2019 Community Health Improvement Plan (e-CHIP) Template

[Insert Logo and/ or CHA Overview Video]

If you need help creating a video that highlights your county's CHA, please contact Adrienne Ammerman, at Adrienne.Ammerman@WNCHN.org.

The 2018 Community Health Assessment priority areas are:

[Guidance: Use the exact language from your CHA. Relates to Accreditation Activity 22.1 B]

- **[Health Issue 1]**
- **[Health Issue 2]**
- **[Health Issue 3 if applicable]**
- **[Health Issue 4 if applicable]**

The following CHIP Scorecard was created and submitted **[INSERT SUBMISSION DATE]** in order to meet the requirements for the **[INSERT COUNTY]** Long and/ or Short Term Community Health Improvement Plans.

[Guidance: 2018 CHIP is due September 9th, 2019]

[Guidance: Optional Language re: Scorecard]

Clear Impact Scorecard™ is a strategy and performance management software that is accessible through a web browser and designed to support collaboration both inside and outside organizations. WNC Healthy Impact is using Clear Impact Scorecard™ to support the development of electronic CHIPs, SOTCH Reports and Hospital Implementation Strategy scorecards in communities across the region.

Scorecard helps communities organize their community health improvement efforts:

- Develop and communicate shared vision
- Define clear measures of progress
- Share data internally or with partners
- Simplify the way you collect, monitor and report data on your results

The following resources were used/reviewed in order to complete the CHIP:

- WNC Healthy Impact
- WNC Healthy Impact Data Workbook - add link when available
- NC DHHS CHA Tools
- NC DHHS County Health Data Book
- NC DHHS/ DPH CHA Data Tools
- [Add other resources here]

[Insert Health Issue/ Priority] - Long Term CHIP or Short-Term CHIP

R Community Result (statement should include geography and population of focus - see CHIP worksheet for more guidance)

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Alignment

[Guidance: List which of the 13 Healthy NC 2020 Focus Areas to which this health issue and related result are aligned.]

[Health Issue] and the related result [Condition of Well-being for Health Issue] are aligned with the following Healthy NC 2020 Focus Areas/ Objectives.

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Experience and Importance

How would we experience [insert result] in our community?

[Guidance: What would be different in your community when you achieve this result? How would community members experience this condition of well-being? What would we see or hear as we move through our community that might be different if we achieve our result? In other words, what looks different? Sounds different? Recommended RBA tool for Clarifying Results & The Experience of Success in Your Community]

What information led to the selection of this health issue and related result?

[Guidance: Give a brief overview & describe in plain language why this issue is important to your community. If you used the prioritization tool, you can include the information gathered from your team/ community about the relevance, impact and feasibility around this issue. Include known risk factors for this issue (located on the Healthy People 2020 website under the Life Stages & Determinants tab for each issue area. You can use details from Chapter 8 of your CHA, "Identification of Health Priorities", and Priority Issue sections.

Headline Indicator for Health Issue (add other data points under story)

Story Behind the Indicator

[Guidance: This section includes story you collect during your process.]

The "Story Behind the Curve" helps us understand why the data on [state the indicator in plain language, e.g. adults with diabetes, children born addicted to drugs, or people dying from drug overdoses] is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

[Guidance: What it helping and what is hurting this issue? What conditions, policies, programs or other factors are helping us do as well as we are doing? What conditions, policies, programs or other factors are contributing to this problem and keeping us from doing better?

You could organize your What's Helping and What's Hurting by what do people most affected by this issue say? What do key stakeholders say? Challenge assumptions. Ask "why" to get to root-causes?

Story data can come from many sources: during Whole Distance Exercise with your coalition or work group; during listening sessions/focus groups with people affected by the issue; the Healthy Impact Key Informant Interview responses on your topic; interviews or surveys with key partners in your community; listening at meetings or community events; etc.

Recommended RBA tool for working on story behind the indicator, identifying partners, and thinking about what works (strategies): Population Turn-the-Curve Report]

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

[Guidance: a prompting question can be, "Why are things as good as they are and not worse?" Ask "why?" multiple time to a single cause to get to root causes. Try to get input about what's help at the individual, organizational, environment and policy levels. You can also include additional number data/indicators that relate to your headline indicator as part of the story of what's helping.]

- Example 1
- Example 2
- Example 3
- Example 4

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

[Guidance: a prompting question can be, "Why are things as bad as they are and getting in the way of things getting better? Try to get input about what's hurting at the individual, organizational, environment and policy levels. You can also include additional number data/indicators that relate to your headline indicator as part of the story of what's hurting.]

- Example 1
- Example 2
- Example 3
- Example 4

Partners with a Role to Play

[Guidance: Partners with a role to play in addressing this priority and contributing to improving the indicator data. These can be current partners or potential partners you would like to engage more actively. Learn about potential new partners at the County Health Rankings Partner Center.]

Partners in our Community Health Improvement Process: [Guidance: you can name and list your team structure and participating agencies in your CHIP process here or simply insert a link if you keep that information on a website. You can also link to partner websites like we have done for the WNC Healthy Impact item listed below. Confirm with your team members that they wish to be listed.]

- Partner 1

- Partner 2
- WNC Healthy Impact

Partners with a Role in Helping Our Community Do Better on This Issue: [Guidance: you can begin this list with the Whole Distance Exercise, but make sure you have asked key community partners who might not have been present for the exercise to contribute to this. Recommendation: do not list an organization/agency/individual on this public facing e-CHIP without talking with them and confirming that they would like to be listed. Offer to link to a website or publication that gives more information about partner organizations.]

- Partner 1
- Partner 2
- Partner 3

Strategies Considered & Process

[Guidance: This section will include:

- **Partner ideas of what works to do better**, based on Story Behind the Curve and Partners/Who has a role to play to do better, from a Whole Distance exercise.
- **What is currently working in your community**
- **Evidence-based strategies**
    - Include evidence-based strategies (including from CDC HI-5 Interventions, CDC Community Health Improvement Navigator, CDC 6/18 Initiative, CDC The Community Guide, County Health Rankings – What Works for Health, and Healthy People 2020 – Evidence-based resources); promising practices in the community; and/or innovative suggestions from stakeholders and residents most affected by the issue.
- **What people most affected by the issue think work**

The sample headings and text below will help organize this information.]

The following actions have been identified by our [team/coalition/partners] and community members as ideas for what can work for our community to make a difference on [name health problem].

Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on [name health problem].*

- Action/Approach 1
- Action/Approach 2
- Action/Approach 3
- Action/Approach 4
- Action/Approach 5

What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on [name health problem].*

- Action/Approach 1
- Action/Approach 2
- Action/Approach 3
- Action/Approach 4
- Action/Approach 5 [Guidance: you can insert links to websites with more information on current actions and approaches in your community]

Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on [name health problem].*

Name of Strategy Reviewed	Level of Intervention
You can insert links to websites where you learned about these interventions.	Individual, Interpersonal, Organizational, Community or Policy

[Guidance: The second column above should reflect that you considered strategies at multiple levels of the socioecological model.]

What Community Members Most Affected by [name health problem] Say *These are the actions and approaches recommended by members of our community who are most affected by [name issue]*

- Action/Approach 1
- Action/Approach 2
- Action/Approach 3

Process for Selecting Priority Strategies

[In this section, write a brief paragraph to describe how you prioritized this list to get to the selected actions listed as programs on this Scorecard. Describe process and criterion used to select 3 strategies. Criterion to consider: Can we feasibly implement a strategy? (based on resources available, community will, etc.) Is the strategy high-leverage (i.e. significant impact for small or moderate effort vs. small impact for large effort)? Does this strategy align with our community values? Can you produce a specific action for the strategy? Does the strategy address one or more of the root-causes of the issue that you uncovered in your exploration of the "Story Behind the Indicators"?] Recommended tools for selecting priority strategies: Strategy Prioritization Worksheet; Identifying Priority Strategies Worksheet.

Program/Strategies/Interventions to Address [Insert Health Problem]

P Health Issue Strategy or Strategic Area

Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

What Is It?

[Guidance: this section is an opportunity for you and your partners to tell the community what you would like them to know about this program. The sample text below includes much of the information that you will collect to complete your state action plan. This is also good place to use My RBA Elevator Speech tool to communicate what you do and demonstrate alignment with what the community is trying to accomplish as a whole.]

[Insert name of action/intervention/alignment strategy/program/evidence-based strategy] [Guidance: For the rest of this guidance when you see "**program type**," it means any of the options from this list] was identified by [group/team/coalition] as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in [name indicator] in our community. This is a [new or ongoing] program in our community.

[Guidance: If this program is ongoing, describe if current interventions are effective, and/or new intervetions are needed, and/or interventions need to be expanded to a new target population.]

The priority population/customers for this [insert program type] are [insert and describe target audience], and the [insert program type] aims to make a difference at the [individual/interpersonal behavior; organizational/policy; or environmental change] level. Implementation will take place in [describe setting for program type].

[Guidance: Describe how (if) this strategy addresses health disparities.]

Partners

The partners for this [insert program type] include:

Agency	Person	Role
		Choose: Lead, Collaborate, Support, or Represent Target Population
		Choose: Lead, Collaborate, Support, or Represent Target Population
		Choose: Lead, Collaborate, Support, or Represent Target Population

Work Plan

[Guidance: This table can be used for project management to track activities related to your project implementation, data collection/ monitoring, trainings and communications. If you already have a preferred method of project management/ tracking, then you do not need to use this table, however, you will need to write a description of your implementation and training activities in this section to meet accreditation requirements.]

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date

PM Performance Measure (select 2-5 performance measures)

Customers

[Guidance: Customers are the people whose lives are affected - for better or worse - by the actions of the program. What are the geographic areas and populations served by this program type? Who do you hope is better off because of this effort? People are "better off" when they have a change in skills/knowledge, attitude/opinion, behavior, and/or circumstance (internal or external). You can have more than one customer. Consider the following types of customers: direct vs. indirect; or internal vs. external. Recommeded RBA tool for clarifying customers: Performance Accountability Worksheet -Section B]

Customers:

- Example 1
- Example 2
- Example 3

[Guidance: To demonstrate that your CHIP will be targeted to identified at-risk groups, add a statement that describes how your identified customers reflect the underserved, at-risk and/or vulnerable populations you identified in your CHA.]

Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at that work that explain the data behind [state the performance measure] and the resources the [insert facility, agency, organization] plans to commit to address the health issue.

[Guidance: This section includes story you collect in different phases of your process: What is the story behind this curve? Why are things getting better? Or Why are things getting worse? What are the causes and forces at work that explain this performance? What else do you need to know in order to fully understand the story behind this curve? Recommded RBA tool to help you think through story behind the curve, partners, and what works: Performance Turn-the-Curve Report]

[How Much or How Well] **What's Helping What We Do?** *These are the positive forces at work in our [insert program type] that influence how much we do or how well we do it.*

- Example 1
- Example 2
- Example 3

[How Much or How Well] **What's Hurting What We Do?** *These are the negative forces at work in our [insert program type] that influence how much we do or how well we do it.*

- Example 1
- Example 2
- Example 3

[Is Anyone Better Off] **What's Helping Communities Served/Customer Change?** *These are the positive forces at work in our [insert program type] that influence customer change.*

- Example 1

- Example 2
- Example 3

[Is Anyone Better Off] **What's Hurting Communities Served/Customer Change?** *These are the negative forces at work in our [insert program type] that influence customer change.*

- Example 1
- Example 2
- Example 3

Partners

The partners for this [insert program type] include:

Agency	Person	Role
		Choose: Lead, Collaborate, Support, or Represent Target Population
		Choose: Lead, Collaborate, Support, or Represent Target Population
		Choose: Lead, Collaborate, Support, or Represent Target Population

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What Works to Do Better?

The following actions have been identified by our [insert facility/agency/organization] as ideas for what can work for this performance measure to make a difference on [name health problem].

Actions and Approaches Identified by Our [Insert Facility/Agency/Organization] *These are actions and approaches that we think can make a difference for this performance measure.*

- Action/Approach 1
- Action/Approach 2
- Action/Approach 3

No-cost and Low-cost Ideas Identified by Our [Insert Facility/Agency/Organization] *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Action/Approach 1
- Action/Approach 2
- Action/Approach 3

What your communities served/customers think would work to do better *These are actions and approaches that our communities served/customers think can make a difference for this performance measure.*

- Action/Approach 1
- Action/Approach 2
- Action/Approach 3

List of Questions/Research Agenda *These are questions to follow-up on for this performance measure. If you still need more information about what works to do better, make these questions part of your information & research agenda.*

- Question 1
- Question 2
- Question 3

Action Plan

[Guidance: After using the criteria specificity, leverage, values, and reach to choose what would work to do better, organize these actions into a plan that specifies the person responsible for each task, the start and end dates and necessary resources. Another option for your Action Plan is using the Action function in Results Scorecard to assign action items and tasks.
