This series is made possible with funding from IDPH and the Community Health Assessment and Planning Grant, 2024

August 22, 2024

IPLAN Basics

IPLAN Training Webinar Series

Laurie Call, IPHI

This session is being recorded.

IPHI Training Team and Peer Presenters

- Laurie Call, Director, Center for Community Capacity Development (CCCD) – Illinois Public Health Institute
- Samantha Lasky, Program Manager CCCD – Illinois Public Health Institute
- Peer Presenters
  - Molly Peters, Administrator – Greene County Health Department
  - Rachael Hendrickson, Public Health Strategist – Boone County Health Department
  - Aldara Henderson, Systems Quality Manager – St. Clair County Health Department
  - Amy Fox, Administrator – Tazewell County Health Department

Zoom Poll Introductions

- What is your experience with IPLAN? How long have you been engaging with IPLAN in some capacity? (less than 1 year, 1-2 years, 3-5 years, 6-10 years, 10-20 years, over 20 years)
- Which best describes your affiliation?
  - Local Health Department (LHD)
  - Community Based Organization (CBO)
  - Student
  - Hospital/health care
  - Government Office (beyond LHD)
  - Other

Today's Training Agenda

- Welcome and Introductions
- Grounding – History and Context for IPLAN
- Section 600 Requirements for IPLAN
  - Community Health Assessment Components
  - Community Health Improvement Plan Components
  - Organizational Capacity Assessment
- IPLAN Resources
- Closing and Evaluation

Purpose and Objectives

Review the substantial compliance components of the IPLAN process based on APEX-PH, including:

- Community Health Assessment (CHA)
- Community Health Improvement Plan (CHIP)
- Organizational Capacity Assessment

Participants will be able to:

- Describe the history of IPLAN and Section 600 requirements for the APEX-PH based IPLAN process and the equivalent option, Mobilizing Action Through Planning and Partnerships (MAPP).
- Estimate the time and resources needed to complete the process.
- Prevent common mistakes related to IPLAN.
- Access IPLAN resources and tools.
- Describe how IPLAN aligns with Public Health Accreditation Board (PHAB) requirements.

Group Agreements

- Actively participate
- Take space/ Make space
- Seek to understand different perspectives.
- Allow facilitator to move conversation along
- Ask questions in the chat or raise hand
- We can "park" items we cannot address today and get back to you
- What else?

Grounding – History and Context for IPLAN

Laurie Call

JoAnne Bardwell, IPLAN Administrator

Illinois Department of Public Health

Definition of IPLAN

Illinois Project for Local Assessment of Needs (IPLAN)

- **Community health 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
  - 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.
- The essential elements of IPLAN are:
  - an organizational capacity assessment;
  - a community health needs assessment; and
  - a community health plan, focusing on a minimum of three priority health problems.

Accessing the Illinois Administrative Code – Section 600

Title 77: Public Health

Chapter I: Department of Public Health

Subchapter H: Local Health Departments

Part 600 Certified Local Health Department Code

Section 600.400 Public Health Practice Standards

- Access the full Administrative Code on the IPLAN Website under the Resources Tab: http://app.idph.state.il.us/Resources.asp?menu=3

Section 600.400 of the Certified Local Health Department Code provides in detail the Public Health Practice Standards for certified health departments:

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

Recertification Requirements

Local Health Department (LHD) develop[illegible]

To request an extension:
Send a formal notice on your LHD letter head to the IPLAN Administrator
- Include the date
- State the reason(s) the request is necessary
- Must be signed by the LHD Administrator
- Submit to DPH.IPLAN@Illinois.gov

LHD submits IPLAN to DPH.IPLAN@illinois.gov at least 60 days before current expiration with:
- LHD certification application
- An electronic copy of the IPLAN
- IPLAN substantial compliance evaluation

[illegible]PH reviews the IPLAN [illegible]thin the 60 days of submission for compliance

If not compliant – LHD is provided findings and are required to resubmit an updated IPLAN to DPH.IPLAN@illinois.gov.

If compliant –
- In substantial compliance:
  - LHD and RHO are notified of approved IPLAN
  - The Director's office is notified of findings for final approval

LHD is awarded a 5-year Certification by the Director's office. The LHD and RHO are notified electronically via letter and certificate

LHD Certification Requirements

Certification Application via LHD Certification Application	Electronic version of IPLAN	IPLAN substantial compliance evaluation	Applicable	Any applicable LHD change requests:

	• IPLAN document must include table of contents with page numbers
	• Board of health approval letter of the IPLAN (signed and dated by your BOH president or representative) which includes the BOH stating they have reviewed the Organizational Self-Assessment Plan.
	• No need to submit the Organizational Self-Assessment Plan. Keep on file for RHO review when onsite.
		• LHD completes
		  • LHD Name (on first page)
		  • Health Priorities (on first and as applicable for pages 3-6)
		  • Page numbers for substantial compliance review (if there is something missing LHD will provide comments to why ie: data not available?)
			• New Personnel Information Form (PIF) if there's been a change in personnel	• (name changes, contact information, or updates to the LHD directory)
				• Please send a formal notice on your LHD letter head, signed, dated and addressed to IPLAN Admin to DPH.IPLAN@Illinois.gov

IPLAN (CHA/CHIP) and IPLAN substantial compliance check list to be submitted to DPH.IPLAN@Illinois.gov

Link to LHD directory: https://idph.illinois.gov/IDPHPrograms/v_LHDDirectory/Show-V-LHDDirectory-Public.aspx

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Evolution of IPLAN

APEX-PH created by NACCHO and CDC in 1991 to increase LHDs organizational capacity and strengthening their leadership roles in their communities.

IPLAN process was derived from APEX-PH in 1992 to meet requirements set forth from the Administrative Code, Section 600.

MAPP To address the importance of strategic planning, CDC and NACCHO developed MAPP in 2001.

After an extensive evaluation of MAPP, NACCHO developed MAPP 2.0 in 2023.

PHAB was formed in 2007 to develop, implement, and oversee national accreditation and created requirements for completing the CHNA/CHIP process for LHD pursuing accreditation.

National public health department accreditation launched in 2011.

The passing of the Affordable Care Act Required, beginning in 2012, non-profit hospitals to create a CHNA, which encouraged their partnership with LHDs to complete the process

Equivalent Planning Process

- Section 600.410 (b) of the Certified Local Health Department Code allows for the use of an “equivalent” planning process for recertification upon written request from IDPH.

The following processes may be considered equivalent to the IPLAN process:

- MAPP - Mobilizing for Action Through Planning and Partnerships Accepted as an equivalent planning process to IPLAN (Section 600.110)
- PHAB accreditation (section 600.400j) The results of the PHAB Accreditation including the community health assessment, organizational capacity or strategic plan and the health plan may be used to meet the corresponding requirements of the certification process as long as the documents are not duplicated from the previous recertification cycle.

Section 600 Requirements for IPLAN

Samantha Lasky

Assessment Protocol for Excellence in Public Health (APEX-PH)

There are two goals of APEX-PH:

- "Assess and improve the organizational capacity of the health department"
- "Work with the local community to assess and improve the health status of the citizens"

APEXPH 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.

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Three Components of IPLAN

LHD Staff Share! - The Importance of IPLAN

Community Health Assessment (CHA) Components

What is a CHA?

Community Health Assessment or CHA:

Systematic approach to collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.

Definitions

Health Problem: A situation or condition of people which is considered undesirable, is likely to exist in the future, and is measured as death, disease, or disability.

Health Equity: Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

IPLAN Community Process

1	Convening the Community Health Committee
2	Analysis of Health Problems and Health Data
3	Prioritize Community Health Problems
4	Conduct Detailed Analysis of Community Health Problems
5	Inventory Community Health Resources
6	Develop a Community Plan

Convening the Community Health Committee

Purpose of the Community Health Committee

- Helps to broaden the perspective of the process by engaging representatives from a variety of other sectors in the community
- Increases awareness of the process
- Helps to build strategic alliances that may be needed to address the IPLAN priorities
- Serves as an initial demonstration of the local health department's willingness to engage the community in the collaborative IPLAN process

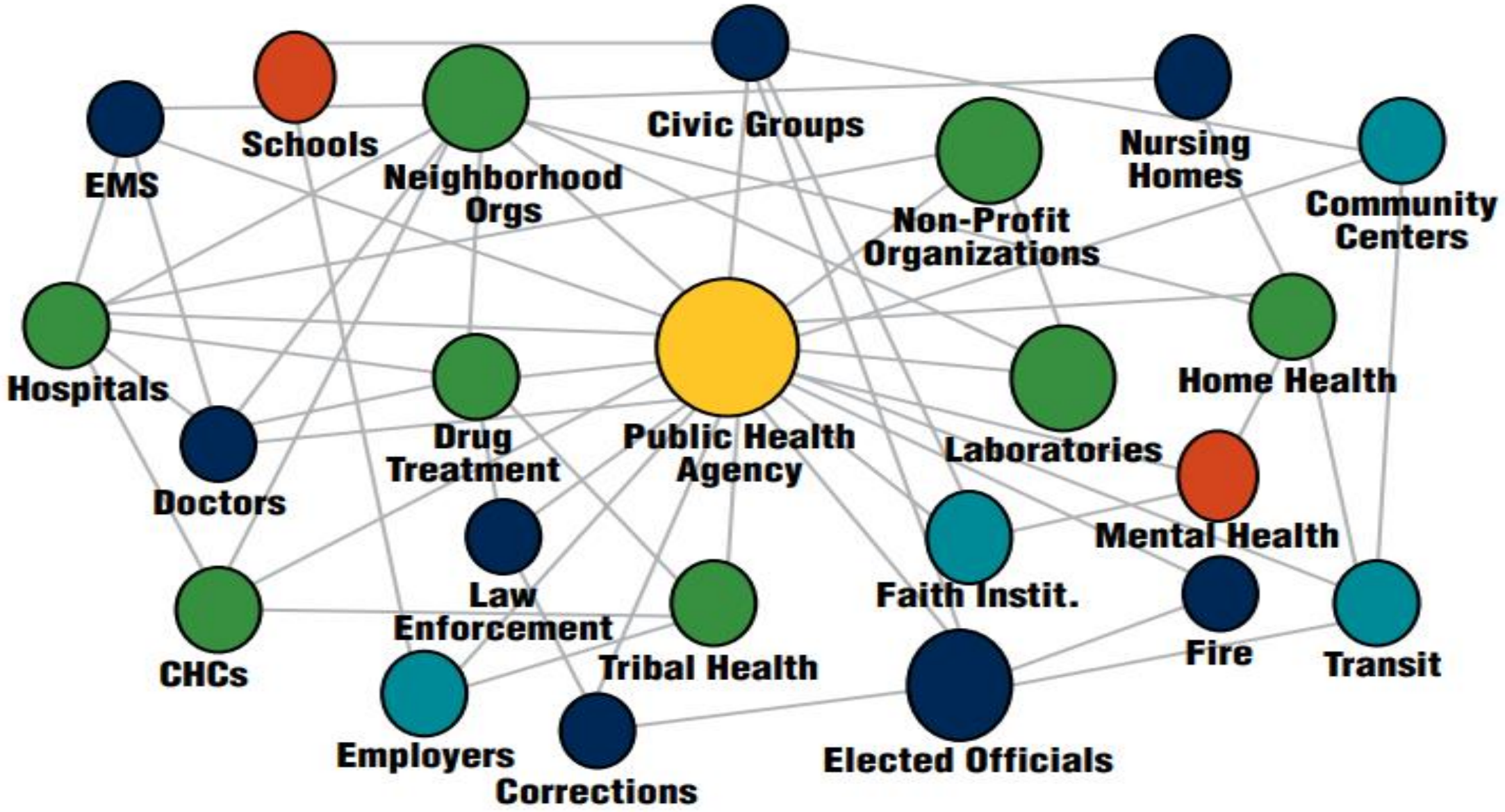
Considerations for the committee

- Size
- Scope
- Roles and responsibilities
- Formation of subcommittees

Representation

- 12 to 15 members
- Individuals and orgs who are involved in the delivery of the Essential Public Health Services
- Representative of the overall community – including community members
- Expertise in specific areas of health and community well-being, access to key assets and resources, and the need for diversity and inclusiveness

A multi-sectoral process may include:



Community Participation in the CHA

The process shall **involve community participation** in the:

identification of community health problems, priority-setting, and the completion of the community health needs assessment and community health plan.

The CHA should include:

- Statement of purpose
- A description of the community participation process and the method used for selecting priorities
- A list of community groups involved

Data Collection

- **Primary data** are collected first-hand through surveys, listening sessions, interviews, and observations
- **Secondary data** are collected by another entity or for another purpose
- **Indicators** are secondary data that have been analyzed and can be used to compare rates or trends of priority community health outcomes and determinants

Source: CDC. https://www.cdc.gov/public-health-gateway/php/public-health-strategy/public-health-strategies-for-community-health-assessment-data-benchmarks.html

Analysis of Community Health Data

- Community health indicators contained in the IPLAN Data System or a similar, equally comprehensive data system developed by the local health department shall be utilized to structure the minimal content of the assessment.
- Description specific to their area and the data it is based on; must provide data sources.

Data Categories:

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

Analysis of Community Health Data

Plan

- Define the community area or jurisdiction
- Identify priority populations
- Determine secondary data needs (indicators that have been analyzed by another entity)
- Determine primary data needs (data you may need to collect from surveys, focus groups, interviews, town halls etc.)

Collect and Compile

- Compile secondary data on the 7 data categories. Use data and indicators for the smallest geographic locations possible (e.g., county-, census block-, or zip code-level data), to enhance the identification of local assets and gaps.
- Use tools like surveys, focus groups, interviews, and town hall meetings to gather primary data about the community, priority populations, health needs, assets/resources etc.

Analyze

- Compare data when possible by age, gender, race/ethnicity or other demographic
  to understand
  tion

Join us for TA on IQuery on October 10th from 1pm-2pm (link in chat)!
bit.ly/m/IDPHIPLANwebinarseries

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Zoom Poll Data Collection

- Does your LHD collect community input data for your IPLAN?

- What methods do you use? Select all that apply.
  - Surveys
  - Focus groups
  - Town halls
  - Photo voice
  - Other (write in chat)

Common Data Sources

- American Community Survey
- Adverse Pregnancy Outcomes Reporting System (APORS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- County Health Rankings
- Illinois Department of Public Health- Health Statistics
- **IPLAN Data System / IQuery**
- National Center for Health Statistics (NCHS)
- State Cancer Registry
- U.S Census
- CDC PLACES
- Youth Risk Behavior Surveillance System (YRBSS)
- National Survey for Children's Health (NSCH)
- Illinois Youth Survey (IYS)
- Illinois EPA EJ Start
- Illinois Healthcare Cost Containment Council (IHCCCC)
- Illinois State Board of Education (ISBE)
- IDPH Opioid Data Dashboard
- CDC SUDORS data (Substance use disorders overdose reporting system)
- National Violent Death Reporting System (NVDRS)

Analysis of Community Health Data

Presentation from Aldara Henderson, St. Clair County Health Department

2023 Community Health Needs Assessment:

Process and Results

Presented By: Aldara Henderson, MPH

Systems Quality Manager

Health DEPARTMENT ST. CLAIR COUNTY

HSHS St. Elizabeth's Hospital

BJC HealthCare Memorial Hospital

Economy and Poverty *ALICE (Asset Limited, Income Constrained, Employed)*

Year	% Poverty	% ALICE	% Above
2010	15	27	58
2012	18	30	52
2014	18	29	52
2016	15	29	56
2018	14	36	50
2019	13	30	57
2021	12	31	57

- **Note: Households (HH) above the Federal Poverty Line earning less than the basic cost of living for the county**

Data Dive Priority Results

Academic Acheivement including K-12, higher education, early childhood learning
Access to Behavioral Health Services
Access to Healthy Lifestyle
Access to Mental Health Services: considering isolation and lonliness
Chronic Diseases and comorbities including obesity
Community Safety including violence and crime
Food insecurity, specifically access to nutrient dense food
Housing, specific to safe and affordable housing and cost burdened renters
Maternal/Infant Health-including poor birth outcomes and infant mortality
Poverty, including disparities in economy
Sexually Transmitted infection
Substance Use Disorder
Suicide
Workforce Preparedness, includes pipeline programs and workforce development for unemployed

2023 St. Clair County Community Health Needs Assessment

Forced Ranking Spreadsheet

Agency Name: St. Clair County Health Department

Instructions: Each participant ranks priorities from highest to lowest importance, taking into account our defined criteria. Once your 5 priorities have been ranked, continue to rank those same five priorities using the defined criteria

Triple Impact: Improve the health of individuals, improve the health of populations, reduce waste, variation and healthcare costs
Magnitude: How wide an issue is this in the community?
Seriousness: How related is this issue to mortality (contributing to the cause of death) of those affected?
Feasibility: Considering available resources, how likely are we to make a significant impact on the issue?

HIGHEST RANKING = 5, LOWEST RANKING = 1

Priorities to be ranked:	Rank your top 5	Triple Aim	Magnitude	Seriousness	Feasibility	TOTAL
Academic Acheivement including K-12, higher education, early childhood learning						
Access to Behavioral Health Services	4	1	2	1	2	10
Access to Healthy Lifestyle						
Access to Mental Health Services: considering isolation and lonliness	5	2	4	3	1	15
Chronic Diseases and comorbities including obesity	3	5	5	5	4	22
Community Safety including violence and crime						
Food insecurity, specifically access to nutrient dense food						
Housing, specific to safe and affordable housing and cost burdened renters						
Maternal/Infant Health-including poor birth outcomes and infant mortality	1	4	1	4	5	15
Poverty, including disparities in economy	2	3	3	2	3	13
Sexually Transmitted infection						
Substance Use Disorder						
Suicide						
Workforce Preparedness, includes pipeline programs and workforce development for unemployed						

Priorities to be ranked:	TOTAL
Chronic Diseases and comorbities including obesity	181
Access to Mental Health Services: considering isolation and lonliness	106
Maternal/Infant Health-including poor birth outcomes and infant mortality	102
Food insecurity, specifically access to nutrient dense food	97
Access to Healthy Lifestyle	80
Access to Behavioral Health Services	49
Substance Use Disorder	48
Poverty, including disparities in economy	28
Housing, specific to safe and affordable housing and cost burdened renters	24
Suicide	16
Academic Acheivement including K-12, higher education, early childhood learning	15
Community Safety including violence and crime	14
Sexually Transmitted infection	0
Workforce Preparedness, includes pipeline programs and workforce development for unemployed	0

Behavioral Health (substance use disorders such as: alcohol, prescription drugs, marijuana, illegal drugs)

Chronic Disease (e.g., Obesity, Diabetes, Heart Disease)

Food Insecurity (access to nutritional food)

Healthy Lifestyle (e.g., exercise, handwashing, eating healthy, smoking)

Maternal & Infant Health (e.g., health issues for women of child-bearing ages, poor birth outcomes, infant mortality)

Mental Health (e.g., Counseling services, coping techniques, reduction of isolation and loneliness)

Health Care Commission **partner agencies** identified the following priorities as their top three for St. Clair County:

1. Chronic Disease
2. Mental Health
3. Maternal/Infant Health

The following three priorities were identified as the top three by **residents** of St. Clair County:

1. Mental Health
2. Behavioral Health
3. Chronic Disease

1. Taking into account the rankings by Health Care Commission partner agencies and the residents of St Clair County via the Community Health Needs Assessment, rank the following priorities from 1 (the most important) to 6:

More Details

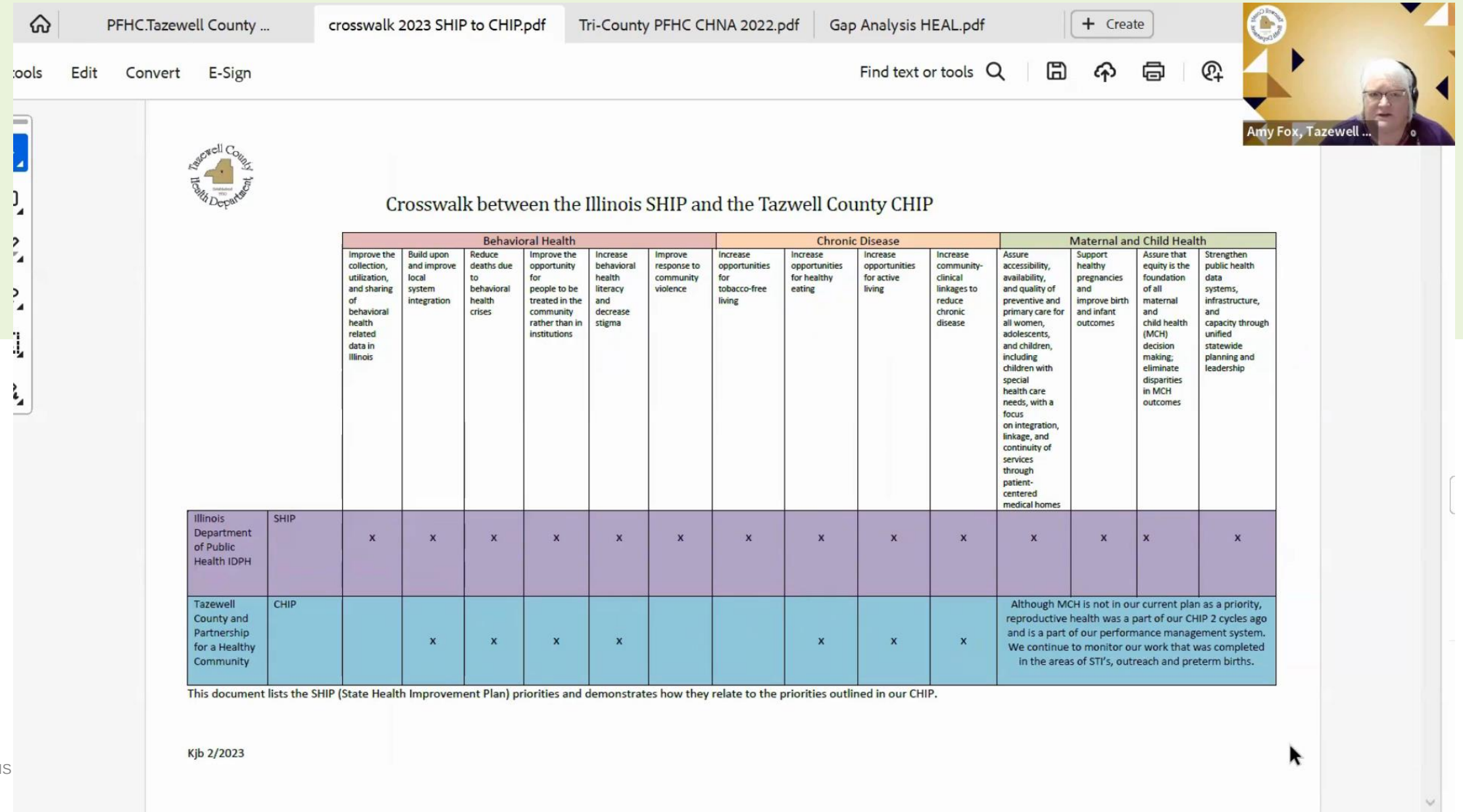
Description of health problems most meaningful to the community

- Secondary data analysis
  - What are the trends showing? What changes have occurred over time?
  - What is the comparison to state or other level data showing?
  - What are the differences between population groups? What are the disparities?
- Compare primary and secondary data.
  - What is the data telling you is meaningful for the community?
  - How does the primary data compare to the secondary data?
  - How does the data help understand what is contributing to the health problem?
- How do the emerging health problems and needs compare to the State Health Improvement Plan (SHIP) priorities? Healthy Illinois 2028

Comparing Local Priorities to SHIP

Presentation from Amy Fox, Tazewell County Health Department

Presentation from Amy Fox, Tazwell County



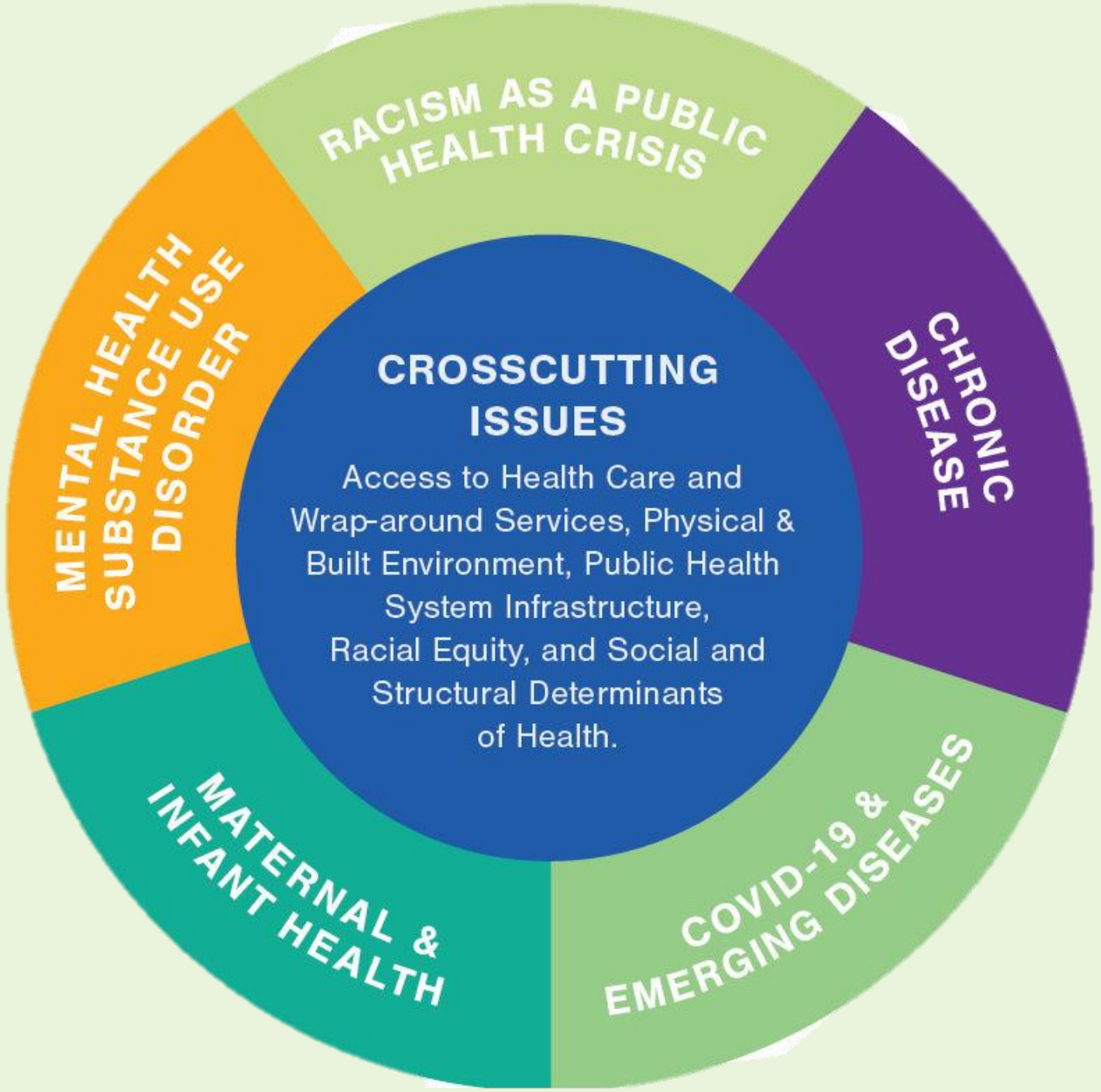
Crosswalk between the Illinois SHIP and the Tazwell County CHIP

		Behavioral Health						Chronic Disease				Maternal and Child Health			
		Improve the collection, utilization, and sharing of behavioral health related data in Illinois	Build upon and improve local system integration	Reduce deaths due to behavioral health crises	Improve the opportunity for people to be treated in the community rather than in institutions	Increase behavioral health literacy and decrease stigma	Improve response to community violence	Increase opportunities for tobacco-free living	Increase opportunities for healthy eating	Increase opportunities for active living	Increase community-clinical linkages to reduce chronic disease	Assure accessibility, availability, and quality of preventive and primary care for all women, adolescents, and children, including children with special health care needs, with a focus on integration, linkage, and continuity of services through patient-centered medical homes	Support healthy pregnancies and improve birth and infant outcomes	Assure that equity is the foundation of all maternal and child health (MCH) decision making; eliminate disparities in MCH outcomes	Strengthen public health data systems, infrastructure, and capacity through unified statewide planning and leadership
Illinois Department of Public Health IDPH	SHIP	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Tazewell County and Partnership for a Healthy Community	CHIP		x	x	x	x			x	x	x	Although MCH is not in our current plan as a priority, reproductive health was a part of our CHIP 2 cycles ago and is a part of our performance management system. We continue to monitor our work that was completed in the areas of STI's, outreach and preterm births.			

This document lists the SHIP (State Health Improvement Plan) priorities and demonstrates how they relate to the priorities outlined in our CHIP.

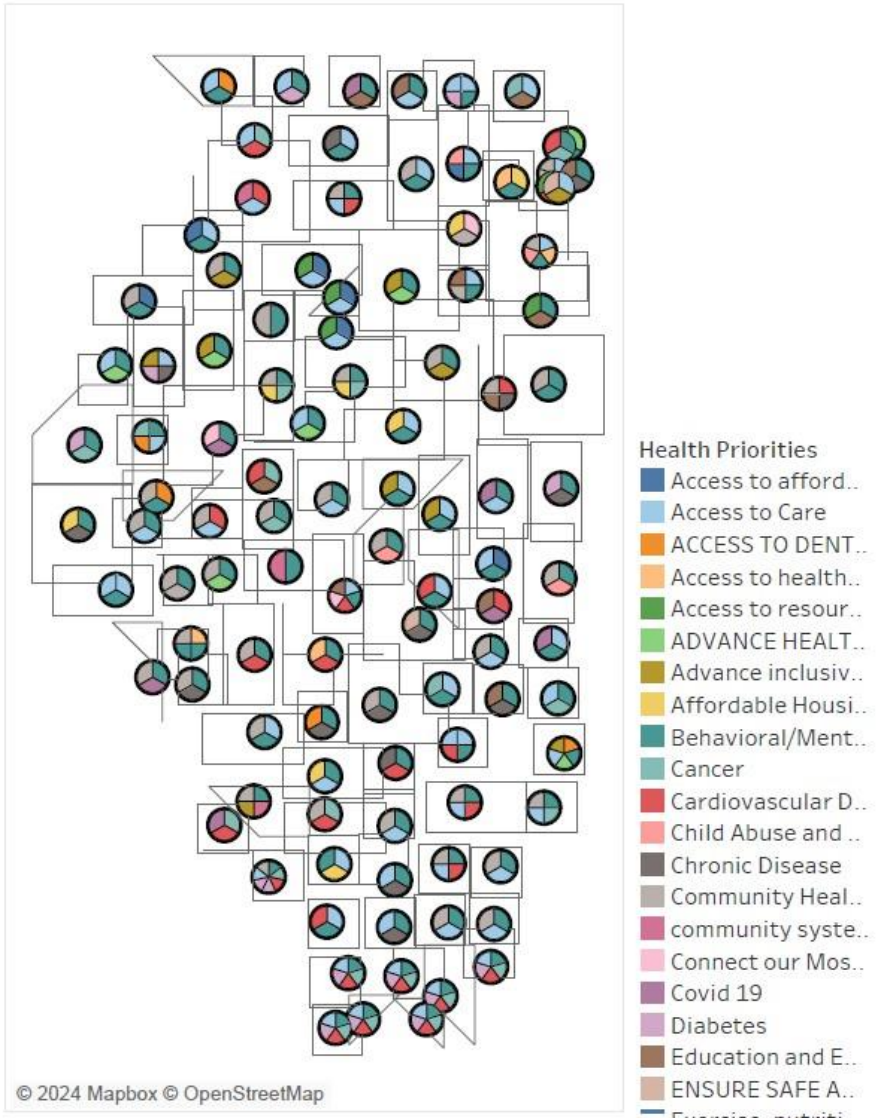
Kjb 2/2023

SHIP Priorities – Healthy Illinois 2028



Source: IQuery Modernization dashboard planned to go live on or before TA session 10/10/24

Priority Health Needs by County based on IPLANS from 97 Local Health Departments



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Description of Health Problems Most Meaningful to the Community

Presentation from Molly Peters, Greene County Health Department

HOW DO WE USE IPLAN IN GREENE COUNTY

- IPLAN processes assist us in ensuring that our community voices are heard through focus groups, stakeholder interviews, and people who are most at risk of social vulnerability
- By convening our partners in multiple ways, we use the stories of our IPLAN to ignite changes, search for grant funding, and encourage grass root efforts for community health improvement
- We reference our IPLAN throughout the years, noting the reasons we are targeting certain focus areas are because of our community assessment

https://greenecountyhd.org/wp-content/uploads/2021/10/Greene-County-IPLAN-2022-2026-with-appendix.pdf

HOW DO WE DETERMINE WHAT IS MOST MEANINGFUL?

- Listen to stories
- Look for opportunities
- Ask questions
- Surveys
- Gather all people

Greene County Health Department

IPLAN Discussion

Prioritization Processes

- Multi-voting Technique
- Strategy Grids
- Nominal Group Techniques
- The Hanlon Method
- Prioritization Matrix

Criteria to Identify Priority Problems	Criteria to Identify Interventions for Problems
Cost and/or return on investment	Expertise to implement solution
Availability of solutions	Return on investment
Impact of problem	Effectiveness of solution
Availability of resources to address the problem (staff, time, money, equipment, community will etc.)	Ease of implementation/ maintenance
Urgency of solving the problem	Potential negative consequences
Size of the problem	Legal considerations
	Impact on systems or health
	Feasibility of intervention

Source: NACCHO: https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

Prioritize Community Health Problems

- The process should be reasonable, clearly understood by committee members, have objective components, and be based on an analysis of available data and community input.
- Prioritization shall result in the establishment of at least three priority health needs
- The IPLAN workbook highlights the Hanlon method for prioritization, but LHDs can use any method for prioritization.

The Hanlon method includes the following objective and subjective variables.

- Rate the of size of the health problem in terms of the percent of the population with the health problem
- Rate the seriousness of the health problem in terms of morbidity, mortality, hospitalization, economic loss, community impact
- Rate the effectiveness of available interventions in preventing the health problem

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.

Direct contributing factor: A scientifically established factor that directly affects the level of a risk factor.

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.

Conduct Detailed Analysis of Community Health Problems

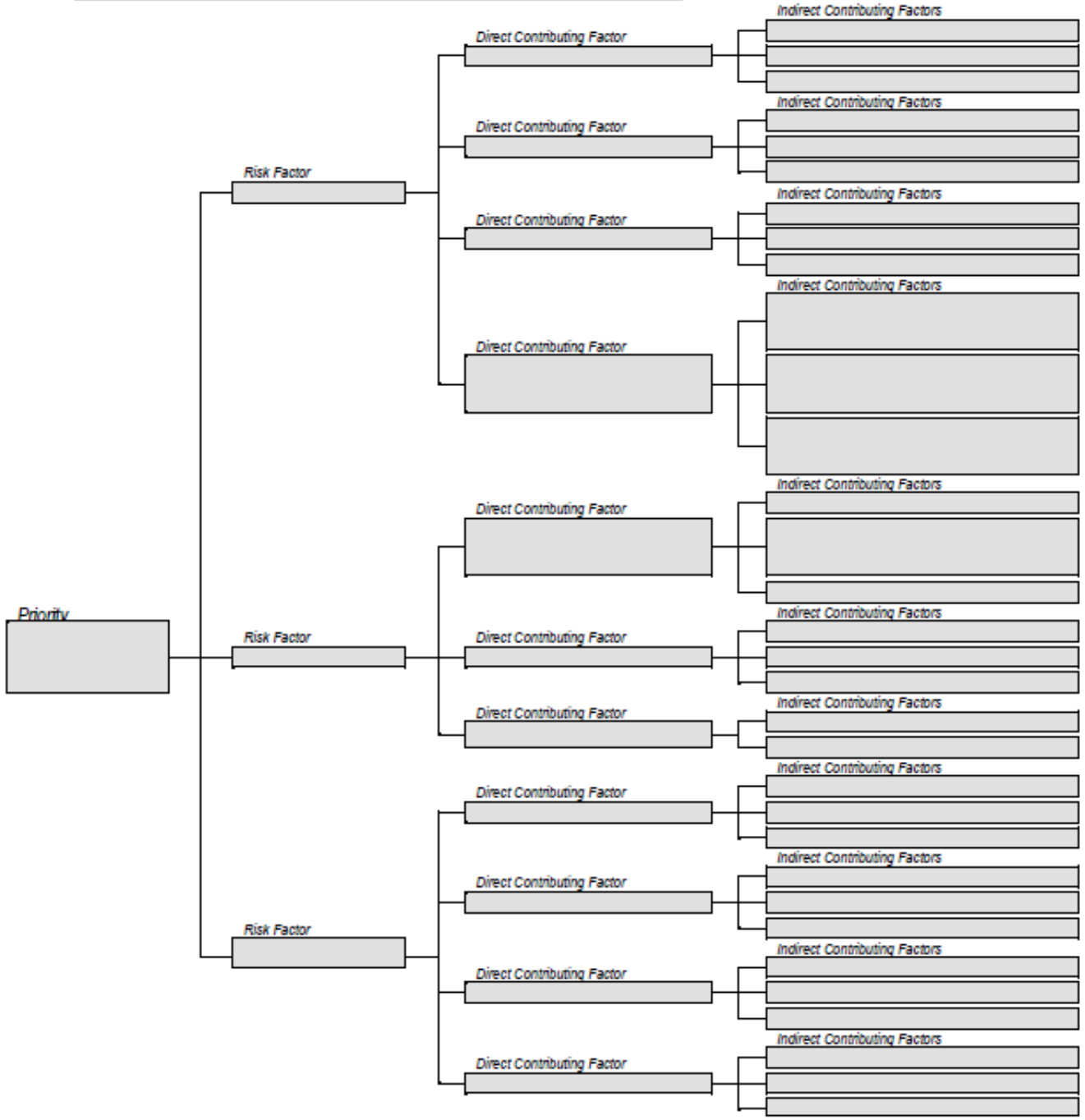
- Conduct an analysis of the risk and contributing factors for each health priority:

Examples of each:

- **Risk factor**: Obesity is a risk factor for Diabetes. This is true because obesity directly relates to the health problem of Diabetes.
- **Direct contributing factor**: Poor diet is a direct contributing factor because it affects obesity.
- **Indirect contributing factor**: Lack of grocery stores that carry fresh vegetables and fruits are indirect contributing factors because they affect poor diet.

- The Health Problem Analysis seeks to explore some of the many reasons that may cause or contribute to a health priority.
- The IPLAN website provides worksheets to help identify risk factors, direct contributing factors, and indirect contributing factors.
  - A worksheet(s) should be completed for each of the three health priorities.
- The interventions and objectives developed for the Community Health Plan should address these factors.

Appendix C: Health Problems Analysis Worksheet



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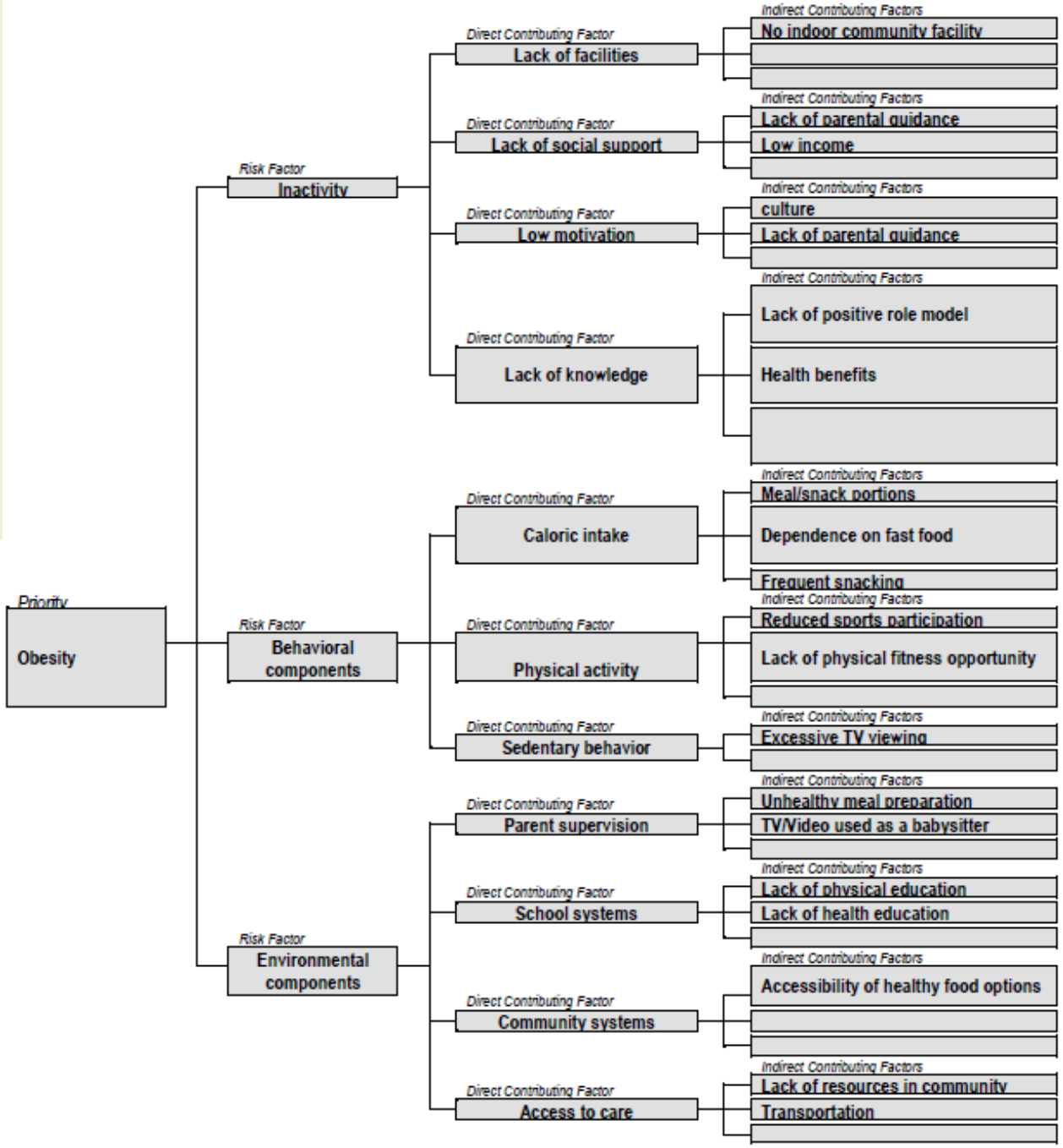
Appendix D: Completed Health Problems Analysis Worksheets



Inventory Community Health Resources

- Addressing the community health priorities will require the resources of the **local public health system**.
- Available health resources will need to be detailed in the Community Health Plan but are identified in the assessment phase of the process
- Community health committee and LHD staff creates an **inventory of community health resources** that are potentially available to address direct and indirect contributing factors as well as **identify potential barriers.**
- Asset mapping is beneficial to be included in this step.

PHAB Requirements for CHA

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

- **Measure 1.1.1 A - Develop a community health assessment**
  - Who is involved (partners and community members)?
  - How involved in developing the CHA?
  - Comprehensive broad based data (primary and secondary)
  - Description of the demographics of the populations (race/ethnicity, languages etc.)
  - Description of health challenges experienced by the population served by the health department based on data, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of health status and health behaviors (compare by demographics)
  - Description of inequities in the factors that contribute to health challenges, which must, include social determinants of health or built environment.
  - Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges.
- **Measure 1.1.2 A – Ensure the community health assessment is available and accessible to organizations and the general public.**
  - Key findings and the full community health assessment 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.

Source: PHAB, Standards and Measures, Initial Accreditation, Version 2022, pages 23-31.
https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf

Community Health Improvement Plan (CHIP) Components

What is the Community Health Improvement Plan?

Community Health Improvement Plan or CHIP:

Long-term systematic plan to address issues identified in the CHNA. Describes how the local health department and the communities it serves will work together to improve the health of the population.

CHIP Components

- Purpose statement
- 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).

CHIP Components

Purpose Statement

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

Description of the Planning Process

- 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.

Community Participation in the CHIP

Presentation from Rachael Hendrickson, Boone County Health Department

Community Participation in the CHIP

- IPLAN/CHIP was presented to community stakeholder groups that work on the current health priorities
- IPLAN was presented to public multiple ways:
  - Community Forum
  - Facebook Live
  - Spanish Facebook post
  - Press release with survey link
  - MAPP Partners provided with media toolkit to advertise public feedback

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Stakeholder Questions

1. Does the Description/Analysis accurately capture the issue?
2. Does this section look through a health equity/access to care/resiliency lens?
3. Are the Measurable Outcomes/Impacts attainable?

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Description of Each Priority

- **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**
- **Direct Contributing Factors**
- **Indirect Contributing Factors**
- **Population Groups at Risk**
- **Objectives and Strategies**
- **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.

Description of Each Priority

Presentation from Amy Fox, Tazewell County Health Department

Presentation from Amy Fox, Tazwell County

IPLAN Objectives

- Objectives are the operational aspects of The Community Health Plan.
- Objectives define what is to be accomplished and provide the foundation for strategies and interventions.
- When written, objectives should be concise statements that provide direction.

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. IPLAN considers outcome objectives to have a five year time-frame.

- Increase to 35 % the proportion of adolescents in XYZ who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days by December 2029.

Impact Objectives: This objective is a measurable statement indicating the desired level of change in a risk factor. Impact objectives are intermediate in time. The time-frame for IPLAN is two to three years.

- By December 2027, reduce the number of youth who take their first drink before age 17 from 67% to 60%.

IPLAN Objectives

Process Objectives: LHDs should provide at least one proven Intervention Strategy to address each written impact objective. Include a discussion of the community resources that will contribute to implementation; estimated funding needed for implementation, and anticipated sources of funding.

- By December 2025, 80 % of low income pregnant women will have received prenatal care during the first trimester of pregnancy.

Example of a Intervention Strategy from Scott County (IPLAN website provide worksheets for organizing these objectives and intervention strategies):

- The community coalition on tobacco will work with schools and community groups to develop education activities on tobacco use and its effects on the lungs, targeting children and adolescents. The coalition will identify community input opportunities to educate the adult population regarding tobacco use and lung cancer. The coalition on tobacco will partner with the agricultural community to address environmental factors.

Examples of where objectives can come from:

- Funding sources (expectations)
- Administrative dictates & policies
- Administrative protocols & priorities
- Community health needs assessment
- Partnership agreements and other external relationships
- Recognized State and/or National public health agendas.
- Advocacy groups and associations

SMARTIE Objectives

Specific	Reflects an important aspect of what your organization seeks to accomplish (programmatic or capacity-building priorities)
Measurable	Includes standards by which reasonable people can agree on whether the goal has been met (by numbers or defined qualities)
Achievable	Is challenging enough that achievement would mean significant progress—a “stretch” for the organization
Relevant	Is related to achieving the overall goal
Timebound	Includes a clear deadline
Inclusive	Brings traditionally marginalized people—particularly those most impacted—into processes, activities, and decision/policymaking in a meaningful way
Equitable	Seeks to address systemic injustice, inequity, or oppression.

Appendix E: Community Health Plan Worksheet #1

Healthy People is an excellent source for objectives. These can be easily adapted for local jurisdictions.

Community Health Plan Worksheet #1

Health Problem:	**Outcome Objective:**
Risk Factor(s):	**Impact Objective:**
Contributing Factors (direct & indirect):	**Proven Intervention Strategy:**
Resources Available:	**Barriers:**

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Community Health Plan Worksheet #1 (partially completed)

Health Problem: Incidence of Cardiovascular Disease	**Outcome Objective:** By the year 2020, reduce the rate of deaths from cardiovascular disease in Knox County adults to no more than 245 per 100,00 population
Risk Factor(s): Hypertension	**Impact Objective:** Reduce the proportion of Knox County adults with high blood pressure to 15% or less by the year 2016.
Contributing Factors (direct & indirect): Primary Care Practices – Brief Screenings	**Proven Intervention Strategy:** Community education and a marketing plan which focuses on chronic disease screening, management, and prevention.
Resources Available: Healthcare providers Local health department Pharmacies	**Barriers:** Financial resources Lack of time Access to primary and preventive health services

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Appendix F: Community Health Plan Worksheet #2

Community Health Plan Worksheet #2

Description of the Health Problem, Risk Factors and Direct Contributing Factors:
Corrective Actions to Reduce the Level of the Indirect Contributing Factors:
Proposed Community Organizations to Provide and Coordinate the Activities:
Evaluation Plan to Measure Progress Towards Reaching Objectives:

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Community Health Plan Worksheet #2 (partially completed)

Description of the Health Problem, Risk Factors and Direct Contributing Factors:

Heart disease is the leading cause of death in Knox County residents during 2002; accounting for 198 of the total 798 deaths.

Based on BRFS results, almost one-fourth (23.4%) of Knox County adults suffer from high blood pressure.

Hypertension is the second leading chronic condition among Knox County residents, affecting 7,450 persons.

Corrective Actions to Reduce the Level of the Indirect Contributing Factors:

Through the collaborative community screening effort, increase the number of Knox County adults who have had their blood pressure checked within the preceding two years, by a minimum of 10% by screening 1000 adults, aged 30-65 years, a year for each of the next five years (2006 - 2011).

Proposed Community Organizations to Provide and Coordinate the Activities:

Healthcare
Physician offices
Colleges
Pharmacies
Local health department
Local media outlets
YMCA

Evaluation Plan to Measure Progress Towards Reaching Objectives:

Program evaluation information will be shared annually with key community stakeholders. In some instances this will include written reports distributed to program providers, task force members, or other key stakeholders. Some program information will be shared via publication in the Knox County Health Department Annual Report.

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PHAB Requirements for CHIP

Source: PHAB, Standards and Measures, Initial Accreditation, Version 2022, pages 155-163.
https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf

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

- **Measure 5.2.1 A - Engage partners and members of the community in a community health improvement process.**
  - A collaborative process for developing the community health improvement plan (CHIP), which includes:
    - A list of participating partners involved in the CHIP process. Participation must include:
      - Various sectors
      - community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes.
  - 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.

- **Measure 5.2.2 A – Adopt a community health improvement plan.**
  - A community health improvement plan (CHIP), which includes all of the following:
    - 2 or more health priorities to be addressed collaboratively
    - At least one objective for each priority
    - Improvement strategy(ies) or activity(ies) for each priority.
      - Each strategy must include a time-frame and the organization(s) who have accepted responsibility
      - 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.
    - Identification of the assets or resources that will be used to address at least one of the specific priority areas.
    - Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.

Measure 5.2.3 A - Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners (see pages 161-163 for more information)

Organizational Capacity Assessment

Organizational Capacity Self-Assessment

- Self-Assessment
  - Internal review of the LHD's capacity to provide public health functions
    - Assists the LHD in creating an organizational plan for improvement

- Alternatives:
  - Organizational strategic plan with SWOT analysis
  - NACCHO Operational Definition of Functional Health Department
  - CDC's National Public Health Performance Standards - Local Public Health System Assessment (LPHSA)

- ***No need to submit this document to IDPH, however, copy must be kept on file for review by the Regional Health Officer.
- Needs a board of health letter that acknowledges they have reviewed and approved the IPLAN and Acknowledgement of completion of Organizational Capacity Assessment. IDPH can do an onsite visit at any time and request to see a copy of the Assessment.

Assessment Steps

IPLAN Resources

The IPLAN Substantial Compliance Evaluation

- The IPLAN Substantial Compliance Evaluation is what IDPH uses to evaluate IPLAN's
- Structuring your IPLAN around it will ensure all necessary components are present
- LHD's are required to fill in the local health jurisdiction, recertification period, priorities, and all page numbers
- Includes rubrics on the last two pages that outline exactly what IDPH is looking for when assessing compliance
- These rubrics can be helpful to reference before submitting the IPLAN

Substantial Compliance Evaluation - CHNA

Local Health Jurisdiction:

Recertification Period:

Region:

Reviewer:

Priority 1)

2)

3)

Optional 4)

COMMUNITY HEALTH NEEDS ASSESSMENT

CATEGORY	COMPLIANCE INDICATOR	LHD Use | Page Number	IDPH Use | 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:

Substantial Compliance Evaluation - CHIP

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:

Substantial Compliance Evaluation -Priorities

		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:

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Substantial Compliance Rubric

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

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	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

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Description of the Problem for each Priority

	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

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Objectives & Strategies for each Priority

	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

Resources

- IPLAN Web-site - http://app.idph.state.il.us/
  - IPLAN Workbook
  - Review Questions for Substantial Compliance
  - Previous trainings
  - Expert Consultant List
- IPLAN Data System (IQuery Web-site being modernized) https://iquery.illinois.gov/iquery/
- CDC - National Public Health Performance Standards - STLT Gateway
- LHD's who have already completed IPLAN
- Healthy People 2030 is an excellent source for objectives. These can be easily adapted for local jurisdictions. Access via www.healthypeople.gov
- The Community Guide is a great resource for proven intervention strategies and can be found at: http://www.thecommunityguide.org/
- National Resources – NACCHO
- IDPH State Health Improvement Plan (SHIP) - Healthy Illinois 2028

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LHD Staff Share! – How They Use IPLAN

This series is made possible with funding from IDPH and the Community Health Assessment and Planning Grant, 2024

Thank you!

Evaluation:
https://survey.alchemer.com/s3/7980235/IPLAN-Basics-IDPH-IPLAN-Webinar-Series-Evaluation

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Join us for the rest of our webinar series!

Register at: bit.ly/m/IDPHIPLANwebinarseries

Webinar Topics and Dates (all 1-2:30pm):

- Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Overview - September 26
- Integrating Racial Equity - October 24
- Quality Improvement - November 21

Group Technical Assistance sessions will be available for the following dates:

- October 10th 1-2pm (IQuery)
- December 4th 1-2pm (topic TBA)