

Welcome to Community Health Improvement Planning Processes

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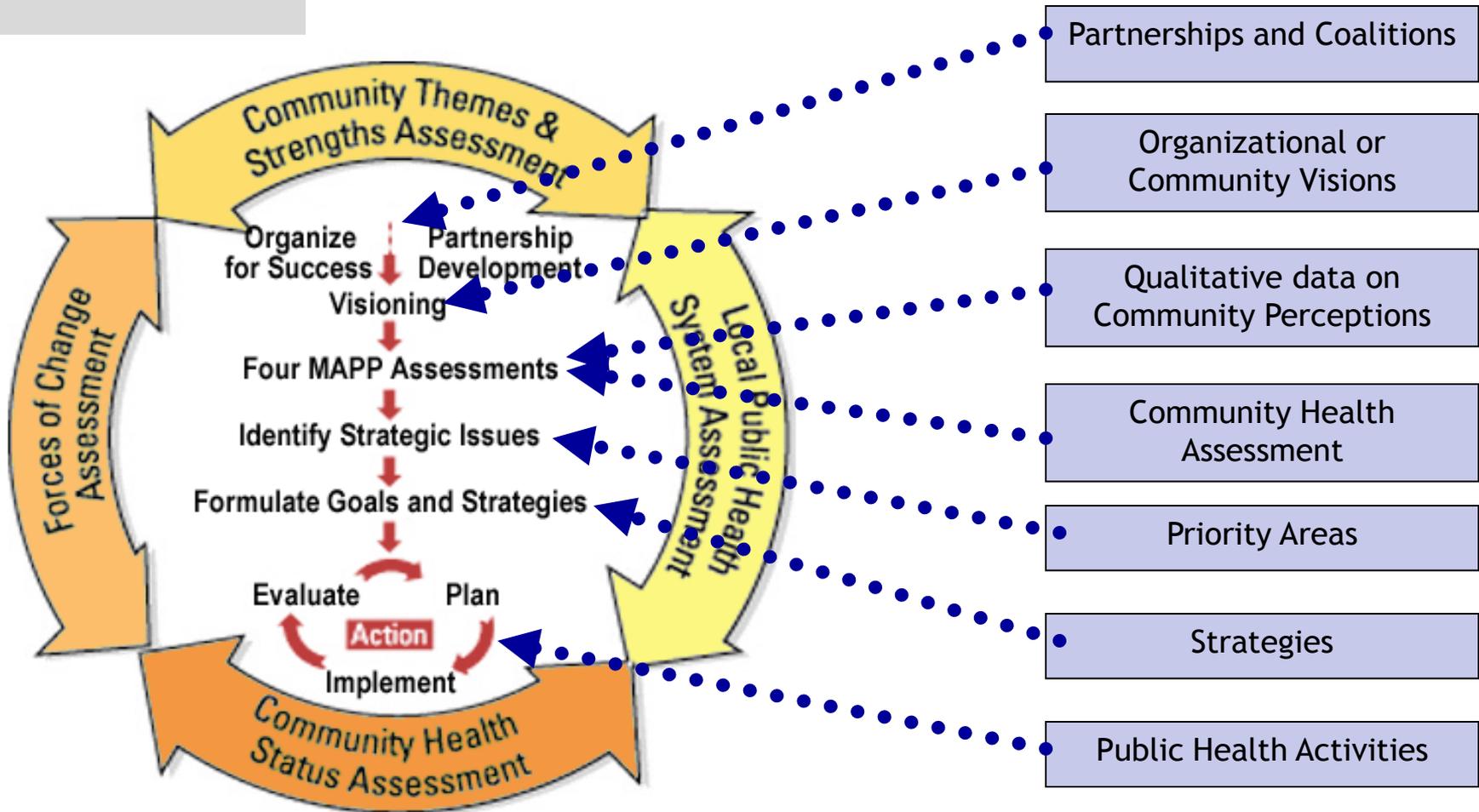
Community Health Improvement Planning Processes

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MAPP as a Framework



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Identify Strategic Issues



Strategic issues are fundamental policy choices or critical challenges that must be addressed in order for a community to achieve its vision.

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The Process



- Determine the method for completing this phase
- Present summary of all four assessments
- Brainstorm potential strategic issues
- Develop an understanding about why an issue is strategic
- Consolidate overlapping or related issues
- Arrange issues into an ordered list
- Disseminate results
- Evaluate the process

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Formulate Goals and Strategies



- Form goal statements related to strategic issues
- Identify strategies for achieving goals

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Example of a Strategic Issue, Goal & Strategy



- **Strategic Issue:**
How can the public health community ensure access to population-based and personal health care services?
- **Goal:**
All persons living in our community will have access to affordable quality health care.
- **Strategy:**
Create a network of reduced cost primary care providers.
Provide free or reduced cost transportation services to care site.



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How to...



1. Determine how goals and strategies will be developed
2. Develop goals
 - Reference vision statement and strategic issues
3. Generate a variety of strategies
 - Resist pressures to settle for an obvious or comfortable strategy
 - Reference MAPP assessment data

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How to Continued....

4. Brainstorm barriers to implementation

Think about...

- Resources
- Community support
- Legal or policy impediments to authority
- Technological difficulties
- Limited organizational or management capacity

5. Draft implementation details

Consider...

- What specific actions need to take place?
- What is a reasonable timeline?
- Which organizations and individuals should be involved?
- What resources are required and where will they come from?

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SHIP / CHIP Example

Strategic Issue: *How can the Illinois [XYZ County] public health system monitor health disparities and identify and implement effective strategies to eliminate them?*

Long-Term Outcomes: A public health system actively engaged in addressing health disparities and the social determinants that affect health outcomes across the lifespan.

Intermediate Outcomes:

- Healthcare is accessible to all residents. (See access strategic issue)
- Public health system partners incorporate strategies to reduce poverty, adverse childhood events and environmental exposure inequalities and increase educational opportunities, support independent living and address other social determinants of health
- PH and HC workers are trained in health disparities and the role of social determinants
- PH and HC workforce is more diverse and culturally and linguistically competent. (See workforce strategic issue)

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2010 ILLINOIS STATE HEALTH IMPROVEMENT PLAN

http://www.idph.state.il.us/ship/09-10_Plan/FINAL_Hearing_SHIP_Draft.pdf



ILLINOIS PUBLIC HEALTH INSTITUTE

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IPLAN (Illinois Process for CHIP development)

- Analysis of Health Problems and Health Data
- Prioritize Community Health Problems
- Conduct Detailed Analysis of Community Health Problems
- Inventory Community Health Resources
- Develop a Community Plan - Including IPLAN Objectives
- Community Health Plan Worksheets
- <http://mapp.naccho.org>

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Community Health Plan Components

- Purpose statement
- Description of the planning process
- Description of each priority/strategy
- One measurable outcome objective (for each priority)
- One measurable impact objective (for each outcome objective)
- One proven intervention strategy (for each impact objective)
- Evaluation plan

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2010 Illinois SHIP

There are five public health system strategic issues in the plan:

- 1) Improve Access to Health Services;
- 2) Enhance Data and Health Information Technology;
- 3) Address Health Disparities and Social Determinants of Health;
- 4) Measure, Manage, Improve and Sustain the Public Health System;
and
- 5) Assure a Sufficient Workforce and Human Resources.

There are also eight priority health concerns addressed:

Alcohol and Tobacco; Use of Illegal Drugs/Misuse of Legal Drugs; Mental Health; Natural and Built Environment; Obesity: Nutrition and Physical Activity; Oral Health; Unintentional Injury and Patient Safety; and Violence.

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2010 Illinois SHIP

The SHIP also identified five cross-cutting plan framing issues that must be used to guide action on and engagement in achieving the outcomes envisioned for each strategic issue:

- Health Care Reform/Policy
- Health Across the Lifespan
- Social Determinants of Health
- Community Engagement and Education
- Leadership/Collaboration/Integration

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The Action Cycle

- Plan
- Implement
- Evaluate



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Establishing the Action Plan



- What will be done?
- Who will do it and when?
- How will it be done?

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Write “SMART” Objectives!

- Specific
- Measurable
- Attainable
- Relevant
- Time-oriented

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

Increase to 35 % the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days by December 2012.

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Write “SMART” Objectives!

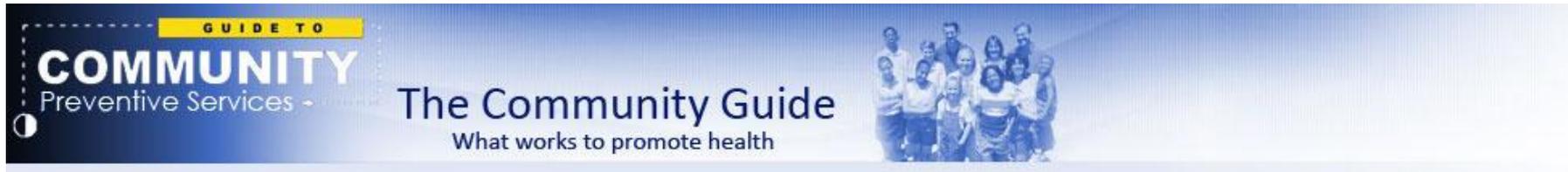
Impact Objective: This objective is a measurable statement indicating the desired level of change in a risk factor. Impact objectives are intermediate in time. The time-frame for IPLAN is two to three years.

By December 2009, reduce the number of youth who take their first drink before age 17 from 67% to 60%.

Process Objective: This objective is measurable statement indicating the desired level of change in a contributing factor. A process objective is short-term (1 to 2 years). IPLAN calls for something a bit different for addressing the impact objective. In lieu of process objectives, Illinois LHDs should provide at least one proven Intervention Strategy to address each written impact objective.

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One Proven Intervention Strategy (for each Impact Objective)



What Works to Promote Health? www.thecommunityguide.org

Lists interventions for many health issues and conditions in 3 categories:

- Insufficient evidence
- Recommended (sufficient evidence)
- Recommended (strong evidence)

EXAMPLE: Increasing Tobacco Cessation Use

- Mass Media Contests (Insufficient evidence)
- Mass Media Campaign with other Interventions: Recommended (Strong evidence)
- Provider reminders used alone: Recommended (Sufficient evidence)
- Reduce out-of-pocket cost for cessation: Recommended (Sufficient evidence)
- Implementing last three bullets together is called “Bundling”

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Community Health Plan Worksheet

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)

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

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Translating MAPP into a Framework for CHIP / SHIP: Team Discussion

<p><i>Elements of MAPP</i></p>	<p><i>Part 1: List any current or previous activities, skills, and products that sound similar to components in MAPP. How could they be incorporated into your CHIP / SHIP framework?</i></p>	<p><i>Part 2: In incorporating these activities, skills, and products into the CHIP / SHIP framework, how would you ensure improvements in the way your agency does business?</i></p>
<p>Phase 1: Organizing for Success & Partnership Development</p> <p><i>Does your community or state partnership represent the key organizational players engaged in improving the public's health?</i></p>		
<p>Phase 2: Visioning</p> <p><i>Is there a vision statement developed by your partnership group?</i></p>		
<p>Phase 3: Four Assessments:</p> <p>Community / Statewide Themes & Strengths Assessment</p> <p><i>Is there a summary of cross-cutting themes?</i></p>		

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Let's Discuss!



- Let's discuss how HDs can use existing data and assessment results with the MAPP Framework to develop CHIPs:
 - CHSA or CHA
 - CTSA or SWOT from SP
 - LPHSA or WA Standards
 - FOCA or SWOT from SP

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Organize Your CHIP or SHIP Process

Example Timeline/Workplan for the MAPP Process

The example timeline/workplan below uses a 12-month timeframe. The activities included under each phase are examples of activities that could be conducted. As emphasized throughout the MAPP guidance, communities should implement each phase in the way that best reflects their community characteristics and needs. The timeline focuses on the planning aspect of MAPP; the implementation and evaluation activities (the Action Cycle) should be sustained long after the MAPP activities below end.

MAPP Phase / Description of Activity	Months (Using a 12-Month Timeframe)											
	1	2	3	4	5	6	7	8	9	10	11	12
Organize for Success / Partnership Development	■	■	■									
• Determine why the MAPP process is needed	■	■	■									
• Identify, organize, and recruit participants	■	■	■									
• Design the planning process	■	■	■									
• Assess resource needs	■	■	■									
• Conduct a readiness assessment	■	■	■									
• Develop a workplan, narrative, and other tools	■	■	■									
Yield to the Community				■	■	■						
• Prepare for and design the planning process				■	■	■						
• Hold planning sessions				■	■	■						
• Collaborate, coordinate and achieve readiness to date				■	■	■						
4 MAPP Assessments							■	■	■	■		
Community Themes and Strengths Assessment							■	■	■	■		
• Identify accommodations, approaches, and resources							■	■	■	■		
• Hold community dialogues and focus groups							■	■	■	■		
• Develop, design and/or collect a community survey							■	■	■	■		
• Conduct interviews with residents / city leaders							■	■	■	■		
• Compile materials and identify challenges and opportunities							■	■	■	■		
Local Public Health System Assessment							■	■	■	■		
• Prepare for the LPHSU/establish accommodations							■	■	■	■		
• Discuss the Essential Services identified by org. activities							■	■	■	■		
• Respond to the performance measure assessment							■	■	■	■		
• Discuss real or identified challenges and opportunities							■	■	■	■		

- What will the process entail?
- How long will it take?
- What results are we seeking?
- How will we know we are finished?
- Who will do the work?

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Gantt Charts for Implementation

- Simple tool that uses horizontal bars to show which tasks can be done simultaneously over the life of the project
- Used extensively in Project Management and Quality Improvement teams

PROJECT: Increase the Percent of Older Adults Receiving Influenza Vaccine

Aim:	Increase by 50% the percent of individuals 65 and over who receive an annual influenza vaccination from their primary care physician or in the hospital in XYZ County from the 2008 baseline of 58%, without decreasing vaccinations in other settings.													
Measures (goals):	1. The percent of eligible persons ages 65 and over who receive an annual influenza vaccine (increase)													
	2. The percent of ordered vaccine that is administered (Increase)													
	3. The number of sites offering influenza vaccines to older adults (Increase)													
Cycle Number	Change Tested	Person(s) Responsible	1	2	3	4	5	6	7	8	9	10	11	12
1	<u>Institute a Reminder System</u>													
P	Create reminder form for distribution by PCPs and hospitals	Sue J.												
D	Distribute reminder forms to PCPs and hospitals and encourage use	Nancy & Jim			—————			—————			—————			
S	Pilot test distribution by contacting PCPs & hospitals at 2 weeks & 4 weeks	Sue, Nancy & Jim												
A	Determine next steps	QI team		—————										
2	<u>Regular Feedback to Physician Offices and Hospitals</u>													
P	Design patient exit logs	John												
D	Conduct patient surveys	John & Mary										—————		
S	Report Results	John & Mary												

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Benefits of CHAs & CHIPs



- Increases visibility of public health
- Creates advocates for public health
- Creates a healthy community and better quality of life.
- Anticipates and manages change
- Creates a stronger public health infrastructure
- Builds stronger partnerships
- Builds public health leadership
- Cuts across silos

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CHAs & CHIPs - Two PHAB Pre-requisites

- Currently, PHAB has required that all applicants submit three documents with their request for an accreditation survey:
 - Community/State Health Assessment
 - Community/State Health Improvement Plan
 - Agency Strategic Plan
- Few specific requirements established to date for the contents of these prerequisites

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Link between CHAs / CHIPs / SPs & PHAB

- CHA/SHA: Link to requirements in Domain 1 and Domain 4
- CHIP/SHIP: link to requirements in Domain 4 and are explicitly required in Domain 5, Standard 3
- SP: Explicitly required in Domain 5, Standard 2
- These documents provide evidence for some of the requirements in these standards.

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Domain 1: Conduct & disseminate assessments [of] population health status...

Standard 1.1 B: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.	Standard 1.2 B: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic risks that affect the public's health.	Standard 1.3 B: Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs or interventions.
1.1.1 B: Demonstrate that a surveillance system is in place for receiving reports 24/7 and for identifying health problems, threats, and environmental hazards	1.2.1 B: Analyze and draw conclusions from data to identify trends over time, clusters, health problems, behavioral risk factors, environmental health hazards, and social and economic conditions that affect the public's health	1.3.1 B Use data to recommend and inform public health policy, processes, programs and/or interventions
1.1.2 B: Communicate with surveillance sites on at least an annual basis	1.2.2 S: At least annually, provide statewide public health data to various audiences in the form of reports on a variety of public health issues	1.3.2 S Develop and distribute statewide health data profiles to support health improvement planning processes at the state level
1.1.3 B: Collect additional primary and secondary data on population health status		1.3.3 S Provide support to LHDs in the development of community health data profiles
1.1.4 L/S Provide reports of primary and secondary data to SHA/LHDs		1.3.2 L Develop and distribute community health data profiles to support public health improvement planning processes at the local level

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Domain 4: Engage with the community to identify and address health problems

Standard 4.1 B: Engage the public health system and the community in identifying and addressing public health problems through an ongoing, collaborative process.

4.1.1 B: Establish and actively participate in collaborative partnerships and coalitions to address public health issues

4.1.2 B: Recruit and engage governing entity members, stakeholders, community partners and the public to participate in collaborative partnerships and coalitions to address important public health issues

4.1.3 S: Provide technical assistance to LHDs and/or public health system partners regarding models for recruiting and engaging the community

4.1.3 L: Link stakeholders to technical assistance regarding models of recruiting and engaging with the community, as requested

Standard 4.2 B: Promote understanding of and support for policies and strategies that will improve the public's health.

4.2.1 S: Disseminate the results of community health assessments to statewide stakeholders

4.2.1 L: Disseminate the results of community health assessments to the community

4.2.2 B: Engage the community about policies and strategies that will promote the public's health

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Domain 5: Develop public health policies and plans

Standard 5.2 B: Develop and implement a health department organizational strategic plan.

5.2.1 B: Conduct a strategic planning process

5.2.2 B: Develop a strategic plan

5.2.3 B: Implement the strategic plan

5.2.4 B: Review and revise the strategic plan

Standard 5.3 L/S: Conduct a comprehensive planning process resulting in a community health improvement plan [CHIP]/state health improvement plan [SHIP].

5.3.1 L/S: Conduct a community/state health improvement process that includes broad participation from the community/stakeholders

5.3.2 L/S: Produce a community/state health improvement plan as a result of the community/[] health improvement process

5.3.3 L/S: Implement elements and strategies of the community/state health improvement plan, in partnership with others

5.3.4 L/S: Monitor progress on strategies and health improvement in order to revise the CHIP/SHIP, as needed

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CHIPs and SHIPs

Standard 5.3 requires:

- Conduct a community/state health improvement process that includes broad participation from the community/stakeholders
- Produce a community/state health improvement plan as a result of the community/health improvement process
- Implement elements and strategies of the community/state health improvement plan, in partnership with others
- Monitor progress on strategies and health improvement in order to revise the CHIP/SHIP, as needed

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Domain 9: Evaluate & continuously improve processes, programs, & interventions

Standard 9.1 B: Evaluate public health processes, programs, and interventions provided by the agency and its contractors.

9.1.1 B: Engage governing entity in establishing agency policy direction regarding a performance management system

9.1.2 B: Establish agency policy and capacity to implement a performance management system

9.1.3 B: Establish goals, objectives and performance measures for processes, programs and interventions

9.1.4 B: Monitor performance measures for processes, programs and interventions

9.1.5 B: Evaluate the effectiveness of processes, programs, and interventions and identify needs for improvement

9.1.6 B: Implement a systematic process for assessing and improving customers' satisfaction with agency services

9.1.7 S: Provide training and technical assistance regarding evaluation methods and tools to SHA and LHD staff

9.1.7 L: Require staff participation in evaluation methods and tools training

Standard 9.2 B: Implement quality improvement of public health processes, programs, and interventions.

9.2.1 B: Establish a quality improvement plan based on organizational policies and direction

9.2.2 B: Implement quality improvement efforts

9.2.3 S: Provide training and technical assistance regarding quality improvement methods and tools to SHA and LHD staff

9.2.3 L: Demonstrate staff participation in quality improvement methods and tools training

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CHA/CHIP/SP/QI Plan



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What questions or comments
do you have?

