This series is made possible with funding from IDPH and the Community Health Assessment and Planning Grant, 2025

October 30, 2025

Managing the Community Action Plan Cycle

IPLAN Training Webinar Series

This session is being recorded.

IPHI Training Team and Peer Presenters

- Laurie Call, Director, Center for Community Capacity Development (CCCD), Illinois Public Health Institute (IPHI)
- Samantha Lasky, Program Manager CCCD, IPHI
- Jasmine Deskins, Program Associate CCCD, IPHI
- Peer Presenter
  - Jessica McKnight, McLean County Health Department

Agenda

- Welcome and Introductions
- Overview of Community Health Improvement Planning
- Key Partners in the CHIP Process
- Developing the Community Health Improvement Plan
- Peer Presentation – Conducting a Joint CHIP – Jessica McKnight
- Implementation of the Community Action Plan
- Tracking Progress of the Community Action Plan
- Closing

Learning Objectives

Participants will be able to:

1

Engage community and public health system partners to develop and implement the community action plan

2

Develop a community action plan with measurable outcomes and ensure community participation

3

Describe how to track community progress throughout the community action plan cycle

Group Agreements

- Actively participate; Stay present; Use video camera as much as possible
- 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
- Complete polls and evaluation questions (funders need data!)
- What else?

Poll 1

1. What stages of the CHIP do you engage partners and community?
    1. Developing goals, objectives, and strategies
    2. Implementation
    3. Tracking progress
    4. Communicating or promoting awareness to the public
2. How do you ensure that your CHIP is being implemented effectively? (open ended)
3. Do you have a system in place to track and report progress on the CHIP? Yes, No, Unsure

Overview of the Community Health Improvement Plan

Laurie Call

IPLAN Admin Code and Plan Report Requirements

Plan Report

- 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*

Admin Code 600.400

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
d.5.B A description of the process used to develop the Community Health Plan
d.3 Community participation is utilized in the development of the Community Health Plan
d.4 The Community Health Plan has been adopted by the board of health
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)
d.5.D At least one measurable outcome objective covering a three or more year time frame related to each priority health need
d.5.E At least one measurable impact objective related to each outcome objective
d.5.F At least one proven intervention strategy to address 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
h. Includes a plan to promote awareness about the public health services availability and health education initiatives

IPLAN Admin Code and PHAB Requirements

Admin Code 600.400	PHAB Standards and Measures
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	No equivalent
d.5.B A description of the process used to develop the Community Health Plan	Measure 5.2.1. a. A list of participating partners involved in the CHIP process. b. Review of information from the community health assessment. c. Review of the causes of disproportionate health risks or health outcomes of specific populations. d. Process used by participants to select priorities.
d.3 Community participation is utilized in the development of the Community Health Plan	Measure 5.2.1.a. A list of participating partners involved in the CHIP process
d.4 The Community Health Plan has been adopted by the board of health	
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)	Measure 5.2.1 b. Review of information from the community health assessment. c. Review of the causes of disproportionate health risks or health outcomes of specific populations.

IPLAN Admin Code and PHAB Requirements

Admin Code 600.400	PHAB Standards and Measures
d.5.D At least one measurable outcome objective covering a three or more year time frame related to each priority health need	Measure 5.2.2.b. Measurable objective(s) for each priority.
d.5.E At least one measurable impact objective related to each outcome objective	Measure 5.2.2.b. Measurable objective(s) for each priority.
d.5.F At least one proven intervention strategy to address each impact objective.	Measure 5.2.2. c. Improvement strategy(ies) or activity(ies) for each priority. i. Each activity or strategy must include a timeframe 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
g.2 Includes a plan to monitor programs to assess progress towards meeting community health objectives as stated in the Community Health Plan	Measure 5.2.2 e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.
h. Includes a plan to promote awareness about the public health services availability and health education initiatives	

Key Partners in the CHIP Partners

Samantha Lasky

Community Participation Process

- How are your communities involved in the CHIP process?
  - Community health committee or stakeholder group
  - Action teams or coalitions
  - Implementation planning
  - Implementation
- In chat or unmute: What is the importance of engaging community in the CHIP process?

Community Participation Process

- Communities should be involved in all parts of the process:
  - Community health committee or stakeholder group
  - Action teams or coalitions
  - Implementation planning
  - Implementation
- What is the importance of engaging community in the CHIP process?
  - Inventory community resources
  - Align partner organizations to move forward in implementing the CHIP
  - Helps to hold accountability for strategy implementation

Community Asset Map - ACHI

- Types of assets include the following:

Human

Physical

Informational

Political

Existing Intervention

https://www.boreal-is.com/blog/stakeholder-mapping-identify-stakeholders/

Power Mapping

MAPP 2.0 – NACCHO, page 140

Power Mapping - Potential Partners and Opponents

- **Stakeholder** name/organization
- **Impact** – How are they impacted?
- **Relevant power(s)** – What type of power do they have?
- **Accountability** – Who do they report to? Who determines their budget? Who is their funder?
- **Influenced by** – Who influences them?
- **Alignment** – Is their work aligned? Are they supportive of it or against it? Do they have existing plans?

MAPP 2.0 – NACCHO, page 140

IDPH Meaningful Community Engagement Tool

- Public Health Community Engagement Gap Assessment Worksheet: A Practical Tool For Advancing Equity Through Meaningful Community Partnership -- Newly Developed by IDPH

- By completing this worksheet, participants will:
  - Understand the difference between outreach and engagement.
  - Recognize structural factors that reinforce inequity.
  - Assess readiness for shared power and co-creation.
  - Develop actionable, equity-centered engagement strategies.

IDPH Worksheet:

Section 2: Identifying the Engagement Gap

Assess the depth and quality of your engagement practices. Move beyond activity counts to evaluate inclusion and consistency.

Engagement Practice	Yes	No	Unsure	Notes / Examples
Members from impacted communities are involved in planning, not just implementation.	☐	☐	☐	
Engagement includes trusted local leaders and/or organizations.	☐	☐	☐	
Events or meetings are held at accessible times and locations.	☐	☐	☐	
Materials are translated, culturally adapted, and written in plain language.	☐	☐	☐	
Communities are compensated for their time and expertise.	☐	☐	☐	
Feedback is integrated into program changes and shared back with communities.	☐	☐	☐	
Formal mechanisms for community input and accountability exist.	☐	☐	☐	

Groups to Move the Work Forward

Components of partner/stakeholder groups:

- Consists of partners who align with the work/priorities
- Can support the development of goals, objectives, and strategies (action plans)
- Meet regularly and manage implementation of the strategies
- Establishes accountability in the process

Characteristics needed for success:

- Buy-in and built trust
- Shared decision-making and ownership
- Compensation for people with lived experience

Breakout Room Instructions

- Assigned to random small groups
  - Person whose last name comes first in the alphabet is the notetaker
  - Person whose last name comes last is the facilitator
- Each group will get a different stage of the CHIP process
  - Group 1 – Developing the plan
  - Group 2 – Implementation planning
  - Group 3 – Implementation
  - Group 4 – Tracking and public awareness
- Each person to answer the following questions about that stage:
  - Who might you engage in this stage of the process? Are there unique partners in your community that could contribute to this stage, who are they?
  - Why would you choose to engage those particular partners or community members?
  - How would you go about engaging them?
  - What are the benefits of engaging partners in the CHIP process?

Report Out

Developing the Plan

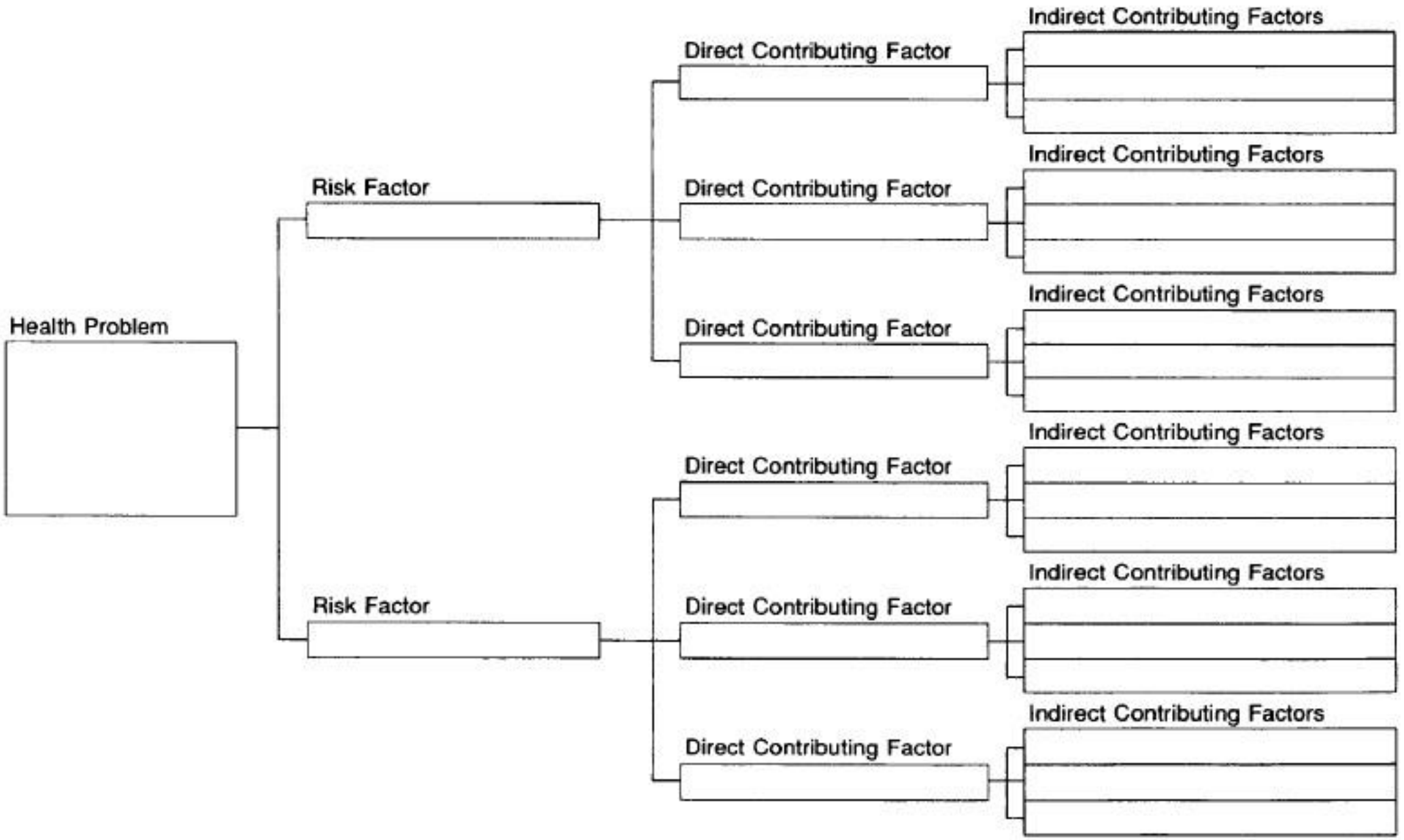
Laurie Call

Key Terminology

- **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.
- **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.

Health Problem Analysis Worksheet

HEALTH PROBLEM ANALYSIS WORKSHEET



Developing Objectives

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 Example

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 Example

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.

Aligning with Healthy People 2030

[About the Objectives - Healthy People 2030 | odphp.health.gov]

SMARTIE Method

SPECIFIC	The objective should focus on a goal of the program and can be based on partner input
MEASURABLE	The objective should include a standard or benchmark to assess progress
ACHIEVABLE	The objective should be attainable based on the program's capacity, while also being meaningful
REALISTIC	The objective should be relevant and based on the program's plan
TIME-BOUND	The objective should include a clear timeline
INCLUSIVE	Is "an opportunity to bring traditionally excluded individuals and groups into processes, activities, decisions, and policy making in a way that shares power"
EQUITABLE	Means "including an element of fairness or justice to address systemic injustice, inequity, or oppression"

CDC From SMART to SMARTIE Objectives

Practice:

Think of a community heath problem in your community. Write an outcome and an impact objective.

Outcome Objective

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 Objective

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**.

Large Group Discussion

- Review the following SMART objective. Discuss in large group how we can integrate Inclusivity and Equity:
  - Inclusivity: How can we include people who are disproportionately affected by the health problem into this process, activity, and the decision-making?
  - Equity: How do we identify activities that seek to address systems of power, injustice, and oppression?

SMART OBJECTIVE – Increase to 35% from baseline, the proportion of adolescents with mental health conditions who engage in the local peer support program by December 2028.

Identifying Proven Intervention Strategies

Outcome Objective Example

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 Example

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.

Discussion Question:
What are some intervention strategies to accomplish decreasing access to alcohol by youth?

Where to find proven intervention strategies.

- County Health Rankings and Roadmaps - What Works for Health - http://countyhealthrankings.org/strategies-and-solutions/what-works-for-health
- Healthy People 2030 – 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

Discussion Question:

What are some resources you recommend to finding interventions that work?

Break

McLean County Health Department

Healthy People. Healthy Places.

Jessica McKnight

Administrator

Community Health Needs Assessment (CHNA)
Community Health Improvement Plan (CHIP)

Not-for profit hospitals must conduct a CHNA and Implementation Plan every 3 years to meet IRS guidelines.

IL certified local health departments are required by the Illinois Department of Public Health to conduct a CHNA and CHIP every 5 years.

Federally Qualified Health Center (FQHC) must do a CHNA and Implementation Plan every 3 years to meet federal requirements.

McLean County Community Health Council

Together We Are Better

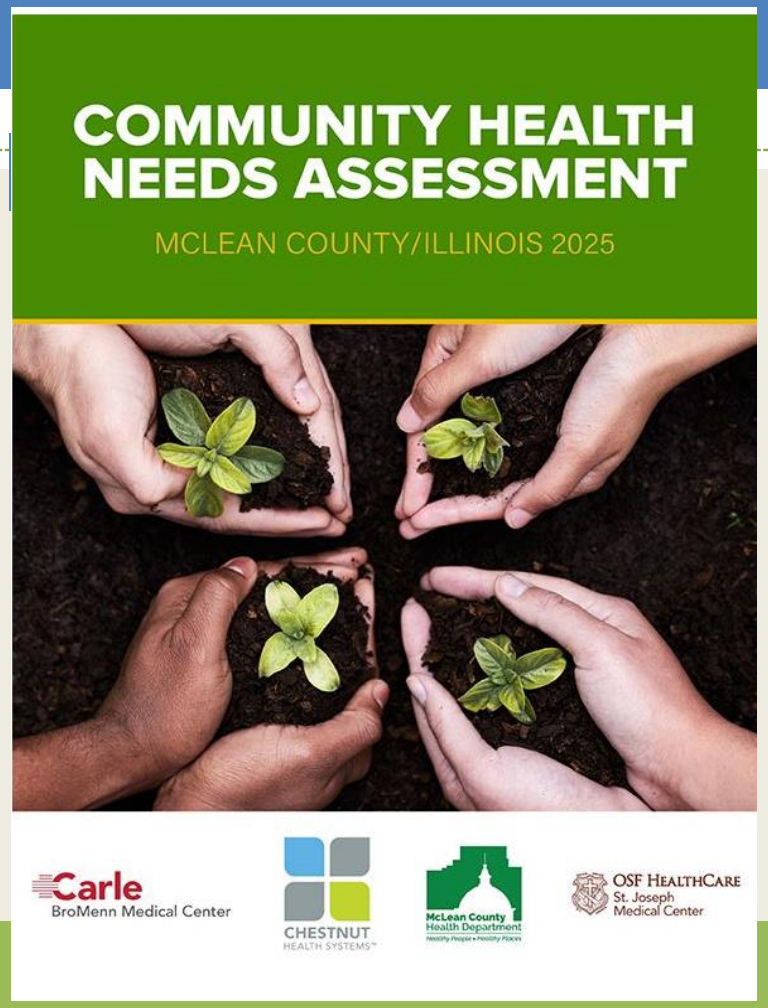
Carle BroMenn Medical Center

CHESTNUT HEALTH SYSTEMS

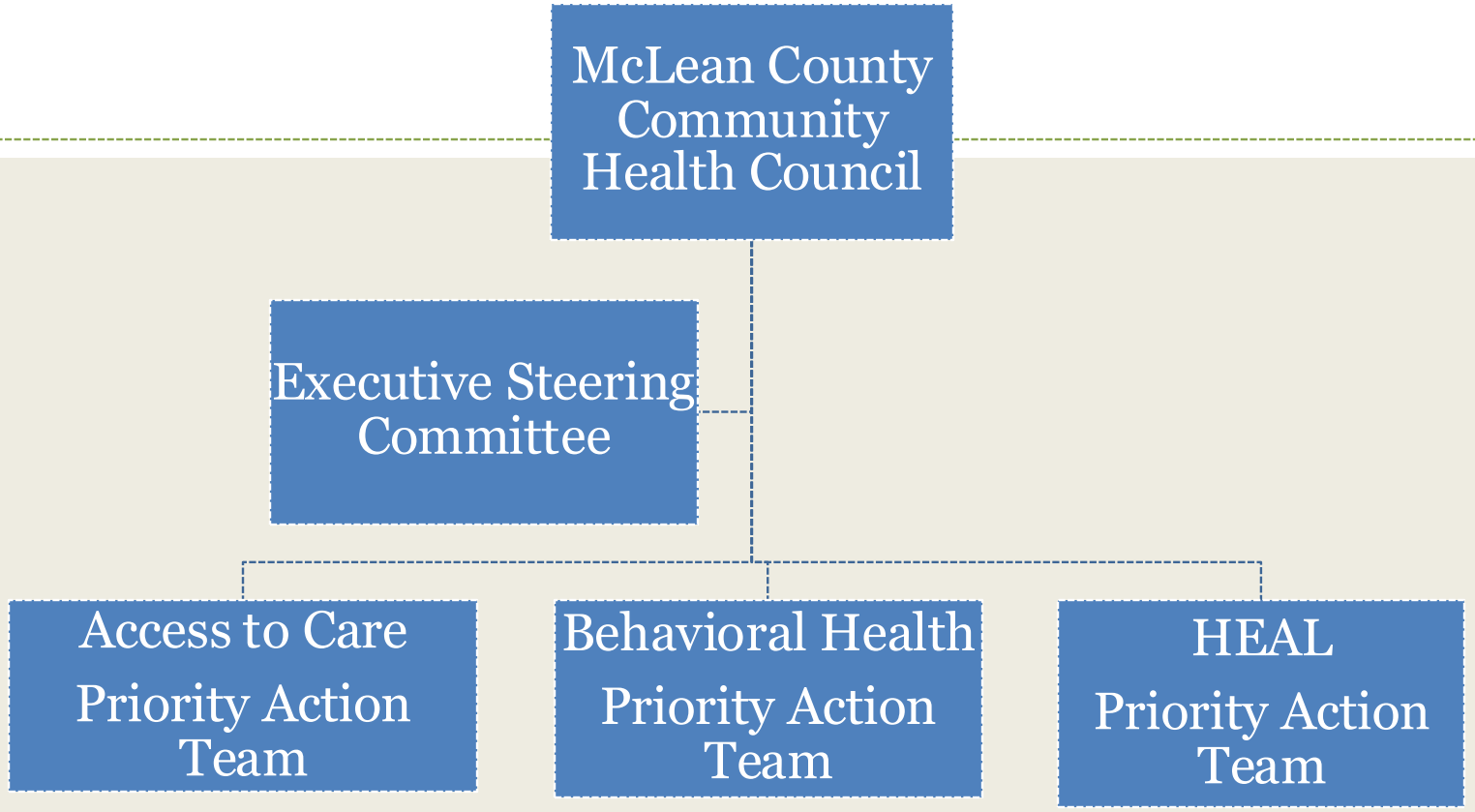
McLean County Health Department
Healthy People. Healthy Places.

OSF HEALTHCARE St. Joseph Medical Center

Current McLean County **JOINT** Reports



Structure


McLean County Community Health Council
Executive Steering Committee
Access to Care Priority Action Team
Behavioral Health Priority Action Team
HEAL Priority Action Team

McLean County Community Health Council (MCCHC)

Comprised of over 40 individuals representing approx. 30 organizations from the sectors below:

Sector	Sector
County and City Government	Education
Public Health	Business/Economic Development
Social Service	Faith
Transportation	Law Enforcement
Housing	Civic Organizations/Service Clubs
Healthcare	Youth & Senior Services

Role of Council Members

- Attend council prioritization meetings
- Review and/or approve the joint reports
- Join implementation priority action teams (PATs) as appropriate (optional)
- Monitor CHIP implementation
- Review annual CHIP progress reports

CHNA & CHIP
Executive Steering Committee

Membership

Meetings

Commitment

CHIP
Priority Action Teams

Membership

Meetings

Commitment

Benefits of Collaboration

Enhanced participation

Shared accountability

“Together we are better”

Local foundation funding

Challenges

Time commitment

The work never ends

Tracking activities

Where to draw the line?

Lessons Learned

- “Who else should be at the table?”
- Get out there and talk about it!
- Established credibility = increased interest

QUESTIONS?

Implementation

Samantha Lasky

Implementation Partners

- Consider the following:
  - Assembling **action teams**, coalitions, or implementation subcommittees
  - Tap **existing groups** within your public health system who are working on your **priorities**
  - Ensure **committees are representative** of the community
  - Identify who is the **owner** of the work and what are their **roles**
  - **Skills** needed for success
  - **Gaps in capacity** – staffing, skills, funding, etc.
    - How to **fill those gaps** with existing internal staff or external partners

Action/Implementation Planning

Key Activities

For Resources:

Consider funding in developing strategies and action/ implementation planning!

Other Key Partners

Timeline

resources will be needed? What barriers exist?

Call to Action – How can the community get involved? How can specific sectors get involved?

What will success look like if this strategy is effectively deployed?

Community engagement and policy specific activities

Tracking Progress of the Community Action Plan

Laurie Call

Determine Tracking and Monitoring Needs

- 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?
- **Others?**

Infrastructure to Support Monitoring

- Evaluation and Monitoring Team
- Evaluation and Monitoring Focus/ Expertise on Action Teams
- Oversight / Accountability Mechanism
- Plans for How Results Will be Used

- Establish a team responsible for monitoring progress of
  - activities and process data
  - indicators
- Report out progress information to partners
  - Determine frequency
  - Evaluate how the process is going (CQI)
  - What changes or improvements are needed regarding the activities?
  - Develop a plan and implement changes or improvements

Tools for Documenting Activity

Activity Trackers help:

- Create an expectation.
- Integrate monitoring into existing processes
- Provide basic tool to document all the activity going on related to a particular issue.
- Keep the focus of the committee/ action team on the priority issue.
- Identify improvement opportunities and successes.
- Provide structured opportunity for group problem-solving.

Components in a Measurement Plan

Process and outcome indicators
Data sources for measuring the indicators
Methods for measurement
Person Responsible for Data
Timing for measurement
Baseline
Target

Sample Measurement Plan

#	Indicator	Baseline	Target	Data Source	Method	Timing
Outcome Objective	**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.**					
1	Percentage of HS students reporting consumption of alcohol withing past 30 days	45%	35%	Illinois Youth Survey	Survey	January 2030
Impact Objective	**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.**					
1.1	Percentage of HS sudents reporting that it would be "very" or "sort of easy" to obtain alcohol	63%	50%	Illinois Youth Survey	Survey	January 2028
Intervention Strategy	Coordinate the provision of BASSET training to the facilities that have made the most underage sales of alcohol to minors. (Beverage Alcohol Sellers and Servers Education and Training (BASSET) is the State of Illinois' responsible beverage seller/server program.)					
1.1.1	# of BASSET Trainings provided to facilities with underage sales in XYZ communities/ county	7 sites served in 2025	At least 10 sites that served annually	BASSET	Training Records	December 31, 2026 (annually)
1.1.2	# of alcohol sales compliance checks conducted annually in XYZ communities/ county	15 sites in 2025	25 sites annually	Illinois Liquor Control Commission	ILCC Website	December 31, 2026 (annually)
1.1.3	# of parent presentations educating on the dangers of underage drinking and consequences for providing access	0 presentations	3 sessions in 2 school districts each	Training records	Sign-in sheets	December 31, 2026 (annually)

Key Evaluation Activities

- Prepare to evaluate
- Engage Stakeholders to develop and gain consensus around your evaluation plan
- Review policy or program goals and decide which are most important to evaluate
- Identify indicators and how to collect data to monitor progress
- Identify benchmarks for success
- Work with key parties to establish data collection systems
- Collect credible data
- Monitor progress toward achieving benchmarks
- Engage stakeholders to review evaluation results and adjust your policy implementation or program(s) as necessary
- Share your results

http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions

When not on track for intended results, apply QI

Institute for Healthcare Improvement Model for Improvement

AIM Statement

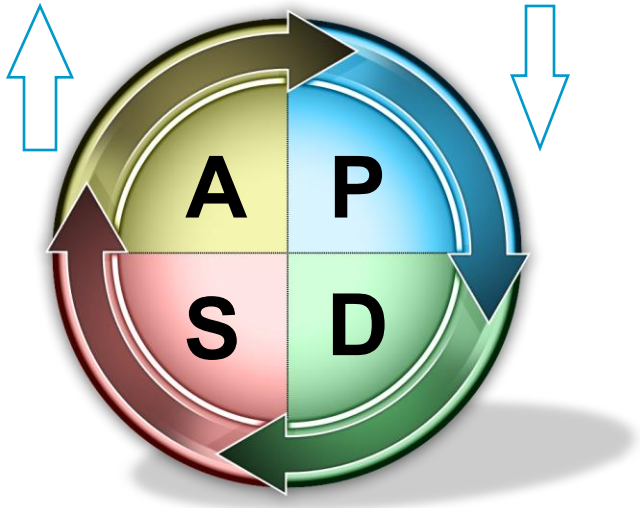
Data

Root Cause Analysis

1. What are we trying to accomplish?

2. How will we know that a change is an improvement?

3. What changes can we make that will result in an improvement?



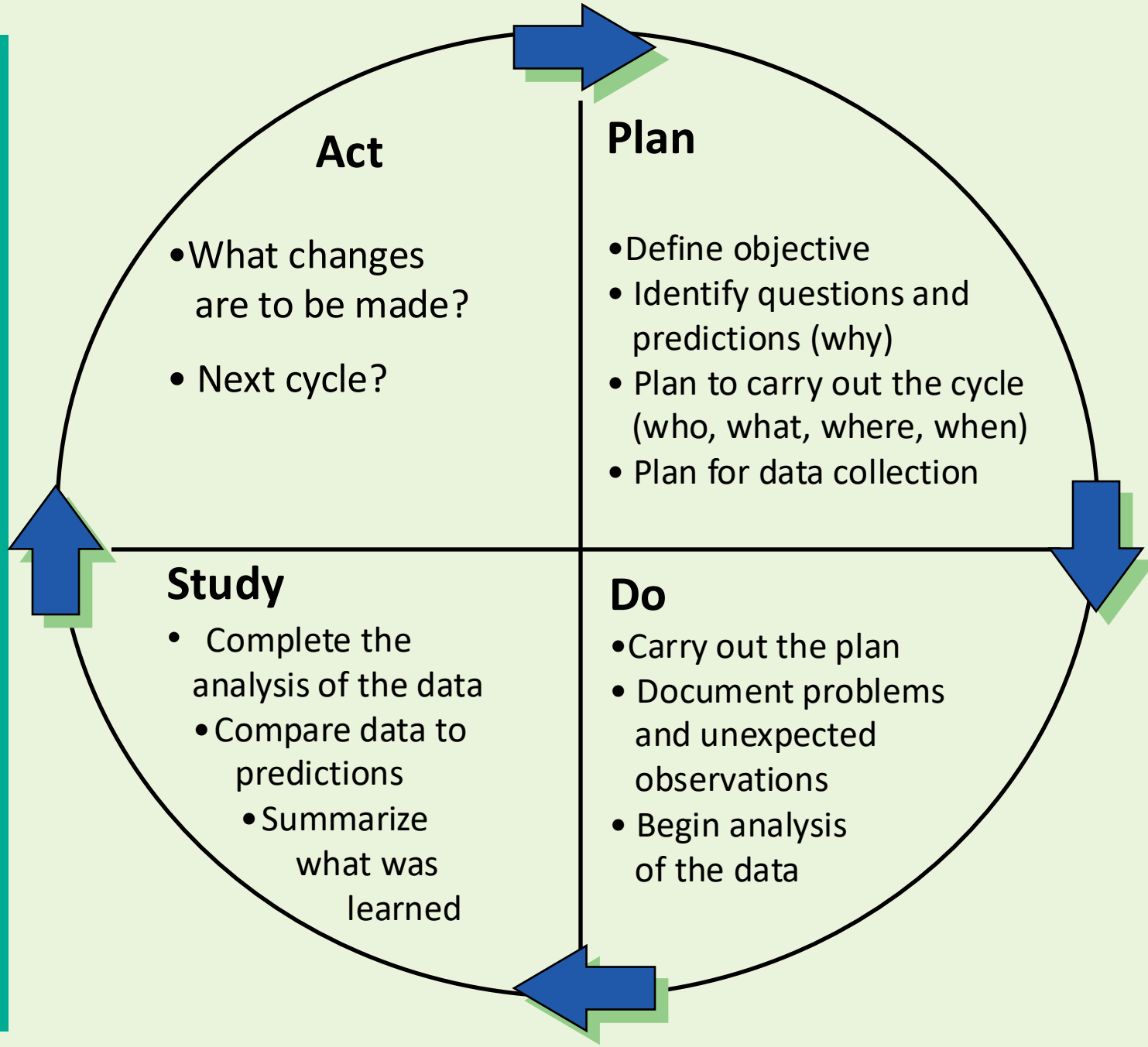
Multiple Cycles

Designed to Accelerate Change.

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

The PDSA Cycle for Learning and Improvement

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



Q&A

Poll 3 – Evaluation Feedback

Closing

Upcoming IPLAN Trainings

- TA Session – November 20, 2025
  1-2pm

Thank You!

IPHIONLINE.ORG

Jessica McKnight

McLean County Health Department

Laurie Call
Laurie.Call@iphionline.org

Samantha Lasky
Samantha.Lasky@iphionline.org

Jasmine Deskins
Jasmine.Deskins@iphionline.org

Resource Slide

- Community Asset Map
- https://www.boreal-is.com/blog/stakeholder-mapping-identify-stakeholders/
- MAPP 2.0 – NACCHO, page 140 and beyond
- Chapter 5. Choosing Strategies to Promote Community Health and Development | Community Tool Box
- CDC From SMART to SMARTIE Objectives
- About the Objectives - Healthy People 2030 | odphp.health.gov
- http://www.countyhealthrankings.org/roadmaps/action-center/evaluate-actions
- Langley, Nolan, Nolan, Norman, & Provost. *The Improvement Guide*
- Quality Improvement in the IPLAN process from the 2024 IPLAN Training Series