

Will County MAPP Collaborative

CHNA/IPLAN Planning Checklist

2013-2014

# Community Health Needs Assessment Checklist

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|  |  | Step 1: Planning and Organizing for Success  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Review legislative requirements and any relevant changes to the CHNA process.  |  | [ ]  | [ ]  |  | Individual Hospitals |
| Review the previous CHNA Report. | The process shall result in the setting of priority health needs.The process shall include an analysis of priority problems that shall lead to the establishment of objectives and strategies for intervention. | [ ]  | [ ]  | Phase 6 Evaluation & Phase 1-5 | MAPP Collaborative – Steering Committee and Action Teams |
| Engage hospital executive leadership; secure CEO and Board commitments. | The process shall include board of health adoption of the community health plan. | [ ]  | [ ]  | Phase 1 -2, 6 | Individual Hospitals & Health Department |
| Determine who in the hospital will participate in the CHNA process.  | The process for developing an assessment of organizational capacity shall address the internal capabilities of the local health department to conduct effective public health functions, including an assessment of operational authority, community relations, information systems and program management; or an organizational strategic plan developed within the previous five years that assesses strengths, weaknesses, opportunities and threats in the local health jurisdiction. | [ ]  | [ ]  | Phase 1Phase 3 LPHSA for Health Dept. | Individual HospitalsHealth Department |
| Obtain feedback and insight from prior CHNA participants and hospital departments (e.g. patient care, mission, planning, finance and community outreach) regarding the process. |  | [ ]  | [ ]  | Phase 6 Evaluation & Phase 1 | MAPP Collaborative |
| Identify any barriers that may exist to doing the CHNA in the community. |  | [ ]  | [ ]  | Phase 6 Evaluation & Phase 1 | MAPP Collaborative |
| Determine resource needs and tools for conducting the CHNA (e.g. expertise and skills needed for each step of the process).  |  | [ ]  | [ ]  | Phase 1 | MAPP Collaborative |
| Determine and approve the CHNA budget. |  | [ ]  | [ ]  | Phase 1 | MAPP Executive Committee |
| Identify potential community partners with whom to conduct the assessment and obtain commitment (e.g. other hospital systems, public health departments, other CBOs). | The process shall involve community participation in the identification of community health problems, priority-setting, and completion of the community health needs assessment and community health plan. | [ ]  | [ ]  | Phase 6 Evaluation & Phase 1 | Specify community partnerships.  |
| Solicit public health expertise and commitment (e.g. consultant groups to assist in the CHNA process and facilitation. - *Specify public health expertise. Attach letter of commitment or contractual agreement terms).* | Community health indicators contained in the IPLAN Data System provided by the Department for assessment purposes or a similar, equally comprehensive data system developed by the local health department shall be utilized to structure the minimal content of the assessment. A local health department may use in its assessment such additional data available, describing the health of its population including natality, mortality, morbidity and risk factors for illness in its jurisdiction. | [ ]  | [ ]  | Phase 1 | MAPP Collaborative |
| Establish a timeline and dated objectives for the CHNA process (recommended at least 10 months in advance of due date *Attach timeline.*). |  | [ ]  | [ ]  | Phase 1 | MAPP Collaborative |
| Communicate and review process timeline to all identified partners and obtain consensus for its acceptance. |  | [ ]  | [ ]  | Phase 1 | MAPP Collaborative |

# Community Health Needs Assessment Checklist

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|  |  | Step 2: Defining the Community  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Establish criteria for defining the CHNA service area (keep definition consistent with other uses and how the area is defined to the community). |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Define and describe the geographical area in terms of:* Location
* Size
* Population densities
* County, cities, towns, villages
* Zip codes
 |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Create a visual map of the service area with relation to the hospital’s location. |  | [ ]  | [ ]  |  | Individual Hospitals |
| Describe the overall population demographics of the service area in terms of: * Population growth trends (births, deaths)
* Age
* Gender
* Race/Ethnicity
* Income
* Employment
* Industry
* Poverty
* Languages spoken
* Education level
 | 2.3 Description of Health Status and Health ProblemsA .Demographic and Socioeconomic Characteristicsb. General Health and Access to Carec. Maternal and Child Healthd. Chronic Diseasese. Infectious Diseasesf. Environmental, Occupational and Injury Controlg. Sentinel EventsA Community health needs assessment shall contain: A description of the health status and health problems most meaningful for the community in the data groupings designated by the Department in the IPLAN Data System. [Section 600.400(a)(2)(C)] The assessment shall, at a minimum, include an analysis of data contained in the IPLAN Data System provided by the Department for assessment purposes. [Section 600.400(a)(1)(B)] Community health indicators contained in the IPLAN Data System provided by the Department for assessment purposes or a similar, equally comprehensive data system developed by the local health department shall be utilized to structure the minimal content of the assessment. A local health department may use in its assessment such additional data available, describing the health of its population including natalitiy, mortality morbidity and risk factors for illness in its jurisdiction. [Section 600.410(a) (2)]. IPLAN Data System means a data base developed by the Department that contains the required data sets to measure community health | [ ]  | [ ]  | Phase 3 - CHSA | MAPP Collaborative & Individual Hospitals |
| Identify priority populations in the community (the historically underserved and most vulnerable) such as undocumented, refugees, homeless, migrants, and uninsured or underinsured. | A Community health needs assessment shall contain: a statement of purpose of the community health needs assessment that includes a description of how the assessment will be used to improve health in the community | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Document a community asset list of existing systems to include but not limited to:* Health care and social service providers
* Physical assets (parks, recreation areas)
* Social organizations
* Community based organizations
* Arts and cultural-based services
* Faith-based organizations

Note: the list should delineate the capacity of the existing community assets (e.g. what services exist for what population groups) Attach community asset list |  | [ ]  | [ ]  | Phase 3 CHSA & CTSA | MAPP Collaborative |

# Community Health Needs Assessment Checklist

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|  |  | Step 3: Engaging the Community  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Ask individuals who are representative of the population to join the steering committee. Steering committee members should include community stakeholders with the broad interests of the community and those with special knowledge or expertise. Representation is suggested, but not limited to, the following sectors: * Health care providers from both the hospital and greater community
* Providers and organizations working with special populations (e.g. medically underserved, low income, minority groups, homeless, immigrants)
* Leaders or representatives of populations with chronic diseases
* Health care consumer advocates
* Academic experts
* Public health experts
* Community leaders
* Community benefit organizations
* Faith based groups
* Local government officials
* School board representatives
* Managed care and health insurance organizations
* Private businesses
 | The process shall involve community participation in the identification of community health problems, priority-setting, and completion of the community health needs assessment and community health Plan (Part III). [Section 600.410(a)(1)] The assessment shall include community participation in the health needs assessment process in order to facilitate the identification of community health problems and the setting of priorities from among those health problems. [Section 600.400(a) (1) (C)]. Community Participation is defined as involvement by representatives of various community interests and groups. Examples of such interests or groups are ethnic and racial groups, the medical community, mental health and social service organizations, the cooperative extension service, schools, law enforcement organizations, voluntary organizations, the clergy, the business community, economic development agencies, unions, disabled persons and senior citizens.) [Section 600.110]a. Committee Members Names, Affiliationsb. Description of Committee’s Process- A Community health needs assessment shall contain: A description of the community participation process, a list of community groups involved in the process. [Section 600.400(a)(2)(B)] | [ ]  | [ ]  | Phase 6 – EvaluationPhase 1  | MAPP Collaborative |
| Invite potential members of the steering committee to an introductory meeting, where they are introduced to the CHNA planning team and identified public health or community partners. Potential members should be given the opportunity to ask questions about the process and the scope of their participation.  |  | [ ]  | [ ]  | Phase 6 – EvaluationPhase 1 | MAPP Collaborative |
| Give potential members a written list of activities, expectations, roles and responsibilities for their membership. Have each member sign a letter of commitment, thus forming the steering committee. (Keep a file of all member contracts) |  | [ ]  | [ ]  | Phase 6 – EvaluationPhase 1 | MAPP Collaborative |
| Generate a matrix or list of steering committee names, titles, affiliations, and what sector each represents. Delineate relevant area of expertise if applicable. (Attach list or matrix of the steering committee) |  | [ ]  | [ ]  | Phase 6 EvaluationPhase 1 | MAPP Collaborative |

# Community Health Needs Assessment Checklist

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|  |  | Step 4: Defining the CHNA Mission, Vision and Values  |
| IRS Checklist Items | IPLAN Checklist Items | Yes | No | MAPP Phases | Responsible Parties |
| In collaboration with the steering committee, define the purpose of the CHNA and its scope (mission).  |  | [ ]  | [ ]  | Phase 2  | MAPP Collaborative |
| In collaboration with the steering committee, define what the future would look like if the mission is fulfilled (vision).  |  | [ ]  | [ ]  | Phase 2 | MAPP Collaborative |
| In collaboration with the steering committee, define shared principles to guide the process and interactions with the community (values).  |  | [ ]  | [ ]  | Phase 2 | MAPP Collaborative |
| Vote on and adopt the CHNA mission, vision and values. Attach approved mission, vision and values (dated). |  | [ ]  | [ ]  | Phase 2 | MAPP Collaborative & Individual Hospitals |

# Community Health Needs Assessment Checklist

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|  |  | Step 5: Developing the Community Health Profile  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Identify federal, regional, state or local health departments or other agencies with current data that can be used in the CHNA. |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Select and define indicators needed. Suggested indicator categories include, but are not limited to:* Environmental health (physical environment, built environment, environmental quality)
* Social/Economic factors
* Clinical care data (capacity, access, utilization)
* Maternal and child health indicators
* Health outcomes (morbidity & mortality)
* Health behaviors (e.g. tobacco use, diet, exercise, alcohol/drug use, unsafe sex, etc.)
* Chronic disease prevalence, risk and protective factors
* Infectious disease prevalence, risk and protective factors
* Violence, Injury and Substance Abuse indicators
 |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Determine a data source (archival or secondary) for each indicator at the smallest possible meaningful level for the community.  |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Identify existing national, state and/or local benchmarks for indicators (e.g. Healthy People)  |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Solicit steering committee input and feedback on indicators and potential data sources.  |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Create a master data table that includes columns for each indicator, its definition, data source(s), and at what level (e.g. state, zip code, census tract) data can be obtained. Attach master data table. |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Compile all data, creating tables, graphs and charts for each indicator.  |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| Summarize key findings.  |  |  |  |  |  |
| Present the community health profile to the steering committee. Attach community health profile. |  | [ ]  | [ ]  | Phase 3 – CHSA | MAPP Collaborative |
| In conjunction with the steering committee, identify trends and gaps in the community health profile to be addressed in the community input phase.  |  | [ ]  | [ ]  | Phase 3Phase 4 | MAPP Collaborative |

# Community Health Needs Assessment Checklist

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|  |  | Step 6: Gathering Community Input  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Research and develop assessment methodologies based on gaps in secondary data and the specifics of the community geography. |  | [ ]  | [ ]  | Phase 1 & 3(CTSA, LPHSA, & FOCA) | MAPP Collaborative |
| Locate and obtain any existing community input data (e.g. from partner agencies or organizations) |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Identify priority populations from which to obtain data (e.g. physicians, faith-leaders, uninsured). |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Determine any cultural or language considerations for data collection.  |  | [ ]  | [ ]  | Phase 1 & 3 | MAPP Collaborative |
| Develop quantitative methodology tools (e.g. survey) and a distribution plan. Attach quantitative data collection tool. |  | [ ]  | [ ]  | Phase 1 & 3 | MAPP Collaborative |
| Determine qualitative methodology (e.g. interviews, focus groups, photovoice) and plan. Attach qualitative data tools. |  | [ ]  | [ ]  | Phase 1 & 3 | MAPP Collaborative |
| Delineate system and partner resources to collect data.  |  | [ ]  | [ ]  | Phase 1 & 3 | MAPP Collaborative |
| Create a timeline for gathering and obtaining community input.  |  | [ ]  | [ ]  | Phase 1 & 3 | MAPP Collaborative |
| Secure commitments for data collection (e.g. dates of focus groups, partners to distribute surveys, etc.) |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Collect community input data.  |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |

# Community Health Needs Assessment Checklist

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|  |  | Step 7: Synthesizing and Analyzing Assessment Data  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Develop charts and graphs to communicate community input findings. |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Create narrative reports for qualitative and quantitative data. |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Present community input data to steering committee for feedback and insight. |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Compare/Contrast input data with health profile data. |  | [ ]  | [ ]  | Phase 3 | MAPP Collaborative |
| Highlight disparities and/or indicators with levels exceeding target benchmarks.  |  | [ ]  | [ ]  | Phase 3Phase 4 | MAPP Collaborative |
| Discuss key findings, trends and patterns to help identify possible causal factors.  |  | [ ]  | [ ]  | Phase 4  | MAPP Collaborative |
| Determine if any additional information or analysis is needed and set a plan for doing so.  |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| Generate a community input report. Data should be presented to the community in a meaningful and accessible way that can be understood broadly (i.e. using tables, graphs, maps, pictures; using non-technical language; available in multiple languages if applicable; in both paper and electronic formats). Attach community input report. |  | [ ]  | [ ]  | Phase 4 |  |

# Community Health Needs Assessment Checklist

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|  |  | Step 8: Identifying and Prioritizing Community Health Needs  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Select a methodology and prioritization criteria for identifying major community health needs.  | 2.4 Prioritizationa. Process Used in Selecting Prioritiesb. Minimum of 3 Priorities SelectedCommunity health needs shall be identified during the community health needs assessment process based on the analysis of data describing the health of the population and on the judgment of the community participants concerning the seriousness of the health problems and needs. Prioritization shall result in the establishment of at least three priority health needs. [Section 600.400(a)(1)(D)] A community health needs assessment shall contain: A description of the process and outcomes of setting priorities. [Section 600.400(a)(2)(D)] The process shall result in the setting of priority health needs. [Section 600.410(a)(3)] | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| Establish who will be a part of prioritizing needs. |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| With the steering committee, identify a list of cross cutting and strategic issues from which to select community health needs.  |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| Validate each list item’s belongingness on the list with applicable health profile and community input data.  |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| Apply prioritization criteria/methodology.  |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| Define 3-5 priority community health issues. List priority issues |  | [ ]  | [ ]  | Phase 4 | . MAPP Collaborative |
| Determine if any issues (e.g. health literacy, socio-economics) will be integrated across all priority issues identified. If so, note rationale. |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |
| Delineate a rationale for why other health needs on the list were not selected.  |  | [ ]  | [ ]  | Phase 4 | MAPP Collaborative |

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|  |  | Step 9: Creating High Level Action Plans  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Create preliminary action teams for each health need identified, and designate at least one steering committee representative to be a member for each team. List action teams and steering committee representative/liaison for each. |  | [ ]  | [ ]  | Phase 5 | MAPP Collaborative |
| Build each action team (ideally 10-12 members) by inviting others with requisite experience and expertise for the health issue identified.  |  | [ ]  | [ ]  | Phase 5 | MAPP Collaborative |
| Communicate roles and responsibilities to action team members and secure commitment. Attach action team member list, contact information, affiliation, and area of expertise (if applicable). |  | [ ]  | [ ]  | Phase 5 | MAPP Collaborative |
| Delineate timeline and expectations for deliverables.  |  | [ ]  | [ ]  | Phase 5 | MAPP Collaborative |
| Identify co-chairs for each action team, one internal (hospital staff) and one external (community member). Attach master list of action co-chairs and contact information. |  | [ ]  | [ ]  | Phase 5 | MAPP Collaborative |
| Develop measurable goals and SMART objectives for health priorities. Attached completed implementation plan templates. | Priorities (Minimum of 3)a. Description of Priority Health Issue- why priority was selected- importance of health problem- data priority is based on- relationship of priority to Healthy People 2010 **(2020)**Healthy People 2010 refer to the National Health Promotion and Disease Prevention Objectives, US Dept of Health and Human Services, Public Health Service. Healthy People 2010 contain a national strategy for significantly improving the health of the nation during this decade and contains measurable targets for striving toward health promotion and prevention of injuries and disease. [Section 600.110] 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 2010 National Health Objectives and…b. Analysis of Priority- identification of population group(s) at risk- risk factors- direct contributing factors- indirect contributing factors…subsequent revisions and factors influencing the level of problem (e.g. risk factors, contributing and indirect contributing factors.) [Section 600.400(d)(5)(C)] The process shall include an analysis of priority problems that shall lead to the establishment of objectives and strategies for intervention. [Section 600.410(a)(4)] Contributing factor means a scientifically established factor that directly affects the level of a risk factor. Indirect contributing factor means a community-specific factor that directly affects the level of the direct contributing factors. These factors can vary greatly from community to community. Risk factor means a scientifically established factor (determinant) that relates directly to the level of a health problem. A health problem IPLAN Category Other Items NeededMAPP Componentsmay have any number of risk factors identified for it. [Section 600.110]c. Measurable Outcome Objective(s)At least one measurable outcome objective covering a five-year time frame related to each priority health need. [Section 600.400(d)(5)(D)] Outcome Objective means a goal for the level to which a health problem should be reduced. An outcome objective is long term and measurable. [Section 600.110]d. Measurable Impact Objective (s)At least one measurable impact objective related to each outcome objective. [Section 600.400(d)(5)(E)] Impact Objective means a goal for the level to which a health problem should be reduced. An impact objective is intermediate in length of time and measurable. [Section 600.110]e. Proven Intervention Strategy(ies)- community resources that will contribute toimplementation- estimated funding needed for implementation- anticipated sources of fundingAt least one proven intervention strategy to address each impact objective. The description should include a discussion of: Community Resources that will contribute to implementation, estimated funding needed for implementation, and anticipated sources of funding. [Section 600.400(d)(5)(F)] A Proven Intervention Strategy means an intervention strategy demonstrated to be effective or used as a national model. [Section 600.110 | [ ]  | [ ]  | Phase 5 | MAPP Collaborative |
| Identify and research best practice interventions.  |  | [ ]  | [ ]  | Phase 5 & 6 | MAPP Collaborative |
| Communicate action plans to overall steering committee and obtain feedback.  |  | [ ]  | [ ]  | Phase 5 & 6 | MAPP Collaborative |
| Solicit Board (or authorized hospital governing party) approval of action plans. Attach proof and date of approval. | Documentation of Board of Health Adoption of Community PlanThe process shall include board of health adoption of the community health plan. [Section 600.410(a)(5)] | [ ]  | [ ]  | Phase 5 & 6 | MAPP CollaborativeHospitalsHealth Department  |
| Adopt implementation plan and make available to community members and stakeholders.  |  | [ ]  | [ ]  | Phase 5 & 6 | Hospitals & MAPP Collaborative |

# Community Health Needs Assessment Checklist

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|  |  | Step 10: Developing the CHNA Report  |
| IRS Checklist Items | **IPLAN Checklist Items** | **Yes** | **No** | **MAPP Phases** | Responsible Parties |
| Develop the CHNA Report. It should include: * Definition and map of the community
* Methodology and timeline of process
* Summary of community engagement (dates, locations, names and affiliations of attendees for all steering committee meetings held)
* The community health profile
* The community input report
* Selection process for identifying priority health needs
* Action teams for selected health issues
* Implementation plans
* Contact information for questions, comments and any other feedback
 | The local health department shall submit the community health plan to the Department. It shall include:* Statement of Purpose – purpose of the health plan and how the plan will be used to improve the health of the community.
* Community Participation - Process used to complete the Community Health Plan
* Priorities (Minimum of 3)
* Description of Priority Health Issue
* Analysis of priority
* Measurable Outcome Objectives
* Measurable Impact Objectives
* Proven Intervention Strategies
 | [ ]  | [ ]  | Phase 5 & 6 | Individual HospitalsHealth Department |
| Present CHNA report to steering committee for feedback.  | Documentation of the Board of Health Adoption of the Community Plan | [ ]  | [ ]  | Phase 5 & 6 | Individual HospitalsHealth Department |
| Finalize CHNA report.  |  | [ ]  | [ ]  |  | Individual Hospitals |
| Present CHNA report to hospital CEO, executive leadership and the Board of Directors. |  | [ ]  | [ ]  |  | Individual HospitalsHealth Department |
| Disseminate the CHNA Report and make it widely available. Data should be presented to the community in a meaningful and accessible way that can be understood broadly (i.e. using tables, graphs, maps, pictures; using non-technical language; available in multiple languages if applicable; in both paper and electronic formats). |  | [ ]  | [ ]  |  | Individual HospitalsHealth Department |
| Submit CHNA report in compliance with federal legislative requirements. |  | [ ]  | [ ]  |  | Hospitals |