objective and a set of impact objectives and intervention strategies for the Food Security priority.

Food Security Selected Objectives

2023 - 2027 Boone County IPLAN based on recommendations by CDC and Healthy People 2030:
Vision: Eliminate barriers to receiving enough nutritious food to lead an active, healthy life.

FS 1: Measurable Outcome

Health Equity: Improving food systems in Boone County to be easily accessible to all residents by September 4, 2027.

FS 1: Measurable Impact

1. Advocate for the expansion of WIC and SNAP benefits through policy change and collaboration with elected officials by September 4, 2027.
2. Onboard at least two organizations to support and expand existing programs and projects that help get more healthy food to children and youth during the school year and summer by September 4, 2027.
3. Facilitate at least one communication campaign to destigmatize and promote supplemental meal programs and food pantries by September 4, 2027.
4. Advocate for the availability and distribution of healthy and culturally diverse foods at local food pantries by adopting at least two strategies from the Nutrition in Food Banking Toolkit by September 4, 2027.

FS 1: Proven Intervention Strategies

1. Proposals have been issued that would reduce or eliminate SNAP benefits, restricting broad based categorical eligibility. This would make it more difficult for affected individuals to access nutritious food. Not only that, but it will make it more difficult for children to access free school meals. The Official Journal of the Academic Pediatric Association recommends that providers advocate for policies that protect and strengthen SNAP and WIC benefits (Heather Hartline Grafton, 2020).
2. The Summer Food Service Program (SFSP) administered by the USDA helps low-income children and teens access nutritious meals during the summer to improve food security when they are not in school (U.S. Department of Agriculture, 2023). The Journal of Children and Poverty reported that a study between 1995 and 2001 found that seasonal differences in food insecurity were greater in states providing small numbers of Summer Food Service Program meals and summertime school lunches than other states (Romig, 2006). Existing programs in Boone County include Summer Food Service Program and Blessing Boxes, which are wooden boxes in the community containing nonperishable food items for community members to give or take.

Objectives and Strategies

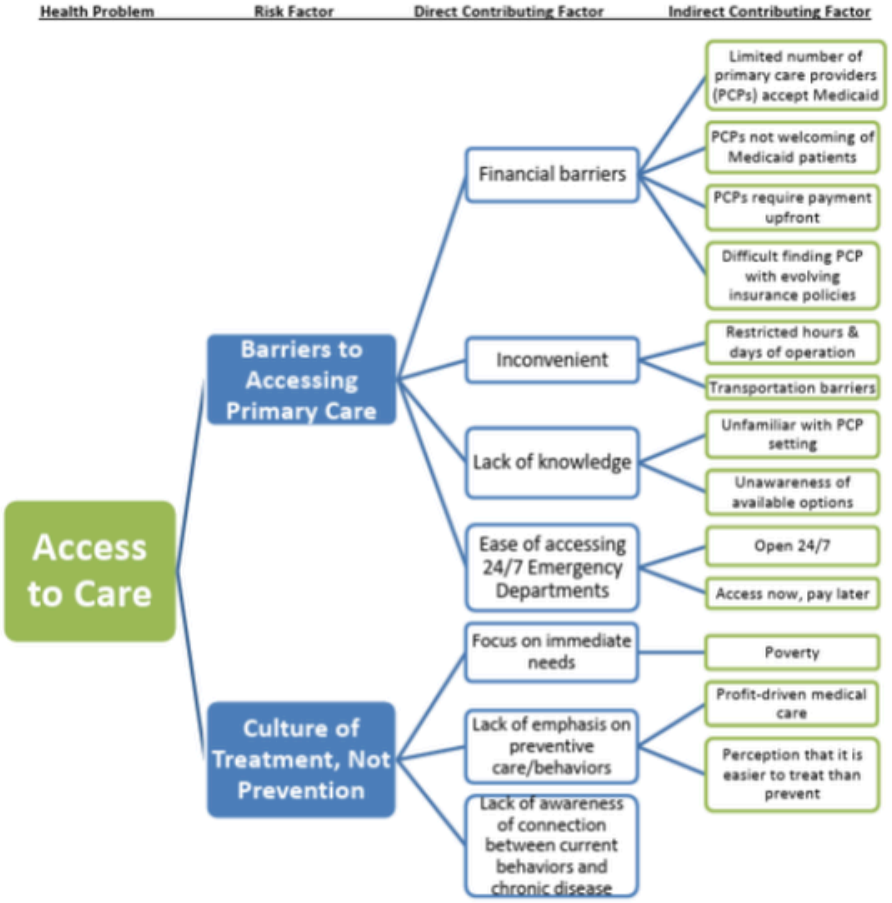
LHD Examples (Continued)

FS 1: Proven Intervention Strategies (Continued)

3. The National Prevention Information Network provides Health Communication Strategies and Resources for using an evidence-based health communications campaign, which often can improve behavior change (Centers for National Disease Control and Prevention, 2023).
4. Feeding America provides a Nutrition in Food Banking Toolkit, which highlights how low-income families are affected by overlapping issues, like chronic or acute diseases, high medical costs, and low wages. Food security responses must address these overlapping issues. This toolkit aims to help the charitable food sector enhance efforts to meet nutrition needs of individuals facing food insecurity.

For a full example of how the Boone County Health Department describes each priority health issue, see pages 49-93. To see the objectives and strategies for the three priorities, refer to pages 61-63 for behavioral health, 78-80 for maternal and child health, and 91-93 for food security. The report can be found at Boone County Health Department IPLAN 2024-2027, at https://cms8.revize.com/revize/boonecountyil/IPLAN%20FINAL.pdf?t=202506051027370&t=202506051027370.

The McLean County Health Department describes each health priority based on primary data and secondary data depicted in charts, graphs, and summarized in narrative form. They demonstrate understanding of the risk factors and direct and indirect contributing factors by completing a health problem analysis visual (shown below).



Objectives and Strategies

LHD Examples (Continued)

Next, for each priority, a rationale for selecting the priority is summarized, along with a descriptive process for how the goals and objectives were developed. Finally, the LHD provides a snapshot of the goal, outcome objectives, impact objectives, and key strategies. An example is shown below for one of the priorities, Access to Care.

The Access to Care Community Health Improvement Plan for 2023 – 2025 focuses on three key strategies:

- **Strategy 1:** Support assertive linkage navigation/engagement programs which link lower income community members with a medical home and insurance coverage.
- **Strategy 2:** Increase the capacity of organizations providing dental services to low-income residents of McLean County.
- **Strategy 3:** Increase service delivery models outside brick and mortar, face-to-face services to increase access and availability of community-based services for low income Mclean county residents.

An overview of the goal and objectives to address Access to Care are listed below:

High-Level Goal for Access to Care: Advance and advocate for equitable and affirming access to care and other resources, which address social determinants of health, to improve the health and well-being of our diverse community by 2026.

- Outcome Objective: By 2026, reduce the percentage of individuals utilizing McLean County hospital emergency rooms for non-emergent conditions.
  - Impact Objective #1: By 2026, decrease the number of Mclean County residents identifying the emergency department as their choice of medical care.
  - Impact Objective #2: By 2026, increase the number of McLean County residents indicating they have access to a dentist.
  - Impact Objective #3: By 2026, decrease the number of McLean County residents indicating that they do not seek care.

The following ten pages (29 – 38) contain the 2023 – 2025 McLean County Community Health Improvement Plan Summary for Access to Care.

For more information, see pages 18-91 of the McLean County Illinois Community Health Improvement Plan 2023-2025, found at https://health.mcleancountyil.gov/DocumentCenter/View/25213/IPLAN_2023_-_2025_McLean_County_CHIP_FINAL_1-25-23.

Objectives and Strategies

MAPP 2.0 Framework

Developing Goals and Objectives

MAPP 2.0 has a Goal Development Worksheet on pages 150-151 of the MAPP 2.0 Handbook for goal brainstorming.

MAPP 2.0 asks LHDs to consider the following questions when identifying SMARTIE objectives:

- **Specific** - What goal are you trying to realize?
- **Measurable** - How much? How often? How many?
- **Achievable** - Will we be able to accomplish this?
- **Relevant** - Is it related to achieving the overall goal? Is it relevant to the priority issue and the vision?
- **Timebound** - When will it happen? What is a realistic timeframe?
- **Inclusive** - How will you include underrepresented voices and share power?
- **Equitable** - How does it seek to address systemic injustices, inequality, or oppression?

Review the MAPP 2.0 Handbook SMARTIE Objectives Worksheet on page 159.

Developing Strategies

MAPP 2.0 emphasizes the importance of developing strategies that address policy, systems, and environmental change.

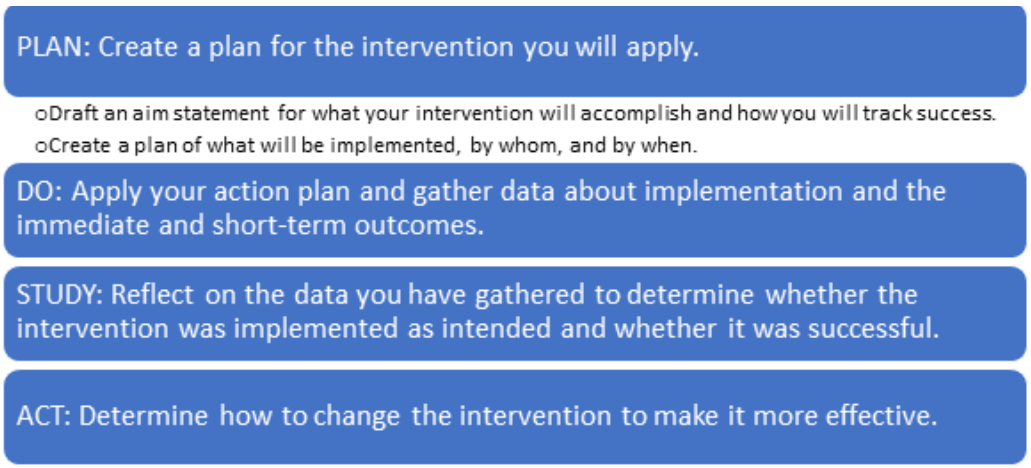
When developing strategies with the community, LHDs should discuss the importance of selecting upstream strategies as it pertains to addressing root causes from an equity perspective. To address root causes of inequity, try to focus strategies on the systems and policies that contribute to health. Additionally, identify community-driven solutions.

Consider the following when developing strategies:

- Addressing inequity requires changes in policy, systems, and environment.
- Choosing evidence-informed strategies that have been shown to work and are good for the community will increase the possibility of success.
- Understand the unique factors and dynamics that make up a community to ensure the strategy resonates
- with people.
- To have the greatest impact and success, engage a broad group of stakeholders, including community members and decision-makers.
- For greater sustainability, select strategies that align with the focus areas and resources of partners in the subcommittee, using the community partner profile.

MAPP 2.0 also encourages the use of the SMARTIE method when identifying strategies.

Another method of identifying strategies is to utilize the PLAN-DO-STUDY-ACT method for strategies from the current Community Health Improvement Plan cycle.



Objectives and Strategies

PHAB Standards and Measures

Measure 5.2.2.a

Required Elements:

- **a.** At least two health priorities.
- **b.** Measurable objective(s) for each priority.
- **c.** Improvement strategy(ies) or activity(ies) for each priority.
  - i. Each activity or strategy must include a time frame and a designation of organizations or individuals that have accepted responsibility for implementing it.
  - ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities

Documentation Examples:

For required element a: The CHIP will designate two or more health priorities to be addressed collaboratively.

For required element b: By establishing one or more measurable objective(s) for each of the health priorities, the CHIP collaborative will be able to determine if progress is being made towards addressing each priority. The objectives could be contained in another document.

For required element c: Improvement strategy(ies) or activity(ies) may be evidence-based, practice-based, promising practices, or they may be innovative to meet the needs of the population. National guidance (e.g., the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People) could be used as sources of strategies or activities, as appropriate.

For i: Time-framed strategies or activities may be contained in another document, such as an annual work plan. If communities are using innovation processes (e.g., design thinking) or quality improvement processes, the strategies or activities may evolve as the community tests out solutions and makes adjustments. In those cases, the improvement strategies or activities included in the CHIP or work plan may describe the timelines for putting in place the process (e.g., that a group will be assembled to consider root causes and develop solutions to test), rather than the specific community actions. Designation of responsible parties may include, for example, assignments to staff or agreements among planning participants, stakeholders, other governmental agencies, or organizations. For this requirement, agreements do not need to be formal, such as an MOA or MOU.

For ii: To achieve health priorities, the CHIP will include recommendations related to policy—either new policies or changes to existing policies. Policy recommendations could, for example, examine correcting historical injustices to provide fair and just opportunities for all to achieve optimal health; they could also address the social and economic conditions that influence health equity, including housing, transportation, education, job availability, neighborhood safety, and climate change. While not all strategies in the CHIP will entail policy recommendations (i.e., providing additional services or new health communications may be appropriate strategies), the CHIP will include at least two policy recommendations (e.g., introducing a healthy vending policy for schools). One of those policy recommendations is designed to alleviate causes of health inequities (e.g., changes in zoning laws). Policy recommendations may be developed by involving communities impacted by health inequities in the identification, development, and implementation of policy changes to improve conditions impacting their health.

Inventory Community Resources

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
600.400.d.1 Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding	600.400.d.1 600.400.d.5.F	The analysis of resources and funding is detailed and sufficient.

Addressing the community health priorities that emerge through the IPLAN process will require the resources of the local public health system. These available health resources will need to be detailed in the Community Health Plan but are identified in the assessment phase of the process. In this phase, the community partners and health department staff create an inventory of potentially available community health resources to address direct and indirect contributing factors. This phase of the process should also unveil potential barriers to addressing the health priorities. The APEX-PH manual provides worksheets for summarizing the information gathered in this and the previous phase. See the worksheets in Appendix P.

Another useful tool for assessing community assets is the Community Asset Map from the American Hospital Association's Community Health Improvement Toolkit. This mapping tool helps identify various types of assets within a community, providing insight into which resources partners value most, the kinds of support they can contribute to collective efforts, and the power they hold in achieving shared goals.

These assets include:

- **Human** – organization staff, programs and services, and their expertise and experience
- **Physical** – geographic location in the community
- **Informational** – networks for communicating to the public and with partners
- **Political** – elected officials, advocates, and policy institutions
- **Existing interventions** – initiatives already in progress in the community

LHDs should continue to assess community resources to leverage for implementation, especially when identifying priorities and choosing strategies. For additional tools to inventory community resources, see the MAPP 2.0 resource on page 79.

It is also important to consider funding as LHDs develop their strategies and begin action planning. At this phase, LHDs must consider what funding they can already access and what possible funding sources they could tap or apply for to increase their ability to achieve these strategies.

Inventory Community Resources

Tips for Inventory Community Resources

- Use the ACHI toolkit to identify questions that LHDs can ask in this phase to assess funding sources.
- Find partners who align with the LHD's work and the priorities; who can support in the development of the goals, objectives, and strategies; and who can support in implementation.
- Apply the tools used to inventory community resources to other parts of the IPLAN process as well as to other work that requires community and partner engagement

LHD Examples

The Hancock County Health Department partnered with Memorial Hospital on their CHNA and Implementation Plan for 2025-2028. The implementation plan included a list of community resources and assets related to each priority area, a list of barriers, and an estimate of funding needs to address the priority areas in narrative form. For example, the following is an excerpt from the Implementation Plan related to the mental health priority for Hancock County.

Community Resources Available for Mental Health

There are few resources that already exist to assist people with their mental health. These resources include counseling services with MHCWI, school psychologists in the local schools, the drug court program, the Hancock County Addiction Coalition, Evergreen Center, many community churches and faith organizations, mental health call /text lines, and many local healthcare providers.

Barriers for Mental Health

Existing barriers to achieving goals to improve mental health include financial costs, external stressors, time constraints, and transportation.

Estimated Funding Needs for Mental Health

By Hancock County Health Department: $0.00
By Mental Health Centers of Western Illinois: $55,000

- Additional counselor
- Staff support for assistance at substance abuse/mental health community educational programs.
- Staff support for assistance in implementing the mental health/stress management educational campaign
- Staff support for providing youth and adult mental health first aid classes
- Staff support for social media promotions and marketing

To see examples of the assets, barriers, and estimated funding needs for Hancock County's other community health improvement priorities, see pages 3-4 for health and wellness, pages 7-8 for mental health, and pages 10-11 for access to care. The Hancock County Implementation Plan can be found at https://www.mhtlc.org/wp-content/uploads/2025/08/Community-Health-Needs-Assessment-Implementation-Plan-2025-2028.pdf.

Inventory Community Resources

LHD Examples (Continued)

The McLean County Health Department conducted a joint Community Health Improvement Plan for 2023-2025 with OSF HealthCare St. Joseph Medical Center, Carle BroMenn Medical Center, and Chestnut Family Health Center. For each priority selected, the report includes a summary of related improvement plan efforts, a description of plans for funding the interventions in the plan, and a list of barriers to achieving health improvements. An example of the assets or related improvement plan efforts for the Healthy Eating and Active Living priority is shown below.

Related Improvement Plan Efforts for Healthy Eating and Active Living

The following organizations received grants in 2022 for implementation in 2022/2023 or FY23 (May 1, 2022-April 30, 2023) from the John M. Scott Health Care Commission. Although the grants are tied to the health priorities selected for the 2019 McLean County Community Health Needs Assessment, the grant programs will also apply to the 2022 McLean County Community Health Needs Assessment and 2023-2025 McLean County Community Health Improvement Plan as the health priorities are the same.

- West Bloomington Revitalization Project received a grant to support programs in West Bloomington that support healthy eating and active living, shrink the surrounding food desert, and improve the built environment to promote exercise. A leader from Carle BroMenn Medical Center and OSF St. Joseph Medical Center will continue to serve on the City of Bloomington's John M. Scott Health Care Commission Grants Committee.
- Other:
    - Carle Health and Fitness Center will continue to offer Free Friend Friday on the first Friday of each month. Members are allowed to bring a non-member friend to utilize the center on this day to encourage physical activity.
    - Carle BroMenn Medical Center will continue to partner with the Tinnervin Foundation and OSF St. Joseph Medical Center to offer food boxes and Smart Meals at mobile health clinics.
    - Chestnut Health Systems will collaborate with McLean County organizations to provide space to community agencies at the 702 West Chestnut Street Community Health and Wellness rooms, which include a teaching kitchen.
    - OSF HealthCare will continue to sponsor the Peace Meal Senior Nutrition Program to seniors living in McLean County.
    - OSF HealthCare will continue to sponsor Girls on the Run for local programming to improve the well-being of grade-school girls.
    - OSF Healthcare will continue to sponsor Student Health 101 emails to all student homes attending Normal Community West and Normal Community High Schools. These weekly emails promoted overall health and well-being education and resources to parents and students.

The report also noted after each summary of related improvement plan efforts that the four organizations comprising the McLean County Executive Steering Committee—Carle BroMenn Medical Center, Chestnut Health Systems, the McLean County Health Department—are all implied resources/partners for the priority area as well.

To see the full example for this priority and others in McLean County, see pages 89-91 for the Healthy Eating and Active Living example, pages 63-67 for the behavioral health example, and pages 36-40 for the access to care example in the McLean County 2023-2025 Community Health Improvement Plan, found at https://health.mcleancountyil.gov/DocumentCenter/View/25213/IPLAN_2023_-_2025_McLean_County_CHIP_FINAL_1-25-23

Inventory Community Resources

MAPP 2.0 Framework

Community Partner Profiles

In Phase III, Continuously Improve the Community, LHDs can use the community partner profiles to inventory resources across their local public health system. The community partner profile is a worksheet that each selected partner completes to demonstrate how their work is tied to the priority issue.

The goal of this activity is to review and analyze community partner profiles for each partner selected for the priority issue subcommittee, in order to further understand their values, mission, resources, and programmatic efforts related to the priority issue.

The profile collects the following information:

- Organizational mission, goals, and values (visioning activity)
- Available assets and resources to assist with the action plan
- Access to and knowledge of appropriate data and metrics
- Alignment of current interventions, programs, and activities
- Engagement and involvement with priority sub-populations experiencing inequities related to the priority issue

Each priority issue subcommittee should review the completed profiles together. They should use the information to identify opportunities to align organization work to support the strategic issue or to determine what resources can be shared to support the strategic issue.

Power Mapping

Power analysis and mapping can be used to determine the best way to engage stakeholders. Power analysis and mapping is a working session, using tools to determine who has the power to make decisions, push and stop efforts, and ultimately influence steps in IPLAN.

For power mapping, using a power matrix can help compare the amount of power a stakeholder has in the community with the degree to which they support the IPLAN process. For example, a stakeholder who has a lot of power and strongly supports the effort may be a partner with whom the LHD will work closely. Power mapping is a valuable tool for individuals actively working with communities, which provides a simple framework to better understand and leverage relationships and networks.

There is another tool called Potential Partners and Opponents Table that can help to identify powerful stakeholders within the priority issue. The potential partners and opponents worksheet asks specific questions related to each partner, focused on their power, accountability to their work, their influences, and the way their work is aligned. Using this pool in tandem with the power mapping matrix can be useful in answering these questions.

Inventory Community Resources

PHAB Standards and Measures

Measure 5.2.2.a

Required Element:

Identification of the assets or resources that will be used to address at least one of the specific priority areas.

Documentation Examples:

The assets and resources could be, but are not limited to, those identified as part of the CHA process. Community assets and resources could be anything that the jurisdiction could utilize to improve the health of the community. They could include, for example, skills of residents, state associations (e.g., service associations or professional associations), institutions (e.g., faith-based organizations, foundations, institutions of higher learning), recreational facilities, social capital, community resilience, or a strong business or arts community. These assets and resources will help the community address priority areas or implement strategies/activities. Including an asset or resource for each priority area is not necessary. They may be included as part of the CHIP, as an addendum, or in a separate document (as long as the link to the CHIP is indicated).

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

Monitor Programs and Promote Awareness

Requirements from Admin Code/Substantial Compliance Checklist

Admin Code 600.400	Substantial Compliance	
	Admin Code:	In Compliance:
g.2 Includes a plan to monitor programs to assess progress towards meeting community health objectives as stated in the Community Health Plan	600.400.g.2	A plan for monitoring the intervention strategies is included in the Community Health Plan.
h. Includes a plan to promote awareness about the public health services availability and health education initiatives	600.400.h	A plan for communicating health initiatives and services to the public is included.

Monitor Programs and Promote Awareness

The administrative code also calls for a plan to monitor intervention strategies in the Community Health Plan as well as a plan for communicating health initiatives and services publicly. This section of the code states "The local health department shall conduct monitoring of programs to assess achievement of mandated programs and progress towards meeting community health objectives as stated in the Community Health Plan." Section 600.400a.2 and g.2.

Action planning with measurable objectives is one aspect of developing an evaluation plan that ensures the outcomes of the strategies can be monitored. An effective monitoring process requires that LHDs:

- involve their community partners who have been involved in the IPLAN process
- identify clear ownership of strategies and key activities
- include measures of success to track
- inventory community resources to accomplish the strategies

When determining how to track and monitor progress of the CHIP, LHDs should consider the following questions:

- What are you already doing to collect data, document your work, etc.?
- What resources do you have?
- How often will you be able to come together to look at data?
- What existing reliable data do you already have?
- Where can you start measuring a couple indicators fairly easily and accurately?
- Where do you have measurement expertise, capacity, and time?

Infrastructure to support monitoring is important in this process. LHDs can achieve this by:

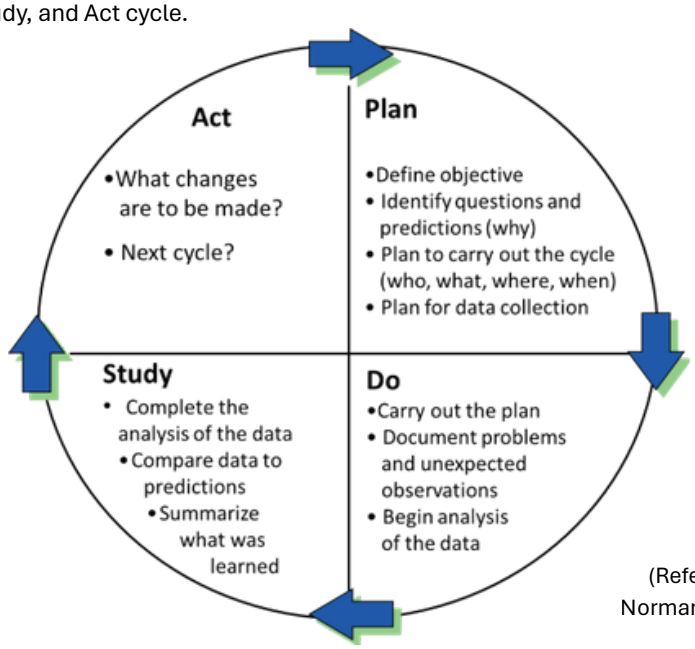
- Developing an evaluation and monitoring team
- Ensuring expertise on action teams for developing GOS and implementation plans
- Ensuring an oversight and accountability mechanism during the planning stages
- Developing plans for how the results will be used

Measurement plans are an excellent tool for accountability and identifying improvement opportunities and successes. The plans help to create an expectation that the existing committee or action team will keep their focus on the priority issue and the objectives and strategies developed. They also provide a structured opportunity for group problem-solving. Measurement plan components typically include:

- Process and outcome indicators
- Data sources for measuring indicators
- Methods for measurement
- Person responsible for data
- Timing
- Baselines
- Targets

Monitor Programs and Promote Awareness

For quality improvement, LHDs can utilize the PDSA cycle for learning and improvement. The PSDA cycle is also known as the Plan, Do, Study, and Act cycle.

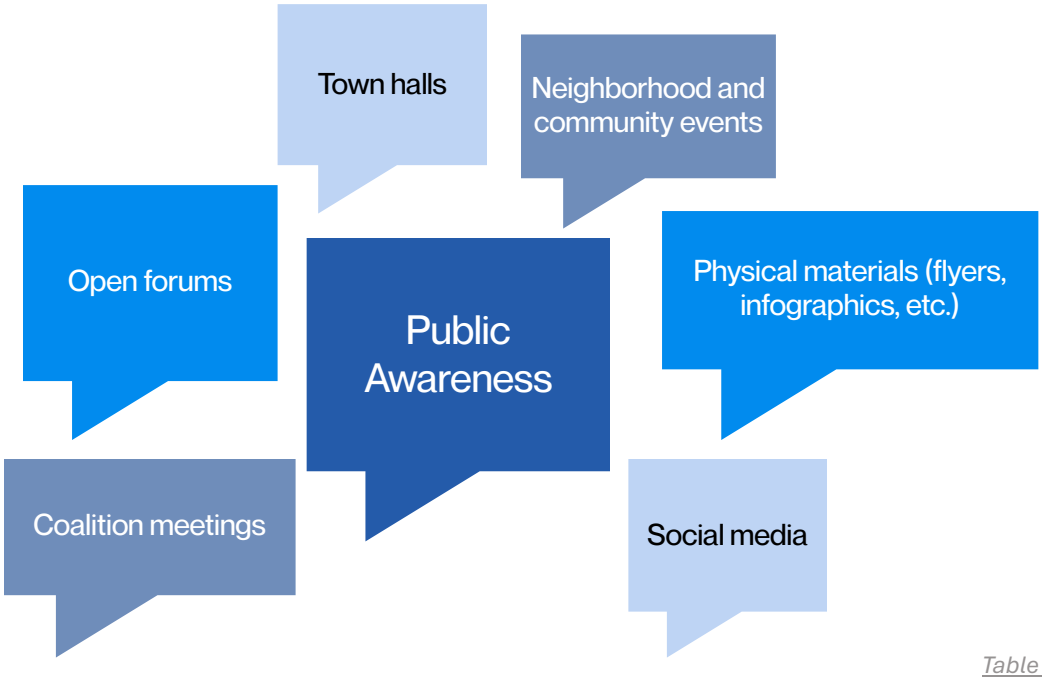


(Reference: Langley, Nolan, Nolan, Norman, & Provost. The Improvement Guide)

Another part of monitoring progress is reporting progress to partners—a vital way to ensure trust and buy-in with LHD partners and community members.

A plan to promote awareness of the Community Health Plan to the public is most effective when LHDs have been building community trust and awareness of their IPLAN process from the beginning. Despite its placement in the workbook, a public awareness plan should not be the final item the LHD considers or develops in the IPLAN process. An effective public awareness campaign should include a process where LHDs share CHNA results as well as the CHIP.

There are many methods for communicating the IPLAN with the public:



Monitor Programs and Promote Awareness

Tips for Monitoring Programs and Promoting Awareness

See the ACHI toolkit, which describes accessibility needs for public sharing of the IPLAN.

Review the Community Tool Box's information on the why, who, and how of communicating with the public.

Check out the ACHI toolkit's insight into evaluating an intervention and assessing its impact.

Watch the detailed training on Quality Improvement in the IPLAN process from the 2024 IPLAN Training Series.

LHD Examples

The Boone County Health Department IPLAN report included a brief description of the ongoing plans to monitor implementation of intervention strategies and to promote community health interventions and services publicly.

To ensure monitoring of implementation progress, each health priority will be managed by a designated taskforce or coalition that meets regularly and formally reviews progress at least twice a year. These groups will complete an IPLAN Progress Report and submit it to the Boone County Health Department (BCHD). BCHD will track countywide progress using its Performance Management System twice yearly and will issue an annual report summarizing progress toward IPLAN objectives.

The Boone County Health Department IPLAN Progress Report can be found as exhibit A in the report appendix. A snapshot of the form is shown on the next page.

Monitor Programs and Promote Awareness

LHD Examples (Continued)

Illinois Project for Local Area Needs (IPLAN) Health Priority Biannual Progress

Please complete the table below, reporting out on the progress towards your health priority objectives, as outlined in the IPLAN/CHIP. The italicized text in the table below is an example. Please return this form to the designated Boone County Health Department (BCHD) staff member. Please advise if any revisions were made to the objectives and provide a rationale, as applicable. Thank you!

Health Priority Assigned: _____

Taskforce/Coalition: _____

Date: _____

Progress							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend**	**Status**
BH 1.2	*Implement at least two new free Narcan distribution sites in partnership with community organizations by September 4, 2025.*	2	*1 new Narcan site at Ida Public Library*	4	September 4, 2025		*On Track/ Not on Track/ Completed*
Revisions							
Rationale							

To promote public health services related to each priority, the Boone County Health Department and each priority taskforce/coalition will promote the availability of public health resources and health education initiatives. The strategic implementation plans for each priority also include a communication goal and set of objectives to be led by the health department's designated Communications Strategic Goal Group. In addition, each health priority taskforce/coalition has a mechanism for promotion and communication and will promote public health services by using evidence-based public health communication strategies.

For more information, see page 45 and, exhibit A on pages 145-146 of the Boone County IPLAN 2024-2027, found at https://cms8.revize.com/revize/boonecountyil/IPLAN%20FINAL.pdf?t=202506051027370&t=202506051027370.

Monitor Programs and Promote Awareness

LHD Examples (Continued)

The DeKalb County Health Department provided a succinct summary of how they plan to monitor the improvement plan and increase awareness and promotion of related services. See their summary below.

Monitoring and Assessment

"The DCHD will monitor the progress and assess the effectiveness of the implemented intervention strategies by monitoring available data related to Substance Abuse from sources such as the DeKalb County Annual Coroners Report, the IDPH Opioid Dashboard, the Illinois Adverse Pregnancy Outcomes Reporting System (APORS), and the Illinois Youth Survey. Monitored data may include the number of non-motor vehicle accidents and opioid related deaths, the number of APORS cases with a diagnosis of various drug exposures, and rates of substance use for vaping among 8th, 10th, and 12th graders. Effectiveness of the intervention strategies will be shown by improvement within the monitored data metrics. Furthermore, the DCHD will conduct assessments and report on monitored data and the effectiveness of implemented intervention strategies during public Board of Health meetings and via the DCHD Annual Report.

Awareness and Promotion

The DCHD will make the public aware of available tobacco cessation programs or resources, harm reduction strategies, and any other efforts to decrease the communities' Substance Abuse, by using a multifaceted multimedia approach. This approach may include, but is not limited to, dissemination of information via press releases, the DCHD website, the DCHD newsletter, social media accounts, e-blasts through local Chamber of Commerce's, print media such as flyers, newspaper or magazine ads, and paid media on platforms such as bus shelters, movie theater ads, and social media. "

For more information, see page 80 of the DeKalb County Health Department 2022-2027 IPLAN, found at https://health.dekalbcounty.org/wp-content/uploads/2024/08/2022-2027-IPLAN-DeKalb-County-Health-Department-FINAL.pdf.

Monitoring Programs and Promote Awareness

MAPP 2.0 Framework

Monitoring and Evaluation

For any indicators the LHD is tracking, make an evaluation plan that addresses the following questions:

- What are our sources of data for each indicator?
- Who will track each indicator (short-, intermediate-, and long-term)?
- Where will the progress on the indicators be tracked?
- How often will indicators be updated?
- What are our baseline and target measures for each indicator?
- How frequently will we assess progress on the indicators to decide if we need to adjust our implementation?

The CQI Tracking Template includes an example of a CHIP tracking worksheet on pages 162-163 of the MAPP 2.0 Handbook.

PHAB Standards and Measures

Measure 5.2.2.e

Required Element:

Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.

Documentation Examples:

The health department or CHIP partnership defines the process that will be used to track the progress on CHIP strategies or activities. This may be included as part of the CHIP, as an addendum, or in a separate document.

(PHAB Standards and Measures, Version 2022 for Initial Accreditation)

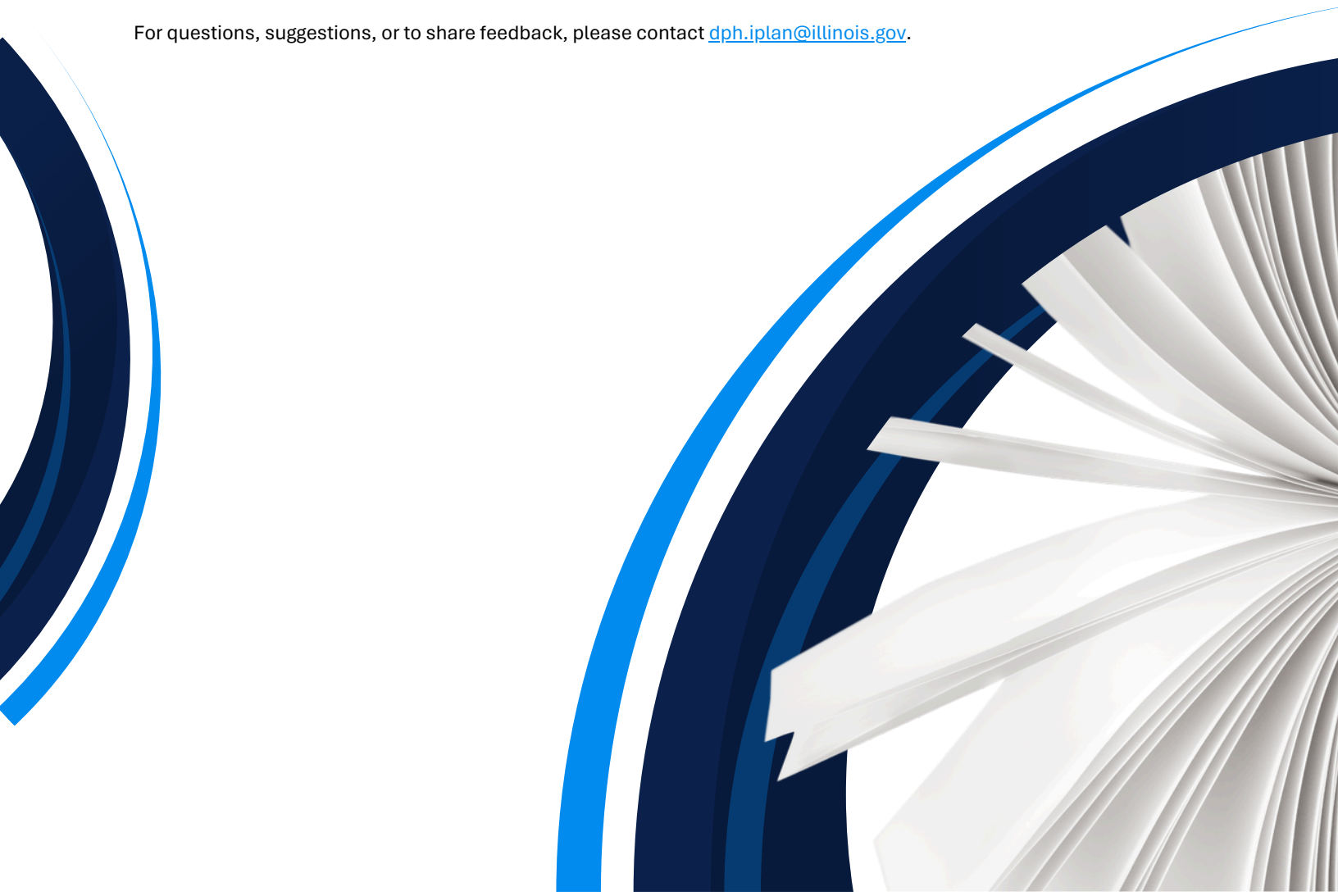
Conclusion

The Illinois Project for Local Assessment of Needs (IPLAN) Workbook is designed to be a living resource that supports Local Health Departments (LHDs) in achieving and maintaining certification through the Illinois Department of Public Health. By aligning the workbook with the Illinois Administrative Code and integrating tools from APEX-PH, MAPP 2.0, and PHAB standards, this updated version provides a more comprehensive, practical guide for implementing the IPLAN process. Examples from peer local health departments are intended to show different ways health departments meet the same requirements.

As community health needs evolve, so too will the resources, examples, and guidance available to support local planning efforts. Users are encouraged to revisit this workbook regularly for updated tools and links and to share their experiences, feedback, and other insights to help strengthen future versions.

Through collaboration, data-driven assessment, and continuous improvement, Illinois' LHDs can ensure that IPLAN remains a cornerstone of effective, equitable, and sustainable public health practice across the state.

For questions, suggestions, or to share feedback, please contact dph.iplan@illinois.gov.



Appendix

Appendix A: Acronyms

Acronyms

Acronym	Full Name / Meaning
ACT	Agency Collaboration Team
ACS	American Community Survey
ACHI	American Hospital Association Community Health Improvement
ADT	Assessment Design Team
AHA	American Hospital Association
APEX-PH / APEXPH	Assessment Protocol for Excellence in Public Health
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
BRFSS	Behavioral Risk Factor Surveillance Survey
CDC	Centers for Disease Control and Prevention
CHA	Community Health Assessment
CHNA	Community Health Needs Assessment
CHI	Community Health Improvement
CHIP	Community Health Improvement Plan
CHSA	Community Health Status Assessment
CQI	Continuous Quality Improvement
CTSA	Community Themes and Strengths Assessment
EPHS	Essential Public Health Services
FQHC	Federally Qualified Health Center
ICBRFS	Illinois Behavioral Risk Factor Surveillance System
IDPH	Illinois Department of Public Health
IPHI	Illinois Public Health Institute

IPHA	Illinois Public Health Association
IPLAN	Illinois Project for Local Assessment of Needs
IQuery	Illinois Query
LHDs	Local Health Departments
LPHSA	Local Public Health System Assessment
MAPP 2.0	Mobilizing for Action through Planning and Partnership (Updated Version)
MOUs	Memorandums of Understanding
NACCHO	National Association of County and City Health Officials
PDSA	Plan Do Study Act
PFHC	Partnership for a Health Community
PHAB	Public Health Accreditation Board
RHO	Regional Health Officer
SDOH	Social Determinants of Health
SHIP	State Health Improvement Plan
SMARTIE Objectives	Specific, Measurable, Achievable, Relevant, Timebound, Inclusive, Equitable
SFSP	Summer Food Service Program
SME	Subject Matter Expert
SWOT Analysis	Strengths, Weaknesses, Opportunities, Threats Analysis
UIC	University of Illinois Chicago
YRBSS	Youth Risk Factor Surveillance System

Appendix B: Glossary

Glossary

Term / Full Name / Acronym	Description
Accreditation	Accreditation means the measurement of health department performance against a set of nationally recognized, practice-focused and evidence-based standards that leads to the issuance of recognition of achievement by the Public Health Accreditation Board (PHAB), the nonprofit entity created to implement and oversee national public health department accreditation.
American Hospital Association Community Health Improvement **(ACHI)**	Referenced as the source of a Community Health Assessment Toolkit, often utilized by non-profit hospitals and partners in the CHNA process.
American Hospital Association **(AHA)**	A national organization that represents and advocates for hospitals and health care networks in the United States. AHA is focused on promoting the health of the public, which includes advising its members on community health needs and planning. It is the parent organization of the ACHI (American Hospital Association Community Health Improvement) section, which provides the widely used Community Health Assessment Toolkit referenced as a resource for the CHNA process.
Assessment Design Team **(ADT)**	The designated team/group within the MAPP 2.0 framework is responsible for supporting the three core assessments in Phase II of the planning process.
Assessment Protocol for Excellence in Public Health **(APEX/APEX-PH / APEXPH)**	The original planning model that the IPLAN process is fundamentally based on, designed to help LHDs assess and enhance their organizational capacity.
American Public Health Association **(APHA)**	The largest and oldest organization of public health professionals in the world, dedicated to improving public health through science, policy, and practice. APHA acts as a leading voice for public health advocacy and standards.
Association of State and Territorial Health Officials **(ASTHO)**	A national non-profit organization that represents the public health agencies of the United States and its territories. ASTHO supports state and territorial health officials in their work to protect and improve the public's health.
Centers for Disease Control and Prevention **(CDC)**	The primary national public health agency of the United States. CDC works to protect America from health, safety, and security threats, both foreign and domestic, by conducting critical science and providing health information.

Term / Full Name / Acronym	Description
Certification or Certified	These terms refer to the requirements for local health departments to be certified by the Illinois Department of Public Health and applies to all local health departments in the State that are conducting or intend to conduct and complete such requirements as set forth in the Illinois Administrative Code, Title 77, Part 600 (Certified Local Health Department Code). Certification is an eligibility requirement for Local Health Protection Grants awarded by the Illinois Department of Public Health.
Community Health Assessment **(CHA)**	An essential element of the IPLAN process that integrates the plans developed during the assessment phase into the ongoing activities of a health department and the community.
Community Health Needs Assessment **(CHNA)**	An essential element of the IPLAN process which involves a public assessment of the health of the community.
Community Health Improvement Plan **(CHIP)**	An essential, required element of the IPLAN process. A long-term plan that integrates the findings and priorities from the CHNA into the ongoing activities of the LHD and community partners.
Continuous Quality Improvement **(CQI)**	A management approach that focuses on continually monitoring and enhancing processes to meet goals, often referenced in the MAPP 2.0 framework for tracking and evaluating plan implementation.
Core Functions of Public Health	The fundamental responsibilities of public health, which IPLAN is grounded in. They are Assessment, Policy Development, and Assurance.
Community participation	“Community participation" means involvement by representatives of various community interests and groups. (Agency Note: Examples of such interests or groups are ethnic and racial groups, the medical community, mental health and social service organizations, the cooperative extension service, schools, law enforcement organizations, voluntary organizations, the clergy, the business community, economic development agencies, unions, disabled persons and senior citizens.)
Department	“Department" means the Illinois Department of Public Health
Director	"Director" means the Director of the Illinois Department of Public Health or his or her designee.
Direct Contributing Factor	A scientifically established factor that directly affects the level of a risk factor.

Term / Full Name / Acronym	Description
Essential Public Health Services **(EPHS)**	Describes the public health activities that all communities should undertake. Originally released in 1994, the framework is well recognized for describing the mission of public health with services related to all core functions of public health.
Equivalent to IPLAN	"Equivalent to IPLAN" means an assessment and planning process approved by the Department that meets the requirements set forth in Section 600.410.
Federally Qualified Health Center **(FQHC)**	A federally funded nonprofit health center or clinic that provides comprehensive primary care and support services to underserved communities.
Health Equity Action Spectrum	A framework in the MAPP 2.0 Handbook that helps depict the linkages between root causes and health outcomes, highlighting social determinants of health.
Health Inequities / Health Equity	Systemic differences in health status that are avoidable and unjust. MAPP 2.0 specifically aims to address the power imbalances and systemic barriers that have resulted in health inequities.
Healthy People	“Healthy People" means a program of nationwide health-promotion and disease-prevention goals set by the United States Department of Health and Human Services. Healthy People provides science-based, national goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts to improve the health of all people in the United States.
Illinois Department of Public Health **(IDPH)**	The principal state agency responsible for overseeing and protecting the health and well-being of Illinois residents. Within the context of IPLAN, the IDPH maintains the IPLAN cycle and certifies LHDs. LHDs are required to submit their CHNA and CHIP documents to the IDPH for review and approval to maintain their certification.

Term / Full Name / Acronym	Description
Illinois Public Health Association **(IPHA)**	The professional membership association for public health workers, educators, and organizations within Illinois. IPHA plays a crucial role in advocating public health policies, providing professional development, and strengthening the state's public health system.
Illinois Project for Local Assessment of Needs **(IPLAN)**	A mandatory community health needs assessment and planning process conducted every five years by all local health departments in Illinois.
Illinois Query (**IQuery)**	A web-based data system utilized by LHDs and state agencies for collecting and disseminating public health data essential to the IPLAN process.
Impact Objective	"Impact objective" means a goal for the level to which a risk factor should be reduced. An impact objective is intermediate in length of time and measurable.
Indirect Contributing Factor	"Indirect contributing factor" means a community-specific factor that directly affects the level of the direct contributing factors. These factors can vary greatly from community to community.
IPLAN	"IPLAN" means the Illinois Project for Local Assessment of Needs, a process developed by the Department to meet the requirements set forth in Section 600.410. IPLAN is a series of planning activities conducted within the local health department jurisdiction resulting in the development of an organizational capacity assessment, a community health needs assessment, and a community health plan.
IQuery	"IQuery" means a web-based data query system administered by the Department for the collection and dissemination of Illinois public health data.
Legally Authorized Representative	"Legally authorized representative" means the person empowered to act on behalf of the local health department and board of health in such matters as executing contracts, signing applications, and undertaking other major administrative tasks.
Local Health Departments **(LHDs)**	The local governmental county or municipal health departments are responsible for delivering public health services at the community level. In Illinois, LHDs are the entities legally mandated to complete the IPLAN (Illinois Project for Local Assessment of Needs) process every five years.

Term / Full Name / Acronym	Description
Local Public Health Jurisdiction	"Local public health jurisdiction" means the geographic area over which a local board of health has legal and regulatory authority.
Mandate/Mandated Program	"Mandate" or "Mandated program" means those programs and activities that are statutorily required of local health departments by a legislative body, such as a city council, county board or the General Assembly.
Mobilizing for Action through Planning and Partnership, Updated Version – **(MAPP 2.0)**	A community-driven strategic planning process that serves as an accepted alternative to the APEX-PH model for the IPLAN recertification.
Memorandum of Understanding	Ensure accountability in participating in the process.
National Association of County and City Health Officials **(NACCHO)**	A national membership organization representing local health departments (LHDs) across the United States.
Organizational Capacity Assessment	A review of a local health department to assess its administrative capacity and its ability to undertake the community health assessment. It is one of the three essential elements of IPLAN.
Organizational Strategic Plan	A process for defining an organization's roles, priorities, and direction over a minimum of three to five years, which can be completed as an alternative to the Organizational Capacity Self-Assessment.
Outcome Objective	"Outcome objective" means a goal for the level to which a health problem should be reduced. An outcome objective is long term and measurable.
Proven intervention strategy	"Proven intervention strategy" means intervention strategy demonstrated to be effective or used as a national model.

Term / Full Name / Acronym	Description
Provisional Certification/ Provisionally Certified	"Provisional certification" and "Provisionally certified" means certification granted to a local health department that meets the requirements for provisional certification set forth in Section 600.200 and is so designated by the Department.
Public Health Accreditation Board **(PHAB)**	The national, independent accrediting body for governmental public health departments, which establishes standards of excellence and accountability that often align with IPLAN requirements.
Public Health System	"Public health system" means the collection of public, private and voluntary entities, as well as individuals and informal associations, that contribute to the delivery of essential public health services.
Risk Factor	"Risk factor" means a scientifically established factor (determinant) that relates directly to the level of a health problem. A health problem may have any number of risk factors identified for it.
Regional Health Officer **(RHO)**	An appointed senior public official responsible for overseeing and regulating public health programs in a region.
Root Cause Analysis	A process to understand the cause-and-effect relationships for health issues, often used to reveal the systems of power, privilege, and oppression that impact health outcomes in a community.
State Health Improvement Plan **(SHIP)**	A statewide plan (or State Health Plan) developed by the statewide public health department, IPLAN priorities are often encouraged to align with.
SMARTIE Objectives **(Specific, Measurable, Achievable, Relevant, Timebound, Inclusive, Equitable)**	An enhanced objective-setting framework used in planning (e.g., MAPP 2.0) where Inclusivity and Equity are added to ensure goals are designed to reduce health inequities and intentionally involve the populations most impacted.
SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats Analysis)	A foundational strategic planning tool used to evaluate an organization's competitive position. In public health, it is used as a component of the Organizational Strategic Plan (which can be completed in lieu of the Organizational Capacity Assessment).
Sentinel Event	"Sentinel event" means any unanticipated event resulting in death or serious physical or psychological injury that could have been prevented or managed by the health care system.
State Health Improvement Plan	"SHIP" means the State Health Improvement Plan that recommends priorities and strategies to improve the health status of Illinois citizens and to improve the Illinois public health system.

Term / Full Name / Acronym	Description
Substantial Compliance	"Substantial compliance" means meeting the requirements set forth in this Part, except for variations from the strict and literal performance of those requirements that result in insignificant omissions and defects, given the particular circumstances and the incidence and history of the omissions and defects. Omissions and defects that have an adverse impact on public health and safety shall not be considered insignificant and shall be considered substantial noncompliance.
UIC (University of Illinois Chicago)	A systems-level term referenced in the MAPP 2.0 framework as a source of power imbalances and historic injustices that have created and perpetuated health inequities
White Supremacy	A systems-level term referenced in the MAPP 2.0 framework which is a source of power imbalances and historic injustices that have created and perpetuated health inequities.

Appendix C: Illinois Department of Public Health Certification Application

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Local Health Department (LHD) certification application

CERTIFICATION IS AN ELIGIBILITY REQUIREMENT FOR LOCAL HEALTH PROTECTION GRANTS AWARDED BY THE DEPARTMENT.

THE PURPOSE OF THIS FORM IS TO ADVISE THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH OF ALL CERTIFICATION ACTIVITIES BY THE LOCAL HEALTH DEPARTMENT FOR WHICH A MINIMUM CERTIFICATION QUALIFICATION STANDARD HAS BEEN ESTABLISHED VIA CERTIFIED LOCAL HEALTH DEPARTMENT ADMIN CODE.

A DETERMINATION AS TO WHETHER THE APPLICANT MEETS ALL REQUIREMENTS WILL BE MADE AND RETURNED TO THE ORIGINATOR WITHIN 60 DAYS OF RECEIPT OF COMPLETED FORMS. SUBMIT THIS FORM AND ALL ATTACHMENTS TO: ILLINOIS DEPARTMENT OF PUBLIC HEALTH, IPLAN ADMINISTRATOR

DPH.IPLAN@ILLINOIS.GOV

LINKS TO ADMINISTRATIVE CODE GOVERNING LHD CERTIFICATION

CERTIFIED LHD ADMIN. CODE | CERTIFICATION | PUBLIC HEALTH PRACTICE STANDARDS | REQUIREMENTS FOR IPLAN OR EQUIVALENT PLANNING PROCESS | DENIAL, SUSPENSION OR REVOCATION OF CERTIFICATION

DATE DROP DOWN AND SELECT DATE

PLEASE FILL IN

LOCAL HEALTH DEPARTMENT:

select from drop down for Local Health Department

CERTIFICATION

drop down selection for certification

NEW LOCAL HEALTH DEPARTMENT:

DATE CURRENT CERTIFICATION EXPIRES

LHD INFORMATION

ADDRESS

PHONE #

CITY

STATE, ZIP CODE

LHD WEBSITE

COUNTIES SERVED

ADMIN NAME

ADMIN EMAIL

APPLICANT STATEMENT BY AUTHORIZED OFFICIAL

To the best of my knowledge, the information contained in this application is true and correct. Documentation exists to demonstrate compliance with the Certified Local Health Department Code **(77 Ill. Adm. Code 600)** and is available for inspection by the Illinois Department of Public Health.

FIRST NAME

LAST NAME

TITLE

SIGNATURE

DATE DROP DOWN AND SELECT DATE

COMPLIANCE WITH SUBPART C: PERSONNEL REQUIREMENTS

1. Section 600.300 (a) Executive Officer

a) *Certified local health department shall have an executive officer. The Department shall approve any individual as an executive officer of a local health department if the individual meets the minimum qualifications for either a Public Health Administrator set forth in* ***Section 600.310*** *or Medical Health Officer as set forth in* ***Section 600.320***

1a. Does the local health department have a Chief Executive Officer that meets the minimum qualifications?

☐ **Yes** ☐ **No**

1b. If yes, indicate the title for which the Chief Executive officer is qualified (check one).

☐ Public Health Administrator Section 600.310

☐ Medical Health Officer Section 600.320

Name of Chief Executive Officer:

1c. Attach the notice of Personnel Information Form (PIF) approval from IDPH **CLICK TO ATTACH**

1d. If no, explain the current circumstances and describe what actions are being taken to employ a Chief Executive Officer.

COMPLIANCE WITH SUBPART D: PRACTICE STANDARDS

2. Section 600.400 (a)

Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and health needs of the community.

1). *A community health needs assessment that systematically describes the prevailing health status and health needs of the population within the local health department's jurisdiction shall be conducted at least once every five years.*

A) The assessment shall be conducted through completion of IPLAN or an equivalent to IPLAN that meets the requirements set forth in ***Section 600.410*** *.*

B) The assessment shall, at a minimum, include an analysis of data contained in the IPLAN Data System provided by the Department for assessment purposes.

C) The assessment shall include community participation in the health needs assessment process in order to facilitate the identification of community health problems and the setting of priorities from among those health problems.

D) Community Health needs shall be identified during the community health needs assessment process based on the analysis of data describing the health of the population and on the judgment of the community participants concerning the seriousness of the health problems and needs. The identified health needs shall be priority ranked. Prioritization shall result in the establishment of at least three priority health needs.

IDPH Illinois Department of Public Health

2. *A community health needs assessment shall contain:*

A) A statement of purpose of the community health needs assessment that includes a description of how the assessment will be used to improve health in the community.

B) A description of the community participation process, a list of community groups involved in the process, and method for establishing priorities.

*C) A description of the health status and health problems most meaningful for the community in the data groups designated by the Department in the **IPLAN Data System** .*

D) A description of the process and outcomes of setting priorities.

2a. Has the local health department complied with Section 600.400 (a) , submitted its community needs assessment to the Department?

☐ **Yes** ☐ **No**

2b. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (a) .

3. **Section 600.400 (b)**

Investigate the occurrence of adverse health effects and health hazards in the community by conducting timely investigations that identify the magnitude of health problems, duration, trends, location and populations at risk.

3a. Does the local health department comply with Section 600.400 (b) ?

☐ **Yes** ☐ **No**

3b. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (b)

4. **Section 600.400 (c)**

Advocate for public health, build constituencies and identify resources in the community by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation and management of public health activities. The local health department shall develop and strengthen communication with units of government, health-related organizations, health providers, citizens, and news media.

1). *The local health department shall meet at least annually with representatives of health-related organizations within its jurisdiction to define inter-organizational roles and responsibilities.*

2). *The local health department shall disseminate health reports that have been developed by the local health department to the board of health, county board or other legislative bodies within its jurisdiction, the media, and the public.*

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

4a. **Does the local health department comply with Section 600.400 (c) ?**

☐ **Yes** ☐ **No**

4b. **If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (c) .**

5. **Section 600.400 (d)**

Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved through a systematic course of action that focuses on local community needs and equitable distribution of resources, and involves the participation of constituents and other related governmental agencies. Develop a community health plan that addresses at least three priority health needs, identified pursuant to **Section 600.400** **.** *during each certification period.*

1). *The local health department shall include in its community health plan an analysis to establish risk factors and contributing factors for each priority health needs, to determine the adequacy of existing resources, and to identify population groups at risk of poor health status within the local health department's jurisdiction.*

2). *The community health plan shall present measurable objectives and strategies for intervention for each priority health need.*

3). *The local health department shall utilize community participation to assist in the development of the community health plan.*

4). *In jurisdictions where a board of health exists pursuant to* **Section 5-25012** *of the Counties Code (Ill. Rev. Stat. 1991, ch. 34, par. 5-25012) [55 ILCS 5/5-25012]; Division 16 or 17 or the Illinois Municipal Code (Ill. Rev. Stat. 1991, ch. 24, par. 11-16-1 and par. 11-17-1 through 11-17-12) [65 ILCS 5/11-16-1 and 5/11-17]; or the Public Health District Act (Ill. Rev. Stat. 1991, ch. 111 ½, par. 0.01 et seq.) [70 ILCS 905], the local health department shall present the community health plan to the board of health for its review. A community health plan shall be adopted by the board of health.*

5). *The local health department shall submit the community health plan to the Department. The plan shall contain:*

A) A statement of purpose of the community health plan that includes how the plan will be used to improve the health of the community;

B) A description of the process used to develop the community health plan;

C) A description of each priority including the importance of the priority health need, summarized data and information on which the priority is based, the relationship of the priority to Healthy People 2000 National Health Objectives and subsequent revisions and factors influencing the level of the problem (e.g., risk factors, contributing and indirect contributing factors);

D) Community Health needs shall be identified during the community health needs assessment process based on the analysis of data describing the health of the population and on the judgment of the community participants concerning the seriousness of the health problems and needs. The identified health needs shall be priority ranked. Prioritization shall result in the establishment of at least three priority health needs.

E) At least one measurable impact objective related to each outcome objective; and

F) At least one proven intervention strategy to address each impact objective. The description should include a discussion of: community resources that will contribute to implementation, estimated funding needed for implementation, and anticipated sources of funding.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

5a. Has the local health department complied with Section 600.400 (d) submitted its community health plan to the Department, and received Department approval of the plan?

☐ **Yes** ☐ **No**

5b. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (d).

6. **Section 600.400 (e)**

Manage resources and develop organizational structure through the acquisition, allocation and control of human, physical and fiscal resources; and maximizing the operational functions of the local public health systems through coordination of community agencies' efforts and avoidance of duplication of services.

1). *The local health department shall, at least once every five years, perform an organizational capacity self-assessment that meets the requirements set forth in Section 600.410. The local health department shall provide the Department with a statement signed by an authorized representative indicating that the organizational capacity self-assessment was completed by the local health department and reviewed by the board of health.*

2). *The local health department shall maintain a current organizational chart which includes all functional elements of the organization and their relationship to each other.*

3). *The local health department shall maintain current written job descriptions, minimum qualifications for each position, and written plans or policies regarding staff recruitment, selection, development, and retention.*

6a. Has the local health department complied with Section 600.400 (e) ?

☐ **Yes** ☐ **No**

6b. If yes, please attach a copy of the statement indicating that the organizational capacity self-assessment was completed and reviewed by the board of health. CLICK TO ATTACH

6c. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (e).

IDPH
Illinois Department of Public Health

7. **Section 600.400 (f)**

Implement programs and other arrangements assuring or providing direct services for priority health needs identified in the community health plan by taking actions which translate plans and policies into services.

7a. Does the local health department comply with Section 600.400 (f) ?

☐ **Yes** ☐ **No**

7b. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (f) .

8. **Section 600.400 (g)**

Evaluate programs and provide quality assurance in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies,and provide feedback on inadequacies and changes needed to redirect programs and resources.

1). *The local health department shall conduct periodic reviews of programs, services, and personnel to demonstrate compliance with applicable professional and regulatory standards.*

2). *The local health department shall conduct monitoring of programs to assess achievement of mandated programs and progress towards meeting community health objectives as stated in the community health plan.*

8a. Does the local health department comply with Section 600.400 (g) ?

☐ **Yes** ☐ **No**

8b. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (g) .

9. **Section 600.400 (h)**

Inform and educate the public on public health issues of concern in the community, promoting an awareness about public health services availability, and health education initiatives which contribute to individual and collective changes in health knowledge, attitudes and practices towards a healthier community.

9a. Does the local health department comply with Section 600.400 (h) ?

☐ **Yes** ☐ **No**

9b. If no, explain the current circumstances and describe what actions are being taken to be in compliance with Section 600.400 (h) .

IDPH
Illinois Department of Public Health

Appendix D: Public Health Accreditation Board (PHAB) Requirements

Public Health Accreditation Board (PHAB)

Standards and Measures Version 2022

Requirements for a Community Health Assessment

Domain 1: Assess and monitor population health status, factors that influence health, and community needs and assets

- Domain 1 focuses on the ongoing assessment of the health of the population in the jurisdiction served by the health department. The domain includes: a continuous and systematic approach to monitoring health status; collection, analysis, and dissemination of data; use of data to inform public health policies, processes, and interventions; and participation in a collaborative process for the development of a shared, comprehensive health assessment of the community, its health challenges, and its resources. The collection and analysis of data about the health status of the community informs the identification of health disparities and factors that contribute to them in order to develop strategies to achieve equity.

Standard 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

- A community health assessment (CHA) paints a comprehensive picture of a community's current health status, factors contributing to higher health risks or poorer health outcomes, and community resources available to improve health. Community health assessments are comprised of data and information from multiple sources, which describe the community's demographics; health status; morbidity and mortality; socioeconomic characteristics; quality of life; community resources; behavioral factors; the environment (including the built environment); and other social and structural determinants of health status.
- Development of a CHA involves a systematic process to collect data and information that provides a sound basis for decision-making and action. In order to alleviate health disparities among subpopulations, the CHA gleans data and information to understand the factors and root causes that contribute to higher health risks and poorer health outcomes to inform strategies and plans to enable all community members to attain their optimal health. The CHA can help frame the narrative to emphasize the conditions that create health and cause disparities in health outcomes. It is important that the CHA be developed by the community, for the community. For this reason, it is important that community members or organizations that represent populations who are at risk or have been historically excluded or marginalized, participate in the health assessment process and are provided with key findings from the assessment in a manner they understand.
- A collaborative approach to developing the CHA in partnership with other organizations and members of the community provides opportunities to develop a shared understanding among the public health system of the community's health needs and assets. The CHA provides valuable insight to inform the basis of community health improvement plan strategies.
- The Standards use the term "community health assessment" to refer to assessment at the state, Tribal, or local level. For state health departments, this is often referred to as a state health assessment and will assess the health of all residents in the state. For local health departments, CHA will assess the health of residents within the jurisdiction it serves. A

local health department's assessment may also assess the health of residents within a larger region, but the submitted assessment will include details that address the requirements specific to the jurisdiction applying for accreditation. Tribal health departments will define their community. The community health assessment is often referred to as a Tribal health assessment and will address the health of the community as defined by the Tribal health department. For example, it may address the health of all residents residing within the Tribe's jurisdictional area, the Tribal residents residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.

Measure 1.1.A: Develop a community health assessment.

Purpose and Significance:

- The purpose of this measure is to assess the Tribal, local, or state health department's comprehensive community health assessment of the population of the jurisdiction served by the health department. The community health assessment tells the community story and provides a foundation to improve the health of the population. It is the basis for priority setting, planning, program development, policy changes, coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population.
- A health assessment identifies disparities among different subpopulations in the jurisdiction, and the factors that contribute to them, in order to support the community's efforts to achieve health equity. Data within the community health assessment may include information about mortality and morbidity, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), social determinants of health, community narrative, assets, and stories. Data should be obtained from a variety of sources, using various data collection methods.

Guidance

- Number of Examples: 1 Community Health Assessment
- Dated Within: 5 years

Required Documentation

1. **Community health assessment (CHA) that must include all of the following elements:** A community health assessment differs from a statistical report in that it is developed collaboratively and with the express purpose of using data collected to draw conclusions about the health status, challenges, and assets of the population served in order to inform the prioritization of policies, strategies, and interventions.

   As such, this process requires not only the collection but also the interpretation of data to inform plans and decision-making, in terms easily understood by its target audience – community members and stakeholders.

   The collaborative partnership may determine that the community health assessment be updated on a different schedule, such as every 3 years.

   Dynamic community health assessments (i.e., websites with continuously updated data) are acceptable, if they address required elements a-g. In these cases, the health department is building on past data that have been collected and adding to those data over

time. The partnership would meet on a periodic basis to review the data that are being collected and determine if there are any changes in data collection or interpretation. A combination of webpage screenshots and other documentation and descriptions may be used to demonstrate the required elements. As dynamic community health assessments may be updated more frequently, a description of the method and frequency of updates can be provided to meet the timeframe requirement, as long as the last updated date is within 5 years.

Similarly, other formats of a CHA will be accepted, as long as required elements a-g are included. The intent of required elements a and b is to describe who is involved in the collaborative process to assess the health of the community and how they are involved. This could be included within, for example, the health assessment, an appendix, a partnership charter, or provided as a memo. It is not necessary for the process description to be within the health assessment document itself.

Participating partners may engage in the CHA in a variety of ways. Participation could include, for example, serving on a steering committee or workgroup for conducting the CHA, contributing to data collection, or contributing to data interpretation. Involving impacted communities in the assessment will inform decisions about what data are collected and how they are interpreted in order to better understand the issues facing those communities, as well as resources or assets to address needs. The collaborative assessment will lay the groundwork for continued engagement in identifying and prioritizing potential solutions to improve community health (addressed in Measure 5.2.1 about the state/Tribal/community health improvement plan).

Required element 1a:

a. A list of participating partners involved in the CHA process. Participation must include:
    i. At least 2 organizations representing sectors other than governmental public health.
    ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.

Partners that represent various sectors of the community could include, for example: hospitals, behavioral health, community clinics, and other health care providers; mortality review committees or boards; environmental public health groups; community foundations and philanthropies; volunteer organizations; religious organizations; community organizers and advocates; unions; parent-teacher associations, tenants, or volunteer organizations; or real estate representatives.

The partnership will include community members directly or include organizations representing those populations who are disproportionately affected by conditions that create poorer health outcomes or for whom systems of care are not appropriately designed. Individuals or organizations that represent populations who have lived experiences with or are disproportionately affected by conditions that contribute to poorer health outcomes could include, for example: historically excluded or marginalized population groups, communities of color, indigenous communities, LGBTQ populations, individuals with limited English-speaking abilities, individuals with disabilities, immigrants, refugees, aging populations, or individuals who are blind, deaf, or hard of hearing. Organizations that represent populations or have expertise addressing inequities could include, for example, local, state, or regional networks and agencies, not-for profits, or civic groups

representing specific issues or subpopulations. (If it is unclear from the documentation who participants are, it may be indicated in the Documentation Form—for example, to clarify who are community member representatives.)

Partners in the CHA process may also include other public health entities, such as public health institutes, other health departments, or military installation departments of public health located in or near the health department's jurisdiction.

Some examples of partners specific to the Tribal setting include other divisions within the Tribal government that may be outside the public health department division (e.g., environmental health, health care, or mental health). There may also be key partners who are external to the Tribal government, such as Tribal Epidemiology Centers; state or local health departments; or businesses. Tribal health departments may self-determine who the partners are and the number of partners that are most appropriate to include in the development of a community health assessment.

Required element 1b:

b. The process for how partners collaborated in developing the CHA.

The process will describe how partners engaged, which could include, for example, recruitment of participants, roles of participants, frequency of meetings or other methods of convening partners, or use of engagement strategies such as stakeholder analysis or power mapping. The process could also describe, for example, the timeline for the assessment, or how data were assessed to draw conclusions about health issues and needs.

The process may follow a national model; state-based model; a model from the public, private, or business sector; or other partnership and community participatory process model. Models could include, for example, Mobilizing for Action through Planning and Partnership (MAPP; NACCHO), Association of Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), SHIP Guidance and Resources (ASTHO), or the University of Kansas Community Toolbox.

Required elements c-g are the data and information that comprise the assessment itself

Required element 1c:

c. Comprehensive, broadbased data. Data must include:
    i. Primary data.
    ii. Secondary data from two or more different sources.

Primary data are data for which collection is conducted, contracted, or overseen by the health department or CHA partnership. The CHA will indicate which data are primary by, for example, describing the methodology for data collection or listing the health department or CHA partnership as the data source. Data collection methods could include, for example, asset mapping, community forums, community listening sessions, surveys (e.g., surveys of high school students or parents), or focus groups (e.g., sessions discussing community health issues). Such information often provides additional context or details to help interpret secondary data sets. Non-traditional and non-narrative data collection techniques are acceptable forms of data collection. For example, an assessment could include photographs taken by members of the Tribe or community in an

organized assessment process (e.g., photovoice) to identify environmental (including the built environment) health challenges, causal loop diagrams, iceberg models, or use of empathy mapping or ethnographic interviews to gather an understanding of current and historical inequities and their impact.

Secondary data sources might include federal, state, Tribal, and local data. If the data collection is conducted, contracted, or overseen (i.e., the data collection instruments are designed) by the health department or the CHA partnership as a whole, it would not meet the intent of the element. However, data collected by a single partner of the collaborative (e.g., EHR data from a hospital that is part of the CHA partnership) would be appropriate. Specific secondary data sources could include, for example, Behavioral Risk Factor Surveillance Survey (BRFSS)/Youth Risk Behavior Surveillance (YRBSS) (if not collected by the health department), County Health Rankings, CDC Disability and Health Data System, CDC Social Determinants of Health (SDOH) and PLACES Data, US Census American Community Survey or Factfinder, AHRQ Social Determinants of Health Database, HRSA Area Health Resource Files, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, CDC Wonder, PH WINS, SAMHSA's Behavioral Health Barometer, CityHealth, or Tribal Epidemiology Center data.

Other secondary sources could include: vital statistics (if not collected by the health department); notifiable conditions data; clinical and administrative data collected by hospitals and/or health care providers, such as hospital discharge rates or insurance claims; local and state chart of accounts; data from local schools, academic institutions, or other departments of government (e.g., recreation, public safety, environment, housing, transportation, labor, education, or agriculture); or data from community not-for-profits (e.g., Aging and Disability Resource Centers), 211 data, community narrative, or other sources of nontraditional community information.

Required element 1d:

d. A description of the demographics of the population served by the health department, which must, at minimum, include:
    i. The percent of the population by race and ethnicity.
    ii. Languages spoken within the jurisdiction.
    iii. Other demographic characteristics, as appropriate for the jurisdiction.

In addition to ethnic and racial composition and languages spoken, demographic information could also include, for example, gender, age, socioeconomic factors, income, disabilities, mobility (travel time to work), educational attainment, home ownership, employment status, immigration status, or sexual orientation.

Required element 1e:

e. A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following:
    i. Health status.
    ii. Health behaviors.

The intent of required element e is to present a summary of themes and findings based on the data in required element c, above. To examine what disparities may exist in the health status in the

community, the CHA could include differences in rates of, for example, illness, death, chronic conditions, self-reported health and well-being, and other types of health outcomes in relationship to demographic factors (e.g., race, ethnicity, gender, sexual orientation, disability status or special health care needs, or geographic location). Similarly, the CHA will examine differences in health behaviors, for example, smoking or vaping rates, eating or exercise habits, or high-risk sexual behavior.

Examples of ways the data could be presented include, for example, a table, or cross-tabulation that demonstrates differences in chronic disease morbidity by race and ethnicity; differences in smoking rates by age; or a map showing poorer health outcomes by zip code. It could also include a description of how themes from focus groups or townhalls varied based on neighborhood or demographics of participants

Required element 1f:

f. A description of inequities in the factors that contribute to health challenges (required element e), which must, include social determinants of health or built environment

Health equity relates to social justice in health; that is, everyone has a fair and just opportunity to be as healthy as possible. The description of factors that contribute to inequities may relate to conditions that vary by population, for example, the availability of affordable housing for low- and middle-income families; availability of culturally and linguistically appropriate services for limited English-speaking populations; or how conditions vary by neighborhood such as school funding or access to health services. Inequities related to the built environment might include vulnerability to climate change, or the availability of grocery stores, parks, sidewalks, or transportation.

As part of identifying factors that contribute to health challenges within the community, the description may also address related policies (e.g., taxation, education, transportation, or insurance status), social or structural determinants of health, or other the unique characteristics of the community that impact health status. Social determinants of health include factors in which people are born, live, and grow that influence health beyond a person's control. Social determinants may include structural determinants or "root causes" of health inequities. Structural determinants include factors such as the political, economic, or social policies that affect income, education, or housing conditions. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual orientation, or other socially defined group of people. The description could include equity indicators, for example, the Social Vulnerability Index or the Index of Concentration at the Extremes.

Required element 1g:

g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges

The intent of this required element is to ensure that when assessing the health of the community, the partnership is also learning about the assets and resources that can enhance community well-being. The CHA does not need to include an exhaustive list of all assets. A section may be dedicated to assets or resources, as a list or narrative, or they may be woven throughout the document. Examples of assets and resources could include, for example, local parks or recreation centers, farmers' markets, public facilities available at a school, or mutual aid groups or support

circles. Intangible assets and resources could also be included. The CHA could spotlight strengths including, for example, stories that demonstrate community leadership, examples of social cohesion, or indications of social capital (e.g., number and diversity of civic organizations).

Measure 1.1.2.A Ensure the community health assessment is available and accessible to organizations and the general public.

Guidance

- Number of Examples: 2 examples
- Dated Within: 5 years

Required Documentation

1. Key findings and the full community health assessment (from Measure 1.1.1) actively shared with others. One example must show actively informing organizations including those that are not members of the community health assessment partnership. The other example must show actively informing the public.

The intent of this requirement is to demonstrate active methods of informing the public and stakeholders, governmental agencies, associations, or other organizations about the key findings and availability of the community health assessment. Passive methods of sharing, such as, posting the CHA on a website alone would not be sufficient to demonstrate active sharing for this requirement. Instead, the health department could demonstrate active sharing through, for example, presentations or press releases to share key findings and where to access the assessment.

Key findings could include, for example, a summary of key points, an executive summary portion of the full assessment, a letter summarizing findings, infographic, or data visualization.

Tribal health departments should ensure that the community health assessment is available to the broadest community possible in the context of the Tribal setting. In respecting the sovereignty of the Tribe to make the most appropriate decision about sharing reports from its data, PHAB does not require that Tribal health departments post their community health assessment on their website. However, documentation must be submitted that indicates with whom the CHA was shared and how it was shared.

Documentation Examples Documentation of notification of organizations could be, for example, copies of emails to partners and stakeholders providing information of how to access the assessment which includes key findings; or meeting minutes showing discussion of where and how partners and stakeholders can access the assessment as well as key findings. The Documentation Form could provide clarification about the organizations, for example, to explain which email recipients or meeting participants were not part of the CHA partnership.

Documentation of notification to the public could be, for example, evidence of hard-copy distribution of the community health assessment's key findings (with information on how to access the full report) to libraries or a press release including instructions for accessing the community health assessment and its key findings. Links to the CHA and key findings could be, for example, published in newspapers, included in the department's external newsletter,

included in a public service announcement, discussed in TV or radio interviews, or included in a social media post.

Requirements for a Community Health Improvement Plan

Domain 5: Create, champion, and implement policies, plans, and laws that impact health.

- Domain 5 focuses on health departments' ability to influence policies, plans, and laws by working across sectors with partners and the community to consider the health implications, correct historical injustices, and provide fair and just opportunities for all to achieve optimal health. Health departments play an important role to serve as a primary and expert resource for reviewing and evaluating policies for their impact on health by considering the evidence and gathering input from among affected stakeholders.
- A collaborative health improvement planning process is an opportunity for the community to determine which strategies can best leverage assets and address health needs. Health departments and their partners can consider a range of policy, systems, and environmental (PSE) changes aimed at creating conditions in which all residents have the opportunity to be healthy. Health improvement planning efforts can take a life course approach to support positive life trajectories.

Standard 5.2: Develop and implement community health improvement strategies collaboratively.

- The community health improvement plan is a long-term, systematic plan to address issues identified in the community health assessment. The purpose of the community health improvement plan is to describe how the health department and the community it serves will work together to improve population health in the jurisdiction. The community, stakeholders, and partners can use a solid community health improvement plan to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.
- The plan is more comprehensive than the roles and responsibilities of the health department alone, and the plan's development and implementation must include participation of a broad set of community stakeholders and partners. The planning and implementation process is community-driven. The plan reflects the results of a collaborative planning process that includes significant involvement by a variety of sectors that make up the public health system.
- The Standards use the term "community health improvement plan" to refer to planning at the state, Tribal, or local level. For state health departments, this is often referred to as a state health improvement plan and will address the needs of all residents in the state. For local health departments, the community health improvement plan will address the needs of the residents within the jurisdiction it serves. A local health department's plan may address the needs of residents within a larger region, but the submitted plan will include details that address the requirements specific to the jurisdiction applying for accreditation. Tribal health departments will define their community. The community health improvement plan is often referred to as a Tribal health improvement plan and will address the community as defined by the Tribal health department. For example, it may address the needs of all residents residing within the Tribe's jurisdictional area, the Tribal residents

residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.

Measure 5.2.1.A Engage partners and members of the community in a community health improvement process.

Purpose and Significance

- The purpose of this measure is to assess the health department's collaborative community health improvement planning process and the participation of stakeholders. While the health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other agencies and organizations to plan and share responsibility for health improvement and advancing equity. Other sectors and stakeholders have access to additional data and bring different perspectives that will enhance planning. The health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

Guidance

- Number of Examples: 1 process
- Dated Within: 5 years

Required Documentation 1a

1. A collaborative process for developing the community health improvement plan (CHIP), which includes

This may be referred to as a state health improvement planning process, Tribal health improvement planning process, or other name. The health improvement process could be a national model; state-based model; a model from the public, private, or business sector; or other participatory process model. National models include, for example, State Health Improvement Plan (SHIP) Guidance and Resources, Mobilizing for Action through Planning and Partnerships (MAPP, developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), and the University of Kansas Community Toolbox. Examples of tools or resources that can be adapted or used include Asset Based Community Development model, National Public Health Performance Standards (NPHPS), Guide to Community Preventive Services, Healthy People 2030, County Health Rankings, or innovation processes such as design thinking. The process may be included within the health improvement plan itself or may be documented through a set of meeting minutes, presentations, or other written description of the process.

Required element a:

a. A list of participating partners involved in the CHIP process. Participation must include:
    i. At least 2 organizations representing sectors other than public health.
    ii. At least 2 community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes.

    Participation includes active engagement to address community health issues or priorities. While the partnership could include other public health entities as appropriate for the

jurisdiction (e.g., public health institutes, other health departments or military installation departments of public health located in/near the health department's jurisdiction), required element a(i) focuses on organizations that represent other sectors, which could include other governmental agencies (e.g., education, transportation, community development); not-for-profit groups, advocacy organizations, associations, or special interest groups related to health assessment priority areas (e.g., employment, housing); businesses; recreation organizations; or faithbased organizations. Members of this group may or may not be the same as members of the state/Tribal/community health assessment partnership.

For required element a(ii), the documentation will include either partner organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes or individual community members. To empower individuals to participate in the improvement of health in their jurisdictions, the list of partners may also include community members. Individuals or organizations that represent populations with higher health risks or poorer health outcomes could include, for example: groups that represent minority health, historically excluded or marginalized population groups (e.g., communities of color or indigenous communities), aging populations (e.g., local, state, or regional aging networks and agencies), not-for profits, or civic groups representing specific subpopulations.

Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists of work groups or subcommittees. (If it is unclear from the documentation who participants are, it may be indicated in the Documentation Form— for example, to clarify who are community member representatives.)

Required element 1b.

b. Review of information from the community health assessment

This could include, for example, meeting minutes demonstrating the state/Tribal/community health assessment was reviewed by the CHIP partnership, or other description describing how the health assessment findings were used in the health improvement planning process

Required element 1c.

c. Review of the causes of disproportionate health risks or health outcomes of specific populations.

To determine which strategies to integrate into the CHIP in order to promote equitable opportunity for health for all, CHIP partnerships could review a range of social determinants of health, which may include structural determinants (or "root causes" of health inequities) and other causes for higher health risks among specific populations. This could include, for example, impacts of structural racism (e.g., redlining), disparities in the built environment, or inequitable distribution of social supports. Documentation demonstrating review of these determinants, could be, for example, a summary of partnership discussions or meeting minutes

Required element 1d.

d. Process used by participants to select priorities.

The intent of this required element is to describe the steps or tools used in the prioritization process. If the MAPP process is used, the description will include the specific steps and tools utilized. Tools to prioritize health issues could include, for example, nominal group or multi-voting techniques, affinity diagrams, or prioritization matrices.

Appendix E: Letter from the Public Health Administrator Examples

Letter from the Public Health Administrator

Dear Partners,

The Boone County Health Department in collaboration with the IPLAN Steering Committee is pleased to present its 2024 Community Needs Assessment and Community Health Improvement Plan (CHIP) which we call the Illinois Plan for Local Area Needs (IPLAN). Our community engaged in a new version of the nationally recognized community health assessment and improvement planning process called Mobilizing Action Through Planning and Partnerships (MAPP). So much has happened since the previous plan was prepared and written five years ago. As a local health department responsible for spearheading this IPLAN process, we not only survived the frontlines of COVID-19 for three long years, we also spent large portions of this past cycle preparing for national accreditation requiring us to hold this new IPLAN to an even higher and robust standard.

I would be remiss not to mention that this IPLAN references the challenges of a global pandemic on the local community and how that has affected local health outcomes. Subsequently, themes emerging from the pandemic and the transition to our post pandemic world are evident in the data and the feedback from partners and community members at large. Growth and knowledge gained from this community trauma will carry us into future decades and will embody the resiliency we employ as we tackle complex community health challenges going forward. We remember the lives lost of our first responders, frontline health care, and essential workers as well as our community members to COVID-19. As our department prepares for the last leg of the journey to becoming the 12th and smallest health department in the state to achieve national accreditation, we are simply just better at doing an IPLAN. We have more data than ever before and we have new data that we have collected locally that was never previously available. We hosted community input sessions this cycle and we have established stronger and more robust relationships with stakeholders who are committed to the public health system in Boone County and who take collective ownership for the problems that were historically tackled in silos.

We celebrate huge gains in the areas of Behavioral Health, Maternal Child Health, and Chronic Disease and the hard work of the coalitions, councils, and task forces who carried the responsibility for implementing the action plan for the previous health priorities. These groups will carry the work of the next 3-5 years forward and will crease the pages of this IPLAN much like the dogeared roadmap my parents kept in the glove compartment of the family car for the upcoming road trip. Buckle-up Boone County and happy reading!

Amanda Mehl, Public Health Administrator

Appendix F: IPLAN Strategic Plan Completion Administrator Letter Example

Southern Seven Health Department
Administrative Office

37 Rustic Campus Drive
Ullin, IL 62992-2226

Phone: (618) 634-2297
Fax: (618) 634-9394
www.southern7.org

May 29, 2025

Director Sameer Vohra, MD, JD, MA
Illinois Department of Public Health
525-535 West Jefferson Street
Springfield, IL 62761-001

Subject: Request for Local Health Department Recertification

Dear Director Vohra,

I am writing to formally request recertification for Southern Seven Health Department as a local health department.

Enclosed with this letter is our application, which includes a Community Needs Assessment and a Community Health Plan, both of which were presented to the Board of Health on May 29, 2025. These documents provide a comprehensive evaluation of our community's health status, identifying priority areas and strategic initiatives designed to enhance the overall well-being of residents.

As required by Administrative Code 600.400.d.4, the Board of Health has reviewed, approved, and adopted the contents of our Community Needs Assessment and Community Health Plan. This process included a review to ensure the assessment accurately represents the community's current health conditions and needs.

We appreciate your consideration of our recertification request and remain committed to upholding the highest standards of public health service. Should you require additional documentation or clarification, please do not hesitate to reach out.

Thank you for your time and attention to this matter.

Sincerely,

Sharon S. Burris

Sharon Burris
Acting President, Board of Health

Appendix G: IPLAN Substantial Compliance Evaluation with Administrative Code/Substantial Compliance Checklist

Local Health Jurisdiction: _____

Recertification Period: _____ **Priority 1)** _____

Region: _____ **2)** _____

Reviewer: _____ **3)** _____

Optional 4) _____

COMMUNITY HEALTH NEEDS ASSESSMENT

LHD Use | IDPH Use

CATEGORY	COMPLIANCE INDICATOR	Page Number	Compliance Per Rubric (NC/C)
PURPOSE	1. The statement of purpose describes how the assessment will be used to improve health in the community		
METHODS	2. The assessment includes community participation to identify community health problems and set priorities from among those health problems		
	3. The assessment includes a description of the community participation process, a list of community groups involved in the process, and the method for establishing priorities.		
ANALYSIS BY GROUPING	4. The assessment includes an analysis of data from IQuery by grouping a) demographic and socioeconomic characteristics b) general health and access to care c) maternal and child health d) chronic disease e) infectious disease f) environmental/occupational/injury control g) sentinel events	a) b) c) d) e) f) g)	a) b) c) d) e) f) g)
	5. The assessment includes a description of the health problems most meaningful for the community by grouping a) demographic and socioeconomic characteristics b) general health and access to care c) maternal and child health d) chronic disease e) infectious disease f) environmental/occupational/injury control g) sentinel events	a) b) c) d) e) f) g)	a) b) c) d) e) f) g)
PRIORITIES	6. Prioritization shall result in the establishment of at least three priority health needs.		
	7. The assessment includes a statement that the SHIP was reviewed, including a description of the alignment or nonalignment between the priority health needs of the local public health jurisdiction and the priorities as set forth by the SHIP		
	COMMUNITY HEALTH NEEDS ASSESSMENT		

COMMENTS:

COMMUNITY HEALTH PLAN

LHD Use | IDPH Use

CATEGORY	COMPLIANCE INDICATOR	Page Number	Compliance Per Rubric (NC/C)
INTRODUCTION	1. The statement of purpose describes how the plan will be used to improve the health of the community		
	2. The plan includes a description of the process used to develop the community health plan		
	3. Community participation is utilized in the development of the community health plan		
	4. The community health plan has been adopted by the board of health		

COMMENTS:

LHD Use | IDPH Use

PRIORITY 1:		Page Number	Compliance Per Rubric (NC/C)
DESCRIPTION OF THE PROBLEM	1. The description includes the importance of the priority health need		
	2. The description includes summarized data and information on which the priority is based		
	3. The description includes the relationship of the priority to Healthy People national health objectives		
	4. The description includes factors influencing the level of the problem (risk factors, direct contributing and indirect contributing factors, population groups at risk)		
OBJECTIVES AND STRATEGIES	5. The priority has at least one measurable outcome objective covering a three or more year time frame		
	6. The priority has at least one measurable impact objective covering a three or more year time frame		
	7. The priority has at least one proven intervention strategy to address each impact objective		
	8. Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding		
	9. Includes a plan to monitor programs and assess progress towards meeting community health objectives as stated in the community health plan		
	10. Includes a plan to promote an awareness about public health services availability and health education initiatives		

COMMENTS:

PRIORITY 2:		Page Number	Compliance Per Rubric (NC/C)
DESCRIPTION OF THE PROBLEM	1. The description includes the importance of the priority health need		
	2. The description includes summarized data and information on which the priority is based		
	3. The description includes the relationship of the priority to Healthy People national health objectives		
	4. The description includes factors influencing the level of the problem (risk factors, direct contributing and indirect contributing factors, population groups at risk)		
OBJECTIVES AND STRATEGIES	5. The priority has at least one measurable outcome objective covering a three or more year time frame		
	6. The priority has at least one measurable impact objective covering a three or more year time frame		
	7. The priority has at least one proven intervention strategy to address each impact objective		
	8. Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding		
	9. Includes a plan to monitor programs and assess progress towards meeting community health objectives as stated in the community health plan		
	10. Includes a plan to promote an awareness about public health services availability and health education initiatives		

COMMENTS:

LHD Use | IDPH Use

PRIORITY 3:		Page Number	Compliance Per Rubric (NC/C)
DESCRIPTION OF THE PROBLEM	1. The description includes the importance of the priority health need		
	2. The description includes summarized data and information on which the priority is based		
	3. The description includes the relationship of the priority to Healthy People national health objectives		
	4. The description includes factors influencing the level of the problem (risk factors, direct contributing and indirect contributing factors, population groups at risk)		
OBJECTIVES AND STRATEGIES	5. The priority has at least one measurable outcome objective covering a three or more year time frame		
	6. The priority has at least one measurable impact objective covering a three or more year time frame		
	7. The priority has at least one proven intervention strategy to address each impact objective		
	8. Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding		
	9. Includes a plan to monitor programs and assess progress towards meeting community health objectives as stated in the community health plan		
	10. Includes a plan to promote an awareness about public health services availability and health education initiatives		

COMMENTS:

OPTIONAL PRIORITY 4:		Page Number	Compliance Per Rubric (NC/C)
DESCRIPTION OF THE PROBLEM	1. The description includes the importance of the priority health need		
	2. The description includes summarized data and information on which the priority is based		
	3. The description includes the relationship of the priority to Healthy People national health objectives		
	4. The description includes factors influencing the level of the problem (risk factors, direct contributing and indirect contributing factors, population groups at risk)		
OBJECTIVES AND STRATEGIES	5. The priority has at least one measurable outcome objective covering a three or more year time frame		
	6. The priority has at least one measurable impact objective covering a three or more year time frame		
	7. The priority has at least one proven intervention strategy to address each impact objective		
	8. Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding		
	9. Includes a plan to monitor programs and assess progress towards meeting community health objectives as stated in the community health plan		
	10. Includes a plan to promote an awareness about public health services availability and health education initiatives		

COMMENTS:

IDPH Reviewers: Do you believe a meeting of the reviewers is required to discuss this IPLAN?

☐ YES

☐ NO

Community Health Needs Assessment Compliance Rubric

Administrative Code	Criteria	Noncompliance (NC)	Substantial Compliance (C)
	Introduction and Methods		
600.400.a.2.A	The statement of purpose describes how the assessment will be used to improve health in the community	There is no statement of purpose, or the statement of purpose is not specific on how the health of the community will be improved	The statement of purpose includes a description of how the community's health will be improved
600.400.a.1.C 600.400.a.1.D 600.410.a.1	The assessment includes community participation to identify community health problems and set priorities from among those health problems	Community participation is not used for both identifying problems and priority setting	Community participation is used to both identify problems and set priorities
600.400.a.2.B 600.400.a.2.D	The assessment includes a description of the community participation process, a list of community groups involved in the process, and the method for establishing priorities	One or more parts is missing or unclear	All parts are described clearly and in detail
	Analysis by Groupings: demographic and socioeconomic characteristics; general health and access to care; maternal and child health; chronic disease; infectious disease; environmental/occupational/injury control; and sentinel events		
600.400.a.1.B 600.410.a.2	The assessment includes an analysis of data from IQuery by grouping	Some important data is missing	Each grouping includes a description of the relevant data in IQuery
600.400.a.2.C	The assessment includes a description of the health problems most meaningful for the community by grouping	There is no mention of what the community felt is important	Each grouping includes a description of which issues the community is most concerned by
	Priorities		
600.400.a.1.D 600.400.a.2.D 600.410.a.3	Prioritization shall result in the establishment of at least three priority health needs	Fewer than 3 priority health needs are identified	3 priority health needs are identified
600.400.a.2.E 600.410.a.4	Includes a statement that the SHIP was reviewed, including a description of the alignment or nonalignment between the priority health needs of the local public health jurisdiction and the priorities as set forth by the SHIP	The priorities in the community needs assessment are not compared to the SHIP	The community needs assessment describes how the priorities are similar to and different from the SHIP

Community Health Plan Compliance Rubric

Administrative Code	Criteria	Noncompliance (NC)	Substantial Compliance (C)
	Introduction		
600.400.d.5.A	The statement of purpose describes how the plan will be used to improve the health of the community	There is no statement of purpose, or it's not specific on how the health of the community will be improved	The statement of purpose includes a description of how the community's health will be improved
600.400.d.5.B	The plan includes a description of the process used to develop the community health plan	The description is missing, vague, or unclear	Each step in the process is clearly described
600.400.d.3 600.410.a.1	Community participation is utilized in the development of the community health plan	Community participation is not utilized	Community participation is utilized in the setting of objectives
600.400.d.4	The community health plan has been adopted by the board of health	The health plan has not been adpoted	The health plan has been adopted
	Description of the problem		
600.400.d.5.c	The description includes the importance of the priority health need	There is no justification of why the health priority is important to the community	The description inculdes a discussion of why the problem is important to the community
600.400.d.5.c 600.410.a.2	The description includes summarized data and information on which the priority is based	Some relevant data is missing	All relevant data is included
600.400.d.5.c	The description includes the relationship of the priority to Healthy People national health objectives	The priorities are not discussed in relation to the national health objectives	The description includes how the priority is similar to or different from the national health objectives
600.400.d.5.c 600.400.d.1	The description includes factors influencing the level of the problem (risk factors, direct contributing and indirect contributing factors, population groups at risk)	The factors influencing the problem are missing or not relevant to the problem	The factors influencing the problem are derived from data or published studies
	Objectives and Strategies		
600.400.d.2 600.400.d.5.D 600.410.a.5	Each priority has at least one measurable outcome objective covering a three or more year time frame	The objective is missing, not measurable, or not appropriate for the time frame	The outcome objective is measurable and appropriate for the time frame
600.400.d.2 600.400.d.5.E 600.410.a.5	Each priority has at least one measurable impact objective covering a three or more year time frame	The outcome is missing, not measurable, or not appropriate for the time frame	The impact objective is measurable and appropriate for the time frame
600.400.d.2 600.400.d.5.F 600.410.a.5	Each priority has at least one proven intervention strategy to address each impact objective	The intervention strategy is missing or not proven	There is a proven intervention strategy for each impact objective
600.400.d.1 600.400.d.5.F	Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding	Resources and funding are not discussed or are deficient	The analysis of resources and funding is detailed and sufficient
600.400.g.2	Includes a plan to monitor programs to assess progress towards meeting community health objectives as stated in the community health plan	There is no plan for monitoring the intervention strategies	A plan for monitoring the intervention strategies is included in the community health plan
600.400.h	Includes a plan to promote an awareness about public health services availability and health education initiatives	There is no plan for communicating the health initiatives and services with the public	A plan for communicating health initiatives and services with the public is included

Appendix H: Certification Codes

Certification Codes

	Code	Certification component	What's involved/needed to satisfy
	600.210	Certification	600.210c) A certified local health department may apply for renewal of certification. c)1) The application shall be made at least 60 days prior to the expiration of the certification period. An application shall be submitted to the Department on forms or in a format provided or prescribed by the Department and shall include a community health needs assessment and a community health plan in accordance with Subpart D. The application shall be signed by an authorized representative. c)2) Upon receipt of a complete application, the Department shall have 60 days to review the application to determine if the applicant is in substantial compliance with the personnel requirements set forth in Subpart C and the practice standards set forth in Subpart D. 600.210e) The Department may conduct an on-site review of the local health department and those documents necessary to determine substantial compliance with this Section.
1	600.300 600.400e)4) 600.300d)	Personnel requirements	Personnel Information Form (PIF)- *no admin code requirement that says pre-authorization before hire is required. *1 PIF submitted within 10 business days when personnel changes including interim*-IDPH has 45 days to respond Copy of IDPH PIF approval notice required to be included with Certification application submission
2	600.400a	Community Health Needs Assessment (CHNA)- 1/3 IPLAN component	LHD completes and submits every 5 years LHD shall use health data available from IPLAN Health Data System-IQuery. Substantial compliance checklist completed by LHD - IDPH has 60 days to respond resources available via the IPLAN and IQuery websites. Top health priorities of LHD available at: SHARE
3	600.400b	Investigation of occurrences	Investigate the occurrence of adverse health effects and health hazards in the community by conducting timely investigations that identify the magnitude of health problems, duration, trends, location, and populations at risk.
4	600.400c	Public Health Advocacy and Communication	Meet with relevant stakeholders to ensure open communications, no duplication of services that could be combined, and education on public health topics.
5	600.400d	Community Health Improvement Plan (CHIP)- 2/3 IPLAN component	LHD completes and submits every 5 years. Usually combined with CHNA. Substantial compliance checklist completed by LHD - IDPH has 60 days to respond resources available via the IPLAN and IQuery websites. Top health priorities of LHD available at: SHARE
6	600.400e	Organizational self-assessment- 3/3 IPLAN component	LHD required to complete at least every 5 years. Letter from Board of Health resources available via the IPLAN and IQuery websites
7	600.400f	Implement CHNA/CHIP	600.400i Documentation of everything in 600.400 should be available for IDPH review
8	600.400g	Evaluation of CHNA/CHIP implementation	600.400i Documentation of everything in 600.400 should be available for IDPH review
9	600.400h	Educate public	600.400i Documentation of everything in 600.400 should be available for IDPH review

Appendix I:
IDPH Introduction to Regional Health Officers

Health Regions and Local Health Departments

[IDPH Health Regions & Local Health Departments]

[Health Regions]

- [All Health Regions]
- [All Local Health Departments]

★ IDPH Regional Office

[Westchester]

[Champaign]

[Marion]

[Metro East]

[Peoria]

[Rockford]

No Local Health Department

Local Health Department Jurisdictional Boundaries

Appendix J: IDPH Public Health Personnel Information Form

ILLINOIS DEPARTMENT OF PUBLIC HEALTH PERSONNEL INFORMATION FORM

LOCAL HEALTH DEPARTMENTS ARE REQUIRED TO HAVE AN AFFIRMATIVE ACTION PROGRAM THAT PROHIBITS DISCRIMINATION IN EMPLOYMENT PRACTICES ON THE BASIS OF RACE, SEX, COLOR, RELIGION, NATIONAL ORIGIN, PHYSICAL OR MENTAL HANDICAP.

THE PURPOSE OF THIS FORM IS TO ADVISE THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH OF ALL PERSONS HIRED OR TO BE HIRED BY LOCAL HEALTH DEPARTMENTS AS AN EXECUTIVE OFFICER FOR WHICH A MINIMUM PERSONNEL QUALIFICATION STANDARD HAS BEEN ESTABLISHED. A DETERMINATION AS TO WHETHER THE APPLICANT MEETS ALL APPLICABLE EDUCATIONAL AND EXPERIENTIAL QUALIFICATIONS WILL BE MADE AND RETURNED TO THE ORIGINATOR WITHIN 45 DAYS OF RECEIPT OF COMPLETED FORMS. SUBMIT THIS FORM AND ALL ATTACHMENTS TO: ILLINOIS DEPARTMENT OF PUBLIC HEALTH, IPLAN ADMINISTRATOR DPH.IPLAN@ILLINOIS.GOV

DATE: drop down and select date

LINKS TO ADMINISTRATIVE CODE GOVERNING PERSONNEL

Executive Officer | Public Health Administrator | Medical Health Officer | Denial of Personnel Application

PLEASE FILL IN

LOCAL HEALTH DEPARTMENT: select from drop down for Local Health Department

EXECUTIVE OFFICER POSITION: select from drop down for the officer position

APPLICANT'S NAME:

DATE OF HIRE: (or to be hired)

APPLICANT INFORMATION

LAST NAME

FIRST **MIDDLE**

MAIDEN/Other Name

PHONE #

PERSONAL EMAIL

WORK EMAIL

LHD GUIDE TO THE PERSONNEL INFORMATION FORM (PIF)

POSITION: Section 600.310 Public Health Administrator (must meet 1 of 3 requirements)

a. The Public Health Administrator shall possess, at a minimum, the following education and experience:

1. A **master's degree** in public health from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency, and **two years** of full-time administrative experience in public health;

EDUCATION MET	EXPERIENCE MET
☐ YES ☐ NO	☐ YES ☐ NO

COMMENTS

2. A **graduate degree** in a related field from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency, which may include but shall not be limited to a master's degree in public administration, nursing, environmental health, community health, health education, and **two years** of full-time administrative experience in public health; or

EDUCATION MET	EXPERIENCE MET
☐ YES ☐ NO	☐ YES ☐ NO

COMMENTS

3. A **bachelor's degree** from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency, and **four years** of full-time administrative experience, of which at least **two years must be in public health**.

EDUCATION MET	EXPERIENCE MET
☐ YES ☐ NO	☐ YES ☐ NO

COMMENTS

POSITION: Section 600.320 Medical Health Officer (must meet all 3 requirements)

a. The Medical Health Officer shall possess, at a minimum, the following education and experience:

1. A **master's degree** in public health from a college or university accredited by the North Central Association or other regional, nationally-recognized accrediting agency, and **two years** of full-time administrative experience in public health;
2. A license to practice medicine in all of its branches in Illinois; and
3. Two years of full-time administrative experience in public health administration.

☐ EDUCATION MET	☐ LICENSURE MET	☐ EXPERIENCE MET
☐ EDUCATION NOT MET	☐ LICENSURE NOT MET	☐ EXPERIENCE NOT MET

COMMENTS

b) An incumbent Medical Health Officer, who has received approval by IDPH, and has been employed as a Medical Health Officer prior to the effective date of this Part, shall be considered in compliance with the education and experience requirements of subsection (a) of this Section, and shall be exempt from the approval procedures specified in Section 600.300. This is for those who have been approved prior to 2017.

COMMENTS

c). Certification in Public Health by the American Board of Preventive Medicine or board certification in a related specialty is desirable but not required.

CERTIFICATION
☐ YES ☐ NO

COMMENTS

PROFESSIONAL LICENSE OR CERTIFICATION	NUMBER	STATE IN WHICH ISSUED	DATE ISSUED	DATE APPLIED FOR
PROF LIC OR CERT_1				
PROF LIC OR CERT_1				
PROF LIC OR CERT_1				

EXPERIENCE

Years of public health and administrative experience YEAR$

This position requires two years of public health or administrative experience with a master's degree or higher, or four years of public health or administrative experience with a bachelor's degree. Explain how you meet the experience requirement.

COLLEGE TRANSCRIPTS CLICK TO ATTACH

ATTACHED RESUME CLICK TO ATTACH

ATTACHED LICENSURE INFORMATION CLICK TO ATTACH

I SIGNIFY THE INFORMATION CONTAINED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I REALIZE THAT MISREPRESENTATION OF THIS INFORMATION AT ANY TIME MAY BE CAUSE FOR REVOCATION OR DISAPPROVAL OF THIS APPLICATION.

SIGNATURE OF APPLICANT _____

APPLICANT EMAIL: _____

SIGNATURE OF BOARD OF HEALTH PRESIDENT OR AUTHORIZED DESIGNEE: _____

BOARD OF HEALTH PRESIDENT OR AUTHORIZED DESIGNEE EMAIL: _____

OFFICE USE ONLY:

STATEMENT BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH

APPLICANT'S NAME:

POSITION OF EXECUTIVE OFFICER POSITION

MEETS THE QUALIFICATION REQUIREMENTS FOR THE

AS DEFINED IN THE "CERTIFIED LOCAL HEALTH **DEPARTMENT CODE", 77 ILL. ADM. CODE 600 SUBPART C: PERSONNEL REQUIREMENTS**

IDPH APPROVALS	EDUCATION MET	EXPERIENCE MET	APPROVAL STATUS	DATE
REGIONAL HEALTH OFFICER	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
COMMENTS				
IPLAN ADMINISTRATOR	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
COMMENTS				
ASSISTANT DIRECTOR	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
COMMENTS				

Appendix K:
IPLAN Template

[location] County IPLAN

[Recertification Period]

[Region Name] Region

Table of Contents

Community Health Needs Assessment

Community Health Plan

Community Health Needs Assessment

Purpose Statement

[Describe how the community health needs assessment is going to be used to improve the health of the community]

Methods

[Describe how you identified problems, how the community participated in that process, and list which community groups participated in that process.]

[Describe how priorities were selected out of all the problems identified, how the community participated in the selection process, and list which community groups participated. If the community groups were the same as in the identification process, you do not need to list them again, just state that they were the same.]

Analysis By Grouping

Demographic and Socioeconomic Characteristics

[For each grouping of health needs, analyze data relevant to that grouping. At minimum, you must use the data available on the IQuery website, but you may use other data sources as well. https://iquery.illinois.gov/iquery/]

[Describe the problems relevant to this grouping that community members found important.]

General Health and Access to Care

[Analysis of data from IQuery]

[Health problems meaningful to the community]

Maternal and Child Health

[Analysis of data from IQuery]

[Health problems meaningful to the community]

Chronic Disease

[Analysis of data from IQuery]

[Health problems meaningful to the community]

Infectious Disease

[Analysis of data from IQuery]

[Health problems meaningful to the community]

Environmental/Occupational/Injury Control

[Analysis of data from IQuery]

[Health problems meaningful to the community]

Sentinel Events

[Analysis of data from IQuery]

[Health problems meaningful to the community]

Priorities

[State the 3 or more priorities that were identified during the Community Health Needs Assessment. Compare the 3 priorities selected to the priorities in the State Health Improvement Plan (SHIP). https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/ship-final.pdf]

Community Health Plan

Statement of Purpose

[Describe how the Community Health Plan will be used to improve the health of the community.]

Methods

[Describe the process used to develop the Community Health Plan. This should include how objectives and intervention strategies were chosen and how research was conducted. It should also include how members of the community were able to participate in the process.]

[State when the Community Health Plan was adopted by the board of health.]

Priority 1: [First priority]

Description

[Describe why the priority was selected out of all the problems identified and why it is important to the community. The description should include all relevant data used in selecting it.]

[Compare the priority to the Healthy People national health objectives.]

Risk Factors: [Risk factors are scientifically determined factors that relate directly to the level of a health problem.]

Direct Contributing Factors: [A direct contributing factor influences the level of a risk factor.]

Indirect Contributing Factors: [Indirect contributing factors influence direct contributing factors. They do not influence the risk factors themselves.]

Population Groups at Risk: [The demographic characteristics that are most associated with the health problem.]

Objectives and Strategies

Outcome Objective: [Outcome objectives are goals for how much health problems should be reduced. They must be measurable.]

Impact Objective: [Impact objectives are goals for how much risk factors should be reduced. They must be measurable.]

Intervention Strategy: [The intervention strategies chosen must be proven to influence the levels of risk factors.]

Community Resources: [Describe the community resources that are available to use in the implementation of the intervention strategy. Be sure to include what funding will be necessary for the strategy and how that funding will be obtained.]

Monitoring and Assessment: [Describe how the health department will monitor the progress of the intervention strategies and assess their effectiveness.]

Awareness and Promotion: [Describe how the health department will make the public aware of its new resources or programs.]

Priority 2: [Second priority]

Description

[Describe why the priority was selected out of all the problems identified and why it is important to the community. The description should include all relevant data used in selecting it.]

[Compare the priority to the Healthy People national health objectives.]

Risk Factors: [Risk factors are scientifically determined factors that relate directly to the level of a health problem.]

Direct Contributing Factors: [A direct contributing factor influences the level of a risk factor.]

Indirect Contributing Factors: [Indirect contributing factors influence direct contributing factors. They do not influence the risk factors themselves.]

Population Groups at Risk: [The demographic characteristics that are most associated with the health problem.]

Objectives and Strategies

Outcome Objective: [Outcome objectives are goals for how much health problems should be reduced. They must be measurable.]

Impact Objective: [Impact objectives are goals for how much risk factors should be reduced. They must be measurable.]

Intervention Strategy: [The intervention strategies chosen must be proven to influence the levels of risk factors.]

Community Resources: [Describe the community resources that are available to use in the implementation of the intervention strategy. Be sure to include what funding will be necessary for the strategy and how that funding will be obtained.]

Monitoring and Assessment: [Describe how the health department will monitor the progress of the intervention strategies and assess their effectiveness.]

Awareness and Promotion: [Describe how the health department will make the public aware of its new resources or programs.]

Priority 3: [Third priority]

Description

[Describe why the priority was selected out of all the problems identified and why it is important to the community. The description should include all relevant data used in selecting it.]

[Compare the priority to the Healthy People national health objectives.]

Risk Factors: [Risk factors are scientifically determined factors that relate directly to the level of a health problem.]

Direct Contributing Factors: [A direct contributing factor influences the level of a risk factor.]

Indirect Contributing Factors: [Indirect contributing factors influence direct contributing factors. They do not influence the risk factors themselves.]

Population Groups at Risk: [The demographic characteristics that are most associated with the health problem.]

Objectives and Strategies

Outcome Objective: [Outcome objectives are goals for how much health problems should be reduced. They must be measurable.]

Impact Objective: [Impact objectives are goals for how much risk factors should be reduced. They must be measurable.]

Intervention Strategy: [The intervention strategies chosen must be proven to influence the levels of risk factors.]

Community Resources: [Describe the community resources that are available to use in the implementation of the intervention strategy. Be sure to include what funding will be necessary for the strategy and how that funding will be obtained.]

Monitoring and Assessment: [Describe how the health department will monitor the progress of the intervention strategies and assess their effectiveness.]

Awareness and Promotion: [Describe how the health department will make the public aware of its new resources or programs.]

[Delete the entire Priority 4 section if an optional forth priority was not selected as part of your IPLAN process.]

Priority 4: [Forth priority]

Description

[Describe why the priority was selected out of all the problems identified and why it is important to the community. The description should include all relevant data used in selecting it.]

[Compare the priority to the Healthy People national health objectives.]

Risk Factors: [Risk factors are scientifically determined factors that relate directly to the level of a health problem.]

Direct Contributing Factors: [A direct contributing factor influences the level of a risk factor.]

Indirect Contributing Factors: [Indirect contributing factors influence direct contributing factors. They do not influence the risk factors themselves.]

Population Groups at Risk: [The demographic characteristics that are most associated with the health problem.]

Objectives and Strategies

Outcome Objective: [Outcome objectives are goals for how much health problems should be reduced. They must be measurable.]

Impact Objective: [Impact objectives are goals for how much risk factors should be reduced. They must be measurable.]

Intervention Strategy: [The intervention strategies chosen must be proven to influence the levels of risk factors.]

Community Resources: [Describe the community resources that are available to use in the implementation of the intervention strategy. Be sure to include what funding will be necessary for the strategy and how that funding will be obtained.]

Monitoring and Assessment: [Describe how the health department will monitor the progress of the intervention strategies and assess their effectiveness.]

Awareness and Promotion: [Describe how the health department will make the public aware of its new resources or programs.]

Appendix L: MAPP 2.0/IPLAN Compliance Indicator Crosswalk

IPLAN-MAPP 2.0 Crosswalk

December 2024

This crosswalk compares the IPLAN Substantial Compliance Checklist requirements with the MAPP 2.0 process.

IPLAN Process	MAPP 2.0 Process	IPLAN Compliance Indicator
The following components are the requirements for Illinois LHDs to complete the Community Health Assessment portion of IPLAN.		
2.1 Statement of Purpose	**Phase I** Develop the Community Vision	Statement of purpose describing how the assessment will be used to improve health in the community
2.2 Community Health Committee	**Phase I** Do a Stakeholder and Power Analysis, Establish or Restructure CHI Leadership Structures, Engage or Orient the Steering Committee, Establish Administrative Structure, Do the Starting Point Assessment, Identify CHI Infrastructure Priorities and Workgroups, Develop the Workplan and Budget **Phase II** Form the Assessment Design Team, Community Partner Assessment, Triangulate Data, Identify Themes and Develop Issue Statements, Develop Issue Profiles Through Root Cause Analysis, Share CHA Findings, **Phase III** Prioritize Issues for the CHIP, Do a Power Analysis of Each Issue, Set Up Priority Issue Subcommittees, Create Community Partner Profiles, Develop Shared Goals and Long-term Measures, Select CHIP Strategies, Develop Continuous Quality Improvement Action Planning Cycles, Monitor and Evaluate the CHIP	The assessment includes a description of the community participation process to identify community health problems and set priorities from among these health problems. Includes a list of community groups involved in the process and the methods for establishing priorities.
2.3 Description of Health Status and Health problems	**Phase II** Do the 3 Assessments: Community Status Assessment, Community Context Assessment, Community Partner Assessment	The analysis includes a description of data from IQuery by grouping and a description of the health problems most meaningful for the community by grouping: demographic & socioeconomic characteristics, general health and access to care, maternal and child health, infectious disease, chronic disease, environment/occupation/injury control, and sentinel events
2.4 Prioritization: Process used to select priorities and minimum of 3 priorities	**Phase III** Prioritize Issues for the CHIP	Prioritization shall result in the establishment of at least 3 priority health needs. The assessment includes a statement that the State Health Improvement Plan (SHIP) was reviewed, including a description or nonalignment between the priority health needs of the local public health jurisdiction and the priorities as set forth by the SHIP

IPLAN Process	MAPP 2.0 Process	IPLAN Compliance Indicator
The following components are the requirements for Illinois LHDs to complete the Community Health Improvement Plan portion of IPLAN.		
3.1 Statement of Purpose	N/A – no perfect equivalent. **Phase I** Develop a Community Vision **Phase III** Goal Development Worksheet (mission, vision, values)	The statement of purpose describes how the plan will be used to improve the health of the community.
3.2 Community Participation	**Phase I** Do the Starting Point Assessment (Leadership support to address health equity, Organize into supporters, detractors, and prospects, Document stakeholder's support and impact and your goals for engagement **Phase II** Triangulate Data, Identify Themes, and Develop Issue Statement (Determine how to engage stakeholders, partners, and community members in data triangulation, identifying themes, and developing issue statements) Develop Issue Profiles Through Root Cause Analysis, Share CHA Findings, **Phase III** Prioritize Issues for the CHIP, Do a Power Analysis of Each Issue, Set Up Priority Issue Subcommittees, Create Community Partner Profiles, Develop Shared Goals and Long-term Measures, Select CHIP Strategies, Develop Continuous Quality Improvement Action Planning Cycles, Monitor and Evaluate the CHIP	The plan includes a description of the process used to develop the community health plan. Community participation is utilized in the development of the community health plan.
3.3 Priorities (3) Description of Priority Health Issue; Analysis of Priority; Measurable Outcome and Impact Objectives and Proven Intervention Strategies	**Phase III** Prioritize Issues for the CHIP, Do a Power Analysis of Each Issue, Set Up Priority Issue Subcommittees, Create Community Partner Profiles, Develop Shared Goals and Long-term Measures (Develop SMARTIE objectives), Select CHIP Strategies, Develop Continuous Quality Improvement Action Planning Cycles, Monitor and Evaluate the CHIP	The description includes the importance of the priority health need. The description includes summarized data and information on which the priority is based. The description includes the relationship to Healthy People national health objectives. The description includes factors influencing the level of the problem (risk factors, direct/indirect contributing factors, pop groups at risk) Each priority has at least one measurable outcome objective covering a 3 or more year time period. Each priority has at least one measurable impact objective covering a 3 or more year time period. ***(Continued on next slide)***

IPLAN Process	MAPP 2.0 Process	IPLAN Compliance Indicator
The following components are the requirements for Illinois LHDs to complete the Community Health Improvement Plan portion of IPLAN.		
3.3 Priorities (minimum of 3) Description of Priority Health Issue; Analysis of Priority; Measurable Outcome and Impact Objectives and Proven Intervention Strategies	**Phase III** Prioritize Issues for the CHIP, Do a Power Analysis of Each Issue, Set Up Priority Issue Subcommittees, Create Community Partner Profiles, Develop Shared Goals and Long-term Measures (Develop SMARTIE objectives), Select CHIP Strategies, Develop Continuous Quality Improvement Action Planning Cycles, Monitor and Evaluate the CHIP	Each priority has at least one proven intervention strategy to address each impact objective. Each strategy includes an analysis of community resources that will contribute, estimated funding needed, and anticipated sources of funding. Includes a plan to monitor programs and assess progress towards meeting community health objectives as stated in the community health plan. Includes a plan to promote an awareness about public health services availability and health education initiatives.
		The Community Health Plan has been adopted by the Board of Health.
The following components are the requirements for Illinois LHDs IPLAN to complete an Organizational Capacity Self-Assessment		
1.1 Description of Type of Organizational Self-Assessment Assessment	There isn't a clear organizational capacity self-assessment as part of MAPP 2.0.	The local health department has submitted a signed and dated statement indicating the organizational capacity self-assessment was completed by the local health department and reviewed by the Board of Health. The organizational capacity self-assessment should assess the internal capabilities of the local health department to conduct effective public health functions, including an assessment of operational authority, community relations, information systems, and program management; or an organizational strategic plan developed within the previous five years that assesses strengths, weaknesses, opportunities and threats in the local health jurisdiction.
1.2 Documentation of Board of Health Review		

Appendix M: Capacity Assessment Worksheets – Organizational Capacity Assessment

Organizational Capacity Assessment

This tool has been replicated from the Assessment Protocol for Excellence in Public Health (APEX-PH) manual for use by Illinois local health departments to support Part I of the Illinois Project for the Local Assessment of Needs (IPLAN).

Instructions:
To complete the Organizational Capacity Assessment, review each indicator listed in the tool and rate its perceived importance using the codes listed below in the left-hand column. Then assess the current status for each indicator using the provided codes listed in the right-hand column below. Add comments or notes where needed, and ensure all sections are addressed before finalizing the assessment.

Perceived Importance Codes
H = High Importance
M = Moderate Importance
L = Low Importance
0 = Not Relevant

Current Status Codes
F = Fully Met
P = Partially Met
N = Not Met at All
0 – Not Relevant
? – Status Unknown

1. Indicators for Authority to Operate	**Perceived Importance Codes: H, M, L, 0**	**Current Status Codes: F, P, N, 0, ?**
A. Legal Authority		
1. The health department has clear authority to act as a law enforcement office for public health problems.		
2. The health department has authority to develop and introduce local regulations when needed.		
3. The health department has the authority to delegate public health duties to municipalities within its jurisdiction.		
4. The health department has agreements for the join exercise of public health powers with neighboring jurisdictions.		
5. The health department exercises authorities to it by the state or federal government.		
Other:		

1. Indicators for Authority to Operate	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Intergovernmental Relations		
1. At least once every two years (biennially), the health department reviews its joint powers agreements, memoranda of understanding, and other agreements with units of government within its jurisdiction or in neighboring jurisdictions to identify problems, propose solutions, and look for areas for further development.		
2. At least biennially, the health department reviews and discusses its formal relationship with the state health authority to identify problems, propose solutions, and look for areas for further development.		
3. The health department is represented on a state public health committee or other body advisory to the state health authority.		
4. Units of government within the jurisdiction of the health department are represented on a committee, subcommittee, or other body advisory to the local department of health.		
5. The health department is regularly consulted by the local elected officials about aspects of local policy relating to health issues.		
6. The health department is regularly consulted by the state elected officials about aspects of local policy relating to health issues.		
7. The director or a representative communicates appropriately and regularly with state legislators who represent the district the health department serves.		
8. The health department is regularly consulted by the local schools when setting health policy.		
9. The health department has a formal and productive working relationship with the state health authority.		
Other:		

1. Indicators for Authority to Operate	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Legal Counsel		
1. The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies, and procedures; relevant laws and ordinances; contracts; and other legal matters.		
2. The health department maintains a current file or library of all relevant federal, state, and local statutes and regulations.		
3. At least biennially, the director and the management staff of the health department review with legal counsel the specific authorities of the department to operate public health programs and to enforce public health laws, ordinances, and regulations, as well as the specific responsibilities these entail. A. As a part of this review, the director and management staff identify the public-health-related legal authority and responsibilities of other organizations in the community. B. The director and management staff of the health department continuously maintain documentation of the scope of the department's powers to adopt its own regulations and the specific responsibilities these entail		
4. Procedures for the enforcement of board authorities and responsibilities are documented and are reviewed at least biennially with legal counsel.		
5. The health department maintains current files documenting the legal status of all health-related organizations operating within its jurisdiction (Department of government, private nonprofit corporation, private unaffiliated and unincorporated group, etc.		
Other:		

2. Indicators for Community Relations	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Constituency Development		
1. The health department has a system that actively involves individuals and groups affected by its planning of services, its methods of service delivery, and its service results.		
2. At least every four years, the health department actively involves all key individuals and organizations within its jurisdiction that might be engaged in public-health-related activities to determine their goals and their perceptions of their roles, authorities, and needs, including: A. Units of government with authority within the jurisdiction of the health department, including the governmental unit from which the department derives its basic authority. B. The general public of the community, at least through some form of community health committee or representation on an advisory body. C. Interest groups, such as environmental protection and conservation groups, local business organizations, the local medical and dental societies, religious organizations, and other key organizations in the community. D. Representatives from hospitals, community health centers, the Visiting Nurse Association, and other health and human service agencies. E. Educational institutions, such as university schools of public health, medicine, and nursing; colleges, private schools, and local school districts. F. Other potential stakeholders in local public health.		
3. The health department cooperates and collaborates with other community agencies that have similar or overlapping missions.		
4. The health department cooperates and collaborates with other agencies that deliver similar programs in the same service area.		

2. Indicators for Community Relations	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Constituency Development (continued)		
5. The health department has formed a citizens' or community committee or has established another formal method of involving the people it serves in the identification of community health problems and the development of a community health plan.		
6. The health department has established mechanisms to guide and ensure active and cooperative relationships with community and professional groups.		
7. Health department staff are aware of relevant programs, policies, and priorities of the federal Department of Health and Human Services (HHS), Environmental Protection Agency (EPA), and other related federal agencies.		
8. The health department has a physician health officer, medical adviser(s), or consultant(s) to assist in maintaining relationships with the private medical community.		
9. The health department has established relationships with a university school of public health, medicine, or nursing, or with other educational institutions within or near its jurisdiction for staff development, internships, consultation, and other capacity-building purposes.		
Other:		

2. Indicators for Community Relations	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Constituency Education		
1. The health department has a documented plan for informing the public about the current health status of the community.		
2. The local media looks to the health department as a source of information about the health of the community.		
3. The health department regularly provides background information and news information to the local media.		
4. At least once a year, the director or a representative of the director meets with the representatives of health-related community organizations to define inter-organizational roles and responsibilities (see item A2 above for a brief list of potential representatives).		
5. Professional staff members of the health department participate in or serve on councils, boards, or committees of public health related organizations at the state and local level.		
6. The health department has current mailing lists (no older than 1 year) of the directors, chairs, and other officials of all citizen groups, service organizations, health care professional organizations, business groups, and other community organizations within its jurisdiction.		
7. The health department has a means of regular public communication, such as a regular newsletter or column in a community newspaper.		
8. The health department makes its own information systems and databases available to interested community groups for their health-related activities.		
9. The health department has an established program for community volunteers and student interns in departmental programs.		
10. The health department widely disseminates reports regarding public health issues to the community.		
Other:		

2. Indicators for Community Relations	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Documentation		
1. The health department maintains files documenting relations and communications with other organizations related to the public health.		
2. The health department maintains current information on the needs of health-related organizations.		
3. In all cases in which a potential duplication of significant public health activities might exist between the health department and another local organization, the director has established a written agreement with the executive officer or board of that organization clarifying functional relationships and identifying areas of collaboration.		
Other:		

3. Indicators for Community Health Assessment	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Mission and Role		
1. The health department has a clear and concrete mission statement that all staff are capable of stating and explaining in relation to their duties.		
2. The health department has established a process for community health assessment and the development of a community health plan.		
3. At least every four years, the health department conducts a public review and discussion of its mission and role, its public health goals, its accomplishments, past activities, and plans in relation to community health.		
4. At least every two years, the health department formally requests all units of government within its jurisdiction to comment on the department's programs, plan, and budget.		
5. The health department has and uses a prepared presentation for informing the community and community groups of its role and authority in relation to the community's health.		
6. The health department maintains a current description (no older than two years) of the public health services, programs, and authorities of the municipalities in its jurisdiction.		
Other:		

3. Indicators for Community Health Assessment	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Data Collection and Analysis		
1. The health department maintains a database of existing health resources and community health status.		
2. The health department receives reports of communicable disease in the community on a daily basis		
3. The health department has qualified professionals to review and analyze reported morbidity and mortality data.		
4. Morbidity and mortality data are reviewed and analyzed for appropriate action on a regular schedule.		
5. The health department is responsible for processing, analyzing, and reporting birth and death certificates, or is part of a state-wide system for obtaining such information.		
6. The health department conducts appropriate statistical analysis of birth and death records and reports these results to the policy board, staff, and community on a regular basis.		
7. The health department conducts or supports periodic risk factor surveys to identify community risk factors, their prevalence, and interrelationships.		
8. The health department regularly collects or requests and receives from the state health authority locally specific data needed for assessing the health of the community A. The data includes at least those data sets suggested in Part II of this Workbook. B. The health department collects or receives additional locally specific data sets such as those included in Part II, Section B.		
Other		

3. Indicators for Community Health Assessment	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Resource Assessment		
1. The health department has joint powers agreements with other units of government in neighboring jurisdictions or within its own jurisdiction for the shared funding and operation of enforcement and service delivery programs where economies of scale and efficiency are possible.		
2. The health department maintains a current roster of qualified health professionals employed by units of government within its jurisdiction for reference in the development of technical study groups, activities related to professional development, and other personnel-related purposes.		
3. The health department participates in joint efforts to pool training needs with neighboring health agencies.		
4. The health department has agreements with health-related organizations operating programs within its jurisdiction for sharing staff expertise.		
5. The health department annually compiles or updates a listing of health-related information systems and databases maintained by community organizations that operate within its jurisdiction.		
6. The health department has an established program for the development of in-kind contributions from private industry, private nonprofit organizations, churches, and other community organizations.		
Other:		

3. Indicators for Community Health Assessment	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
D. Planning and Development		
1. The health department has staff with education and experience in planning and evaluation.		
2. The health department uses health data, including vital records, in its community health planning process.		
3. The health department has a standard, ongoing process to examine internal and external trends, to make forecasts, and to systematically develop long term plans for its future.		
4. The health department has a published strategic plan that includes the current year.		
Other:		

3. Indicators for Community Health Assessment	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
E. Evaluation and Assurance		
1. The health department monitors program impact indicators on a regular basis.		
2. The health department has community health objectives that are time-limited and measurable.		
3. The health department reviews and revises community health programs on the basis of the community health plan.		
Other:		

4. Indicators for Public Policy Development	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Community Health Assessment and Planning		
1. The health department director assures and facilitates the completion of a community health assessment process.		
2. The health department and the community identify and set priorities for addressing health problems based on the results of the community health assessment.		
3. The health department and the community develop a community health plan based on the results of the community health assessment and priority-setting processes.		
4. The health department director and the community involve the policy board in the review and revision, if necessary, of the proposed community health plan.		
5. The policy board adopts the community health plan.		
6. The policy board acts as an advocate on behalf of the health department for allocation of resources needed to implement the community health plan.		
7. The policy board monitors the implementation of the community health plan.		
Other:		

4. Indicators for Public Policy Development	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Community Health Policy		
1. The policy board obtains Information from an established citizens' advisory group and from the health department regarding public policy issues affecting the public health.		
2. The policy board identifies any additional public policy issues affecting public health and analyzes those issues.		
3. The policy board establishes priorities and formulates strategies for action on high priority health policy issues.		
4. The health department facilitates the formulation of public health policy in the community.		
5. The policy board and the health department director monitor and evaluate the impact of public policy on specific health problems.		
6. The policy board advocates changes in public policy to correct the public health problems of the community.		
Other:		

4. Indicators for Public Policy Development	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Public Policy and Public Health Issues		
1. The local governmental unit collaborates with the policy board and the health department director in developing public policy which may impact public health.		
2. The elected officials at the local level actively solicit the opinions of the professional staff and/or health department director on scientific issues in policy development.		
3. The health department director and policy board participate at both the state and local levels in governmental decision making which may have an impact on local health issues.		
Other:		

5. Indicators for Assurance of Public Health Services	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Public Policy Implementation		
1. The policy board uses its authority to assure necessary services to reach agreed upon goals for its constituents.		
2. The policy board assists the health department in utilizing all resources in the community to assure the desired services to all its citizens.		
3. The health department assures or provides direct services for priority health needs identified in the community health assessment.		
4. The health department assures and implements legislative mandates and statutory responsibilities.		
5. The health department maintains a level of service without interruption to avoid crises affecting the health of the community.		
Other:		

5. Indicators for Assurance of Public Health Services	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Public Health Services		
1. The health department monitors the availability of personal health services and assures an appropriate level of those health services in the community.		
2. The health department seeks to assure that all citizens receive the level of personal health services referred to in B1, above, regardless of their ability to pay.		
3. The health department identifies barriers to access to health care and develops plans to minimize them.		
4. The health department provides the services necessary to assure a clean, safe, and secure environment for the community.		
Other:		

5. Indicators for Assurance of Public Health Services	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Involvement of Community in the Public Health Delivery System		
1. The policy board and senior management of the health department work with employee groups in assessing health risks of employees and in managing those risks.		
2. The policy board and senior management participate in the development of health policy issues in colleges, schools, and industry to assure an optimum, healthy environment for special groups.		
3. The policy board and the health department director assure health protection and health promotion services utilizing community-based organizations.		
Other:		

6. Indicators for Financial Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Budget Development and Authorization		
1. A department budget is adopted annually by the policy board.		
2. The budget accurately reflects the priorities established in the organizational action plan.		
3. Budget justifications reflect health department programs and health problems within its jurisdiction.		
4. Professional or community groups help the health department present and justify its budget.		
5. Health department management staff are involved in developing the proposed budget.		
6. The health department receives locally assessed tax funds from the unit of government to which it is responsible.		
7. The health department has the authority to recommend and charge fees for the services it provides		
8. The health department has an adequate contingency fund for dealing with public health emergencies.		
Other:		

6. Indicators for Financial Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Financial Planning and Financial Resource Development		
1. The health department has a predictable source of funds to allow the development and implementation of a long range plan (minimum, 5 years).		
2. The health department has a financial management capacity that provides for securing funding for, or the orderly phasing out of, discretionary programs for which funds are not available.		
3. The health department has a diverse funding base to lessen disruption of services caused by withdrawal of funds from any one source.		
4. The health department maintains or has access to foundation directory and other Information about sources of public and private funding for public health activities.		
5. The health department has a current description of state and federal funding sources available to it and to organizations within its jurisdiction.		
6. The health department maintains current information on the health-related budgets and expenditures of all units of government within its jurisdiction.		
7. The health department has staff skilled in writing successful grant applications.		
8. The health department has agreements with units of government within its jurisdiction that allow the use of local expenditures to be documented as "match" in its grant requests.		
9. The health department has contracts to provide public health services to or for community organizations, private nonprofit corporations, and health care organizations.		
Other:		

6. Indicators for Financial Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Financial Reporting and Administration		
1. Expenditures follow the budget and financial plan of the health department.		
2. A description of the health department financial management system is a part of orientation for new policy board members and staff.		
3. Financial reports are understood by policy board members and administrative and supervisory staff.		
4. The financial position of the health department is routinely reviewed by the policy board and administrative and supervisory staff.		
5. An administrative officer or finance director is designated by the policy board to oversee all finances of the health department, including meeting all legal financial requirements, adherence to department fiscal policies, and reporting to the policy board regularly on financial matters.		
6. The policy board and staff understand their legal accountability and liability, as well as their general responsibility to the public for wise financial management.		
Other		

6. Indicators for Financial Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
D. Audit		
1. The health department has an independent, outside, annual financial and performance audit which conforms with requirements stipulated by general accounting principles.		
2. The annual audit is reviewed and clearly understood by the policy board and key department staff.		
Other:		

6. Indicators for Financial Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
E. Documentation		
1. A written standard budget development and review procedure is authorized by the policy board and is available to staff and the public.		
2. Appropriate journals, ledgers, registers, and financial reports are kept, using generally accepted accounting procedures.		
3. Copies of the health department annual financial audit are available to policy board members, department staff, and the public.		
4. A written procedure for participating in state and federal grants, and public and private foundation funding awards, is authorized by the policy board and available to department staff and the public.		
Other:		

7. Indicators for Personnel Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Policy Development and Authorization		
1. A written job description, including minimum qualifications, exists for each position in the health department.		
2. Written personnel policies and procedures are developed or revised with staff input.		
3. Personnel recruitment, selection, and appointment procedures are documented.		
4. If another unit or department of government carries out personnel functions for the health department, the relationships with that unit or department are clearly defined and documented in a written agreement.		
5. If labor unions represent department staff, there is an established working relationship and labor contract between the health department policy board and each respective labor union.		
6. Both the policy board and senior management of the health department have input into any labor union contract negotiations.		
7. There is a documented procedure, authorized by the policy board and developed with input from senior management of the health department and staff where appropriate, for employee grievances, reprimands, suspensions, and dismissals.		
8. There is a documented, structured salary administration plan that is authorized by the policy board and that is designed to attract and retain competent staff.		
Other:		

7. Indicators for Personnel Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Personnel Administration and Reporting		
1. The health department director is responsible for internal administration of the department.		
2. The policy board employs the health department director and conducts a periodic, written appraisal of the director's performance.		
3. Written staff performance appraisals are conducted by supervisors with employees at established intervals.		
4. The performance appraisal system is monitored by the health department director.		
5. Union contract provisions are administered in a well-coordinated manner with documented provisions for non-union employees.		
6. Health department announcements and program information are distributed to all employees via a standard mechanism.		
7. There are regularly scheduled meetings by work group, work site, division, and department.		
8. The policy board receives routine reports from the health department director relative to new employees, staffing changes, dismissals, grievances, etc.		
9. The health department director selects qualified individuals as staff for the department.		
10. The health department provides appropriate confidentiality for all personnel records.		
Other:		

7. Indicators for Personnel Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Staffing Plan and Development		
1. Staffing patterns and levels match policy board authorized programs and services and current levels of demand for services.		
2. The health department has a written plan or policy regarding staff recruitment, selection, development, and retention.		
3. All employees have structured, routine, group opportunities to discuss program methods and procedures, current levels of demand for services, and quality of work issues with their respective supervisors.		
4. The health department staff have access to training provided by the state health authority in areas relevant to local health problems.		
5. The health department has access to the staff development resources of a school of public health or of other relevant educational institutions.		
6. The health department has clearly expressed its staff development needs to schools of public health or to other educational institutions.		
7. The health department uses volunteers to support programs where possible and manages its volunteer program through clearly defined policies and procedures.		
8. There are adequate provisions for liability insurance protection for department board members, staff, and volunteers.		
9. The health department has a documented staff development program, monitored by the department director, which includes employee-supervisor annual plan development and cost projections, with routine review and update.		
10. The health department personnel administration system and personnel policies and procedures are reviewed with each new policy board member and department staff member.		
11. The health department encourages and supports staff participation in professional organizations.		

7. Indicators for Personnel Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. Staffing Plan and Development (continued)		
12. The health department staffing plan includes provisions for "backup staff" to enable critical scheduled operations to continue without interruption when temporary vacancies occur.		
13. The health department has the ability to fill new and vacant positions in a timely manner.		
Other		

7. Indicators for Personnel Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
D. Personnel Policy and Procedure Audit		
1. A periodic personnel administration audit is performed by a department team to determine if authorized personnel policies and procedures are being followed.		
2. The findings of the personnel administration audit are reported to the policy board.		
3. There is a written, standard employee exit interview conducted with every employee leaving the health department, which includes identification of reasons for resignation.		
4. The health department director monitors all employee exit interview results, and periodically reports such information to the policy board.		
Other:		

7. Indicators for Personnel Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
E. Documentation		
1. There is a standard, written description of the health department personnel management system which is available to policy board members, department staff, and the public.		
2. All personnel transactions are documented.		
3. An up-to-date coordinated, structured, and confidential file is maintained for every employee and volunteer.		
4. All job descriptions, policies, and procedures are consolidated and available to policy board members, department staff, and the public.		
5. All recruitment, selection, appointment, and applicant grievance procedures are available in writing to policy board members, department staff, and the public.		
6. The salary administration plan is written and available to policy board members, department staff, and the public.		
Other:		

8. Indicators for Program Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
A. Organization and Structure		
1. Operating programs are authorized by the policy board.		
2. The director regularly reviews and discusses with the health department's management staff the perceived roles and authorities of units of government within its jurisdiction.		
3. There is a current organizational chart which shows all functional elements of the organization and their relationship to each other.		
4. Staff meetings are held at reasonable frequencies, include appropriate staff, and are called and structured by appropriate individuals.		
5. The health department maintains emergency contact staff (on site or on call) to respond to local public health emergencies.		
Other:		

8. Indicators for Program Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
B. Evaluation		
1. The health department collects and regularly analyzes information describing program administration and funding, program activities, workload, client characteristics, and service costs needed to evaluate the process of program activities.		
2. The health department collects and regularly analyzes information that is needed to evaluate the Impact and outcome of program activities on risk factors and health status.		
3. Program objectives are time-limited and measurable.		
4. Operating programs are reviewed or revised on a regular periodic schedule.		
5. The health department routinely examines the working environment to ensure that it facilitates program objectives and that the physical plant is "barrier free" and meets state and local building standards.		
Other:		

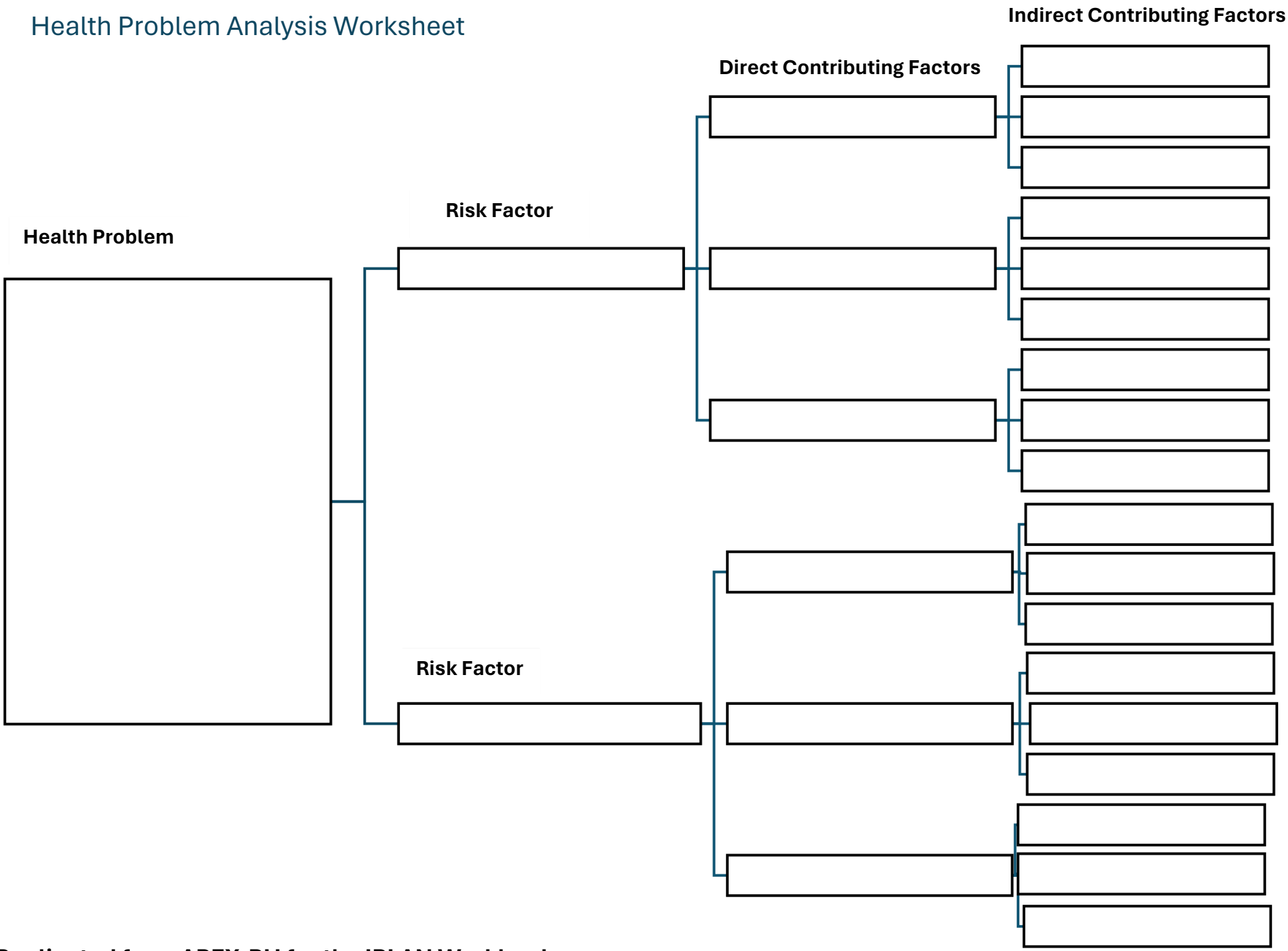
8. Indicators for Program Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
C. General Information Systems		
1. The health department has a management information system that allows the analysis of administrative, demographic, epidemiologic, and utilization data to provide information for planning, administration, and evaluation.		
2. The health department has a plan for the introduction and/or expansion of computer-based systems.		
3. The health department has a technical library of books and other publications relevant to its public health activities for immediate reference by its staff, and method for keeping materials current.		
4. The health department annually compiles or updates a listing of health-related information systems and databases maintained by units of government within its jurisdiction.		
5. The health department subscribes to an on-line, computer-based data system that provides direct access to health-related data or that has direct access to public health and population data compiled by state agencies."		
6. The health department maintains current information on federal databases and information systems relevant to its programs.		
Other:		

8. Indicators for Program Management	Perceived Importance Codes: H, M, L, 0	Current Status Codes: F, P, N, 0, ?
D. Shared Resources		
1. The health department has formal or informal agreements with other units of government within surrounding its jurisdiction for sharing expensive, less-used equipment (e.g., mainframe computer systems).		
2. The health department participates in shared service or purchase agreements where volume purchasing can reduce costs, such as for printing, supplies, and other materials.		
3. The health department has agreements with community organizations for sharing space, clerical. support, and other resources.		
Other:		

9. Indicators for Policy Board Procedures	**Perceived Importance Codes: H, M, L, 0**	**Current Status Codes: F, P, N, 0, ?**
1. Health department policy board members attend policy board and committee meetings.		
2. New policy board members routinely receive orientation through an established and documented orientation program of the health department.		
3. Policy board meetings are scheduled on a regular basis, with sufficient frequency to ensure board control and direction of the health department.		
4. Policy board materials, including agenda and study documents, are mailed to members no less than three days in advance of board meetings.		
5. Policy board meetings deal primarily with policy determination, review of plans, making board authorizations, and evaluating the work of the health department.		
6. There are written board and administrative policies consistent with the mission statement.		
7. The health department publishes the schedule of regular policy board meetings in local news media.		
8. Minutes of board and committee meetings are written and circulated to board members and the health department staff and are available to the public.		
Other:		

Appendix N: Health Problem Analysis Worksheet – The Community Process

Health Problem Analysis Worksheet



Replicated from APEX-PH for the IPLAN Workbook

Appendix O: Community Setting Priorities Among Health Priorities Worksheet – The Community Process

A Method for Setting Priorities Among Health Problems

Local communities commonly face an increasing range of pressing health problems which they must meet with limited or decreasing resources. To direct these resources well, they must establish priorities among the multitude of problems confronting them. For this difficult, yet necessary, task they need a process which is fair, reasonable, and easy to use. The process should ensure that all health problems are addressed in the same way.

The most commonly used methods set priorities on the basis of the size and seriousness of the problem and the effectiveness of available interventions. Some methods also allow other factors to be considered. The method described below is a modification of a method developed by J. J. Hanlon. A worksheet for use with this method is provided. The instructions below are organized around the completion of the worksheet.

A. Rate the Size of the Health Problems
Give each health problem being considered a numerical rating on a scale of 0 through 10 that reflects the percentage of the local population affected by the particular problem--the higher the percentage affected, the larger the numerical rating. Enter the number in Column A of the worksheet.

The table below is an example of how the numerical rating might be established. The scale shown is for illustrative purposes only, and is not based on scientific or epidemiologic data; a community establishing priorities should establish a scale appropriate to the level of the health problems in that community.

Percent of population with the health problem	"Size of Problem"
25% or more	9 or 10
10% through 24.9%	7 or 8
1% through 9.9%	5 or 6
.1% through .9%	3 or 4
.01% through .09%	1 or 2
less than .01 % (1/10,000)	0

Alternatively, the "Size of Problem" ratings could be established by giving the health problem with the highest frequency a rating of 10, the problems with the lowest frequency a rating of 0 or 1, and the other problems rated according to where they are relative to the most common or least common problems.

B. Rate the Seriousness of the Health Problems

To score the seriousness of a health problem, enter a number between 0 and 10 into Column B of the worksheet on page, the more serious the problem, the higher the number. In the priority setting process being described here, the seriousness of a health problem is considered to have a greater impact than its size; for this reason, in the final calculation, the "Seriousness Rating" given will be multiplied by a factor of 2.

Every community must establish its own criteria for rating the seriousness of health problems. Once criteria for rating the seriousness of health problems have been decided, the seriousness of every health problem must be judged against the same criteria.

The following questions may be helpful in setting criteria for rating the seriousness of health problems:

- What is the emergent nature of the health problem? Is there an urgency to intervene? Is there public concern? Is the problem a health problem?
- What is the severity of the problem? Does the problem have a high death rate or high hospitalization rate? Does the problem cause premature morbidity or mortality?
- Is there actual or potential economic loss associated with the health problem? Does the health problem cause long term illness? Will the community have to bear the economic burden?
- What is the potential or actual impact on others in the community (e.g., measles spread in susceptible population)?

An example of criteria for scoring for seriousness is shown in the table below.

How Serious a Health Problem is Considered	***Seriousness* Rating**
Very Serious (e.g., very high death rate; premature mortality; great impact on others; etc.)	9 or 10
Serious	6, 7, or 8
Moderately Serious	3, 4, or 5
Not Serious	0, 1, or 2

C. Rate the Health Problems for the Effectiveness of Available Interventions

The effectiveness of interventions to reduce the health problem is an important component in priority setting. However, precise estimates are usually not available for specific health problems. It may be helpful to define upper and lower limits of effectiveness and assess each intervention relative to these limits. For example, vaccines are a highly effective intervention for many diseases; those diseases would receive a high "Effectiveness of Intervention Rating." At the other end of the scale are diseases such as arthritis, for which interventions now available

are mainly ineffective. With this in mind, each health problem should be scored for the effectiveness of available interventions according to the table below, and the number entered in Column C of the worksheet.

Effectiveness of Available Interventions in Preventing the Health Problem	"Effectiveness Rating"
Very Effective 80% to 100% effective (e.g. vaccine)	9 or 10
Relatively Effective 60% to 80% effective	7 or 8
Effective 40% to 60% effective (e.g., laser treatment for diabetic retinopathy to prevent blindness)	5 or 6
Moderately Effective 20% to 40% effective	3 or 4
Relatively Ineffective 5% to 20% effective (e.g., smoking cessation interventions)	1 or 2
Almost Entirely Ineffective Less than 5% effective	0

D. Apply the "PEARL" Test

Once health problems have been rated for size, seriousness, and effectiveness of available interventions, they should be judged for the factors of propriety, economics, acceptability, resources, and legality. (The initial letters of these factors make up the acronym "PEARL," which can serve as a mnemonic for this aspect of priority-setting.) Questions to be answered for each factor are given below

- **P**ropriety-Is a program for the health problem suitable?
- **E**conomics-Does it make economic sense to address the problem? Are there economic consequences if a program is not carried out?
- **A**cceptability-Will the community accept a program? Is it wanted? (For example, a smoking cessation program may not be accepted or wanted in a community whose livelihood depends on the tobacco industry.)
- **R**esources-Is funding available or potentially available for a program.
- **L**egality-Do current laws allow program activities to be implemented?

Any health problem which receives an answer of "No" on any question should either be dropped from consideration for the present or, alternatively, the reason for the "No" answer can be considered and, if it can be corrected, consideration of the health problem might continue.

Calculate Priority Scores for the Health Problems

Priority scores are calculated from the scores recorded in columns A, B, and C for each health problem, and are recorded in column D. The following formula is used for this calculation (letters represent the values in columns A, B, C, and D on the worksheet

$$D = [A + (2 X B)] x C$$

For example, suppose the following values appear in columns A, B, and C:

Column A= 6
Column B = 4
Column C = 2

The following calculation would be carried out for the priority rating to be recorded in column D:

D = [6 + (2 x *4)] x 2* = *28*

***Assign Ranks to the H*ealth Problems**
Once priority scores have been recorded for all health problems, assign a priority rank for each problem, based on the size of its priority scores, and record it in column E. For example, the health problem with the highest priority score should be given a rank of 1, the problem with the next highest priority score, a rank of 2, and so on. Health problems with the same priority score should be given the same priority rank.

Appendix P: Health Problem Priority Setting Worksheet – The Community Process

Health Problem Priority Setting Worksheet

List the health problems as determined through data collection, community perceptions, or other means. Make additional copies of this worksheet, as necessary.

Health Problem	**A** **Size**	**B** **Seriousness**	**C** **Effectiveness Of Intervention**	**D** **Priority Score** (A + 2B) C	**E** **Rank**

Community Health Plan: Worksheet

HEALTH PROBLEM	OUTCOME OBJECTIVE
RISK FACTOR(S) (may be many)	IMPACT OBJECTIVE
CONTRIBUTING FACTORS (Direct/Indirect: may be many)	PROCESS OBJECTIVE
RESOURCES AVALIABLE (governmental and nongovernmental)	BARRIERS

Replicated from APEX-PH for the IPLAN Workbook

Community Health Plan: Worksheet 2

DESCRIPTION OF THE HEALTH PROBLEM, RISK FACTORS AND CONTRIBUTING FACTORS (including high risk populations, and current and projected statistical trends:
CORRECTIVE ACTIONS to reduce the level of the indirect contributing factors:
PROPOSED COMMUNITY ORGANIZATION(S) to provide and coordinate the activities:
EVALUATION PLAN to measure progress towards reaching objectives: