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 & 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.

MEASURE 5.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 process	**Dated Within** 5 years
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.		
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.	**For required element a:** 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 faith-based organizations. Members of this group may or may not be the same as members of the state/Tribal/community health assessment partnership.		

MEASURE 5.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 process	Dated Within 5 years
	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.)		
b. Review of information from the community health assessment.	**For required element b:** 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.		
c. Review of the causes of disproportionate health risks or health outcomes of specific populations.	**For required element c:** 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.		
d. Process used by participants to select priorities. The CHIP process must address the jurisdiction as described in the description of Standard 5.2.	**For required element d:** 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. **<u>Documentation Examples</u>** 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.		

MEASURE 5.2.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Adopt a community health improvement plan.

Purpose & Significance

The purpose of this measure is to assess the community health improvement plan (CHIP). The health improvement plan provides guidance to the health department, its partners, and stakeholders for improving the health of the population within the health department's jurisdiction. The plan reflects the results of a collaborative planning process that includes significant involvement by key sectors. Partners can use a health improvement plan to prioritize existing activities and set new priorities. The plan can serve as the basis for taking collective action and can facilitate collaborations.

MEASURE 5.2.2 A: Required Documentation 1	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
1. A community health improvement plan (CHIP), which includes all of the following:	This may be referred to as a state health improvement plan, Tribal health improvement plan, or other name. A health improvement plan looks at population health across the jurisdiction. While programs in the health department may have program-specific plans, those plans do not fulfill the purpose of the health improvement plan to address the jurisdiction's priorities.		
a. At least two health priorities.	**For required element a:** The CHIP will designate two or more health priorities to be addressed collaboratively.		
b. Measurable objective(s) for each priority.	**For required element b:** Establishing one or more measurable objective(s) for each of the health priorities will enable the CHIP collaborative to determine if progress is being made towards addressing each priority. The objectives could be contained in another document.		
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.	**For required element c:** Improvement strategy(ies) or activity(ies) may be evidence-based, practice-based, promising practices, or 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 2030) 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 workplan 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 between planning participants, stakeholders, other governmental agencies, or organizations. For this requirement, agreements do not need to be formal, such as an MOA or MOU.		

MEASURE 5.2.2 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
	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 or address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, and climate change. While not all the 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.		
d. Identification of the assets or resources that will be used to address at least one of the specific priority areas.	**For required element d:** 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, 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. It is not necessary to include an asset or resource for each priority area. 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).		
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. The CHIP must address the jurisdiction as described in the description of Standard 5.2.	**For required element e:** 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.		

MEASURE 5.2.3 A:

Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to ensure that the strategies of the community health improvement plan are implemented, assessed, and revised as indicated by those assessments. Any plan is useful only when it is implemented and provides guidance for activities and resource allocation. Effective community health improvement plans should not be stagnant, but dynamic to reflect the evolving needs of the population served. Health departments should continuously work with multi-sector partnerships to evaluate and improve the community health improvement plan.

MEASURE 5.2.3 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Community health improvement plan (CHIP) activity or strategy implemented. Examples must be from different health improvement plan priority areas. The Documentation Form must indicate to which CHIP strategy or activity the example applies. If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide implementation from an earlier CHIP. (Documentation must demonstrate the linkage between the activities or strategies and the prior CHIP. Although the prior CHIP may be more than 5 years old, the implementation must have occurred within 5 years.)	Implementation may be done by health department staff or other partners involved in the health improvement plan. Providing a tracking document or workplan for this requirement is **not** sufficient evidence. **Documentation Examples** Examples could include newspaper articles; photos demonstrating walking paths or no smoking signs; meeting minutes demonstrating the establishment of coalitions; or notes from meetings held with policy makers or partners.		

MEASURE 5.2.3 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 2 years
2. An annual review of progress made in implementing **all** strategies and activities in the community health improvement plan (CHIP). If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide (1) an annual review from a previous plan or (2) detailed plans for the annual review process.	The intent is to show a full review of progress on all CHIP strategies and activities. A review of one or a few strategies or activities would **not** meet the intent. If no progress has been made on a strategy or activity, this can be indicated in the report. **Documentation Examples** Documentation could include, for example, an annual report, a presentation shared with the CHIP partnership, or written summary to accompany a tracking document.		

MEASURE 5.2.3 A: Required Documentation 3	Guidance	Number of Examples 1 example	Dated Within 2 years
3. Revisions to the community health improvement plan (CHIP) based on the review in Required Documentation 2 (above). If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide (1) revision of an earlier plan or (2) detailed plans for a revision process.	Strategies or activities may need revision based on, for example, a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets. The revisions may be in the objectives, improvement strategies, planned activities, time-frames, targets, or assigned responsibilities listed in the plan. Developing changes in collaboration with partners and stakeholders involved in the planning process will strengthen the collaborative implementation of the health improvement plan.		

MEASURE 5.2.4 A:

FOUNDATIONAL CAPABILITY MEASURE

Address factors that contribute to specific populations' higher health risks and poorer health outcomes.

Purpose & Significance

The purpose of this measure is to assess the health department's intentional approach to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequities. Differences in populations' health outcomes are well documented. Factors that contribute to these differences are many and include the lack of opportunities and resources, economic and political policies, structural racism and other forms of discrimination, and other aspects of a community that impact on individuals' and population's resilience. These differences in health outcomes require engagement of the community in strategies that develop community resources, capacity, and strength.

MEASURE 5.2.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or procedure	**Dated Within** 5 years
1. A policy or procedure that demonstrates how health equity is incorporated as a goal into the development of programs that serve the community.	The policy or procedure will show that the health department has established an approach to address differences in populations' health outcomes and the factors that contribute to differences, such as, lack of opportunities and resources, economic and political policies, discrimination, and other aspects of the community that influence health. The policy or procedure might address how factors that contribute to higher health risks are incorporated into processes, programs, and interventions. The policy or procedure could be organization-wide or could cover specific program(s). Characteristics of populations addressed in the policy or procedure could include, for example, social, racial, ethnic, cultural, sexual orientation, gender identity, linguistic characteristics (including non-English speaking populations), or individuals with disabilities. The policy or procedure might consider, for example, how the health department integrates more explicit language to build awareness of social determinants of health and health equity within its programming, health promotion, education, and communication strategies or in the health department's engagement with partner organizations and community stakeholders. Other methods might consider a deliberate approach within data collection and analysis to develop a deeper understanding of inequities or the root causes of disparities, such as, information on structural oppression and intersectionality (such as, structural racism, classism, exploitation, gender discrimination, heterosexism, ableism, cisgenderism, or xenophobia).		

MEASURE 5.2.4 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 5 years
2. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. The documentation must define the health department's role in the strategy as well as the roles of stakeholders, partners, or the community.	The example could be related to strategies in the state/Tribal/community health improvement plan, but it does **not** need to be. The example could follow the policy or procedure provided in Required Documentation 1, but evidence of this is **not** required. The health department does not need to have led the strategy, but the health department's role will be indicated to show how the department participated in implementing the strategy. Public health strategies implemented may address social change, social customs, policy, services, health communications (e.g., a campaign to promote antiracism or LGBTQ acceptance), level of community resilience, or the community environment which impact on health inequities. Implementation of the strategy is required; a plan would not be sufficient for this requirement. For example, policy changes could examine correcting historical injustices to provide fair and just opportunities for all to achieve optimal health. Policy changes considered may address the social and economic conditions that influence health equity including, for example, housing, transportation, education, job availability, neighborhood safety, and zoning. Collaboration with partners or stakeholders could include, for example, community or volunteer organizations, community hospitals, businesses and industries, academic institutions, or others including those who represent populations affected by health or social inequities. Tribal health departments may decide which subpopulations within the Tribal population or community that their public health initiatives are developed to address. Analyses that inform these decisions may be obtained from external sources such as Tribal Epidemiology Centers, state reports, or local sources. **Documentation Examples** Documentation could include, for example, a press release; report to the governing entity or the community; or other document that outlines efforts, achievements, or implementation updates.		