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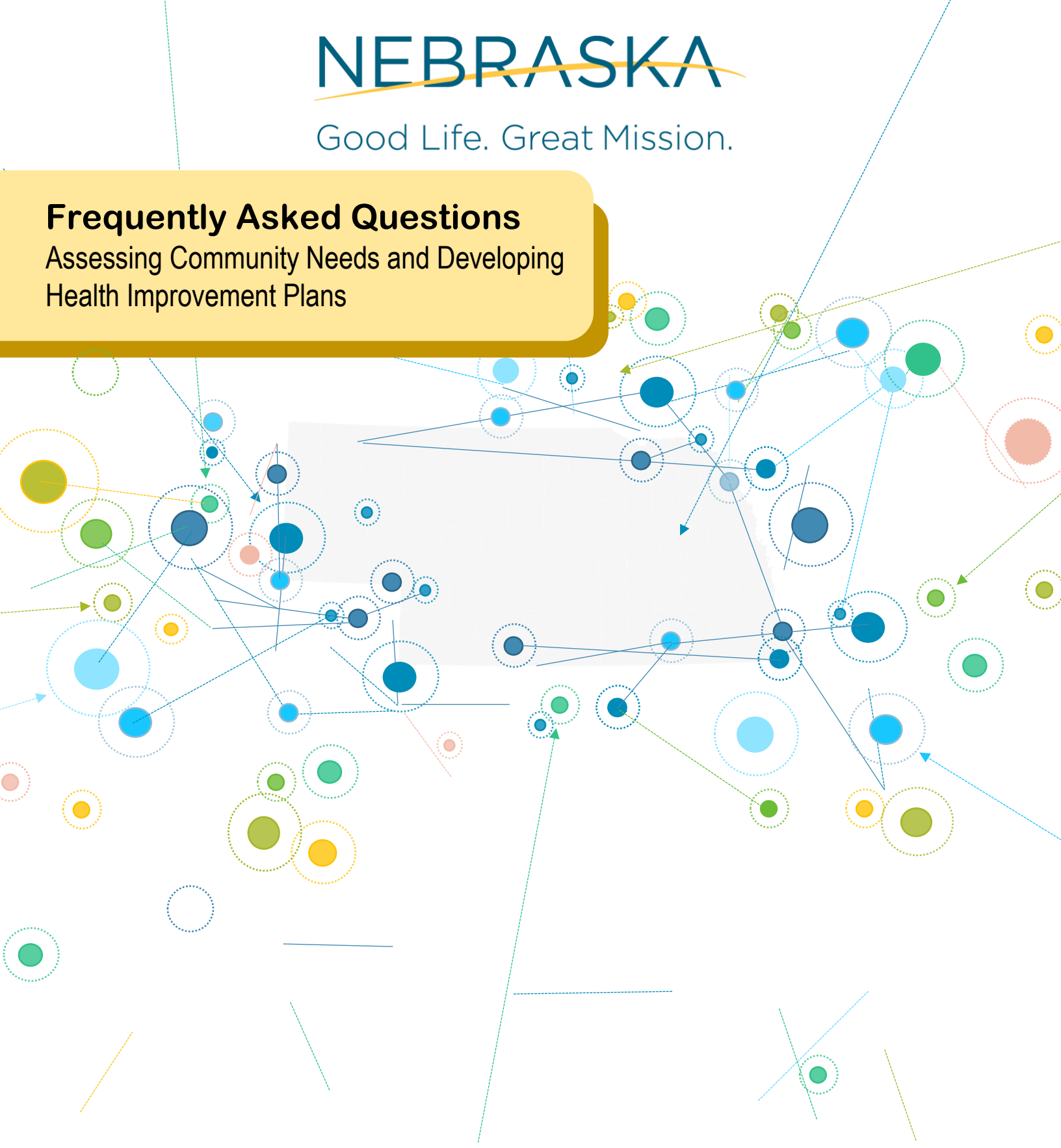
Frequently Asked Questions

Assessing Community Needs and Developing Health Improvement Plans



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Partners for Insightful Evaluation

MERC

GIS & Human Dimensions Evaluation and Consulting

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Contents

Purpose

This document includes guidance and resources on common questions that Nebraska tribal and local health departments (T/LHDs) may have when doing their Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHIP). Although it is written with the CHA/CHIP in mind, and therefore generally targeted toward T/LHDs, it may be beneficial for other organizations doing community needs assessments and planning.

Responses based on existing resources and feedback obtained from LHDs, tribal entities, the Nebraska Department of Health and Human Services (NDHHS) Division of Public Health, and other key partners. The goal is to help organizations and communities tailor their assessments and strategic planning based on resources, staffing, and other considerations. Additional information is shared through links in this document and the Resource Inventory, a supplemental document offering more in-depth information on specific topics. For questions about this document, please contact Niki.Kubiak@nebraska.gov.

Getting Started

Q: Why do a CHA and CHIP?

A: A community Health Assessment (CHA) tells the community story and provides a foundation to improve the health of the population. It is the basis for priority setting, planning, program development, policy changes, coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population. A health assessment identifies disparities among different subpopulations in the jurisdiction, and the factors that contribute to them, in order to support the community's efforts to achieve health equity. Data within the CHA may include information about mortality and morbidity, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), social determinants of health, community narrative, assets, and stories. Data should be obtained from a variety of sources, using various data collection methods.

A CHA differs from a statistical report in that it is developed collaboratively and with the purpose of using data collected to draw conclusions about the health status, challenges, and assets of the population served in order to inform the prioritization of policies, strategies, and interventions. As such, this process requires not only the collection but also the interpretation of data to inform plans and decision-making, in terms easily understood by its target audience – community members and stakeholders.

A community health improvement plan (CHIP) is a plan that outlines the priorities and actions necessary to address the health needs of a specific community or population. The Community Toolbox explains that the CHIP model is desirable for the following reasons:

- It takes a community perspective
- It's inclusive and participatory
- It demands a comprehensive view of health
- It sees equity as a key
- It's flexible
- It builds in accountability

- It builds in performance monitoring
- It can incorporate or fit in with other models
- It sees the process as ongoing and long-term

Q: I've never done this before – where do I start?

A: Nebraska T/LHDs generally follow a formal process for doing their CHA and CHIP. The process (and any modifications to it) typically depends on the resources available. To start getting oriented to CHAs/CHIPs:

1. Most people assigned to work on CHA/CHIP efforts in Nebraska **start by reading through previous reports** or documents from their organization. That provides context on what has been done in the past.
2. Review what **processes** could be used. See question about What process should we use to learn more.
3. Use free resources. A common one, especially for those looking to build capacity for doing CHAs/CHIPs, is the **Community Toolbox website** through the University of Kansas. Other resources are referenced throughout this FAQ and the Resource Inventory.
4. **Connect with Public Health Performance Improvement Network (phPIN), other LHDs, tribal entities, and community organizations who do needs assessments**. Many are willing to share ideas and approaches for their CHA/CHIP. The Nebraska Association of Local Health Directors (NALHD) and the Office of Public Health Practice, College of Public Health at the University of Nebraska Medical Center (UNMC) are great resources for learning more about the CHA/CHIP and finding existing tools or templates.

Q: How long does it take to complete a CHA/CHIP?

A: This varies based on what process is used and other factors, such as capacity and deadlines related to public health and/or hospital accreditation. The **full MAPP process takes about two years if implemented in its entirety**. However, it may be appropriate to modify or condense some aspects to shorten that duration. Most Nebraska LHDs modify it to best meet their needs (see question about modifying the MAPP for specific suggestions).

A **handful of Nebraska T/LHDs mentioned they have been able to get their process down to about six months**. Those tend to be organizations that build upon previous CHAs/CHIPs so they aren't starting from scratch. The compiling, collecting, analyzing, and summarizing of the CHA data is often what takes the longest for T/LHDs. One way to streamline that is to view the CHA as a continuous data collection process, which is what Lincoln-Lancaster County Health Department reported (in 2023): *"We currently track about 90 plus indicators in [our] county, so we wanted to create a continuous CHA. Data is dynamic, it doesn't work in decades or half a decade timescales, so that's one of the things that we are working on."* For some T/LHDs, this means collecting data through different assessments over time or capturing it from the same data source on a quarterly or annual basis.

Once the CHA is completed, the CHIP is developed. Most T/LHDs in Nebraska noted that the CHIP planning process takes place over a series of two or three meetings with community stakeholders, which can typically be done within a month or two. The CHIP generally outlines

activities and goals that can be carried out for the next three to five years, though some LHDs consider efforts beyond that time frame to impact their priorities more effectively.

Q: How frequently do I need to do the CHA/CHIP?

A: Although PHAB requires CHAs/CHIPs to be done every five years, many Nebraska LHDs align with their local hospital(s) for efficiency and collaboration purposes. That generally means that LHDs use a three-year cycle to match the hospital accreditation requirements and partner closely with hospital staff, which enhances the capacity to carry out the CHA/CHIP. In 2023, the South Heartland District Health Department, however, noted they do a full CHA every six years and a mini-CHA at the halfway point. The full CHA includes more comprehensive data collection while the mini-CHA focuses on specific topic area (such as health equity or focus groups with populations that were missed in the community survey during the full CHA). Some LHDs are also transitioning to using their CHA to make updates to their CHIP so they do not have to start from scratch with developing their plan.

Q: What process should we use?

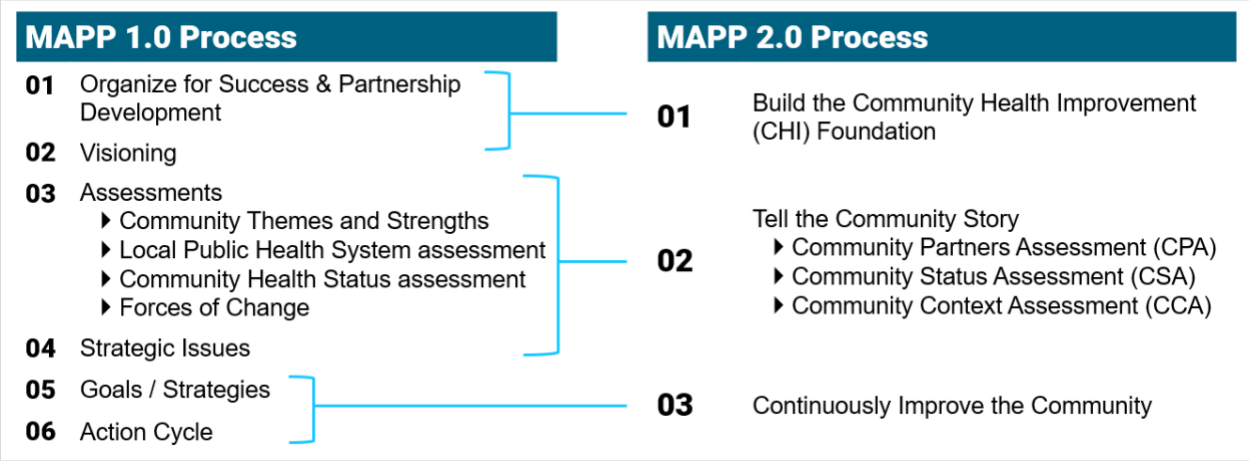
A: The process(es) you use depends on a variety of factors. Many Nebraska LHDs use the MAPP (Mobilizing for Action through Planning and Partnerships) framework. The National Association of County and City Health Officials (NACCHO) created the MAPP and launched an updated version (MAPP 2.0) in 2023 (see question about how the MAPP has changed to learn more). At least one Nebraska LHD noted that the MAPP process can be easy to understand but difficult to do in practice because it takes a lot of planning and effort. While most LHDs use the MAPP, PHAB does not require a specific framework or approach. Because of that, tribal entities and LHDs may use or modify any evidence-based processes. Some of those processes include:

Evidence-Based Process	Notes About Process
Planned Approach to Community Health (PATCH Model)	This model, developed by CDC, contains five phases, including 1) community participation and coalition development; 2) data collection; 3) problem identification and priority setting; 4) strategy or intervention planning; and 5) evaluation.
Community Health Assessment aNd Group Evaluation (CHANGE) Tool	This is another model from CDC. It involved eight steps and is estimated to take 3-5 months to complete.
Indian Community Health Profile Project Toolkit	This guide is design to assist tribal health departments or entities through a process for assessing their overall community health status. It has been used by a tribal entity in Nebraska.
Community Health Assessment Toolkit	This guide was developed by the American Hospital Association and provides nine steps for hospitals and health systems to collaborate when conducting the CHA/CHIP.

If your health department is seeking national accreditation through PHAB, it is important to make sure that your process meets the standards and measures for the CHA and CHIP: Version 2022 Measure 1.1.1 A, 1.1.2 A, 5.2.1 A, 5.2.2 A, and 5.2.3 A.

Q: How has the MAPP framework changed?

A: A brief description of MAPP 2.0 and how it differs from earlier iterations is available here, though the key change is that it is more streamlined. The original process had six phases, which were condensed into three (see figure below) and one of the stand-alone assessments was integrated into the other three. It also has an increased emphasis on community engagement, assessment, and health equity. The original framework included a Health Equity Supplement. In MAPP 2.0, health inequity, social determinants of health, root causes of health inequity, and optimal health are imbedded in Phases 2 and 3.



Q: We want to use the MAPP, but how can we modify the process to make it work for us?

A: Many organizations may not have the time or capacity needed to carry out MAPP 2.0 in its entirety. If that is the case, then health departments may decide to use a different process or approach. They may also decide to use the MAPP framework as a resource for how to do specific elements of a CHA/CHIP process. Because this is an evidence-based approach, there is no recommendation for how to change it.

For those pursuing accreditation/reaccreditation, it is important to ensure that what you include in the process meets PHAB standards and measures for CHA and CHIP. (Reference: Version 2022 Measure 1.1.1 A, 1.1.2 A, 5.2.1 A, 5.2.2 A, and 5.2.3 A.)

Based on input from Nebraska LHDs and tribal entities, the following MAPP steps are essential to the CHA/CHIP process:

- **Phase 1, Step 3 – Engage and Orient the Steering Committee.** Many T/LHDs noted that having a steering committee to guide the overall CHA/CHIP process helped to ensure strong buy-in from partners and ultimately the community.
- **Phase 2, Step 3 – Do the Assessments.** The Community Status Assessment in particular is valuable for the CHIP process: *"Unless we hear from what the community's telling us, we're aiming in the dark. So it's just very important for us to get a pulse on the community's health status."*
- **Phase 2, Step 4.3 – Organize Summary Data from the Assessment into Cross-Cutting Themes.** Nebraska T/LHDs noted that examining the themes related to social determinants of health (SDOH) was especially important.

- **Phase 2, Step 6 – Share Findings.** *"Presenting the data, not only to our staff but also to the community so that we could engage them to demonstrate what some of the areas of improvement can be and allowing them to be a part of that whole process."*
- **Phase 3, Step 1.1 – Review Issue Profiles and Determine Whom to Involve.** Having a variety of stakeholders involved in the decision-making process helps ensure there is consensus and buy-in on what the priorities will be and how they will be measured.

Q: Should we bring in outside help? If so, from whom and for what?

A: Given how complex and involved the CHA/CHIP process is, many Nebraska LHDs and tribal entities use contractors for different components of the project. This is typically based on:

1. Whether staff have the skillsets needed
2. How much staff time is available
3. To what degree staff have access to necessary data; and
4. Who is best to present and facilitate community conversations.

When contractors or consultants are used, it is often for collecting and analyzing data for the CHA and/or facilitating meetings to develop the CHIP. Below are common services that may be helpful. If you are looking for agencies who provide those services, reach out to Niki.Kubiak@nebraska.gov.

Type of Service	What They Do
Data Collectors	Create and implement data collection tools. This includes: ✓ Developing surveys ✓ Formatting and collecting surveys online, on paper, over the phone, or in person ✓ Developing interview or focus group protocols ✓ Conducting interviews and focus groups ✓ Obtaining lists of contacts to send survey to a representative group of people in the counties you want to assess This may also include the development of transcripts for interviews and focus groups
Data Analysts	Conduct analyses of quantitative (numbers) and qualitative (words) data. As part of this process, data analysts: ✓ Assess data quality ✓ Clean the data for analysis ✓ Analyze the data ✓ Interpret the results of the data. In some cases, data analysts may also help with the data collection.
Facilitators	Provide expertise in facilitating meetings or events. Facilitators often: ✓ Set agendas ✓ Act as a moderator ✓ Lead/facilitate discussions ✓ Keep everyone focused on the topic ✓ Encourage participation among all participants ✓ Help bring differing perspectives together ✓ Document and summarize the key points from the discussion
Evaluators	Assess processes and/or the impact of activities, programs, and interventions. This is often done through: ✓ Creating an evaluation plan

	✓ Proposing evaluation questions and data sources ✓ Collecting and analyzing data ✓ Summarizing findings from all data ✓ Making recommendations as appropriate.
Consultants/ Technical Assistance Providers	There are organizations that can assist with all the above or provide general guidance and/or support with your CHA/CHIP. They may provide recommendations on how to effectively carry out the project given the needs and capacity of your organization or community.

Q: Who should we partner with to do this well?

A: The CHA/CHIP is meant to be a community-driven process, and the people and agencies who should be involved will likely be specific to your community or service area. Various resources include lists of organizations that may be beneficial to include. For example:

- The Community Toolbox includes an outline to help you in creating partnerships.
- The MAPP 2.0 Handbook includes a Stakeholder Wheel (pg. 69) and a Stakeholder Brainstorm Toolkit (pg. 68) to help you identify partners you may have not already considered. There are seven general categories.
    - **Government**, including elected officials, state agencies, tribal nations, and other health departments.
    - **Organizations and Coalitions**, which could include nonprofits or community groups that focus on topics such as cancer, diabetes, or health equity.
    - **Business and Industry**, such as health insurance, agricultural, and professional associations.
    - **Healthcare**, including hospitals, community health centers, rehabilitation facilities, nursing homes, emergency medical services, and healthcare providers.
    - **Education**, which may include public schools, private schools, higher education, trade schools, and teachers.
    - **Complementary service providers**, such as parks and recreation, philanthropy, and public safety.
    - **Community Services**, and organizations that serve vulnerable populations such as Hispanics, Asians, African Americans, LGBTQIA+, undocumented immigrants, and those experiencing homelessness.
- The MAPP 2.0 supplemental tools also include a Starting Point Assessment, which has a series of questions to consider who should be involved.

While reviewing the list of recommended partners, determine who might be missing. It is also important to include members who have expertise in relevant social determinants of health. In addition to considering how you can best represent the community as a whole, one Nebraska LHD noted they think about who is influential: *"For us, if we can get our hospital CEO at the table, others will follow because they're there."*

Among Nebraska LHDs and tribal entities, two types of key partners have specifically been identified for CHA/CHIP efforts, particularly to help ensure alignment and sustainability:

1. **Local hospitals**. Many Nebraska LHDs align with the local hospital(s) for efficiency and collaboration purposes. Often they work closely with hospital staff, which enhances the capacity to carry out the CHA/CHIP.

    a. It may also be helpful to connect with the Rural Nebraska Health Association and/or the Nebraska Hospital Association for more information on hospitals and opportunities for alignment or partnership building.
2. **Community organizations representing key populations.** This includes a range of community-based organizations, which may include cultural centers or nonprofits.
    a. There may also be an opportunity to align assessments happening within those organizations to improve efficiencies. As an example, Public Health Solutions partnered with Blue Valley Community Action in 2023 to carry out the CHA to streamline data collection.

Another key consideration is **working with tribal entities**. It is possible to build upon existent collaborations where trust and relationships have been developing in the last few years. Current collaboration efforts exist in Nebraska between non-tribal LHDs and tribal communities, including a LHD and a Tribal organization which have been engaged through their respective CHIP processes (reported in 2023), and Society of Care, a trauma-informed initiative of the Santee Sioux Nation delivering behavioral health services through Morningstar Counseling & Consultation (https://www.morningstar-counseling.com/), traditional healing, training, and supportive services provided with cultural humility to self-identified Native American youth, families and communities located on reservations, rural, and urban areas throughout Nebraska.

See the Resource Inventory (pages 4-5) for additional information on working with partners.

Q: How do I effectively coordinate the CHA/CHIP process?

A: The first step is ensuring that there is **strong internal infrastructure within the T/LHD**. This means having good support from the staff, board, and leadership: *"It makes the process ten times harder when you don't have that buy-in."* Many also assign a point person within the organization to lead the CHA/CHIP effort (often in conjunction with any accreditation efforts if applicable) though for many LHDs, it becomes an all-hands-on-deck project. That is particularly the case for data collection efforts and the CHIP planning sessions.

Most Nebraska T/LHDs also noted that it was important to **have steering committees**. The CHA/CHIP is meant to be a community-driven process and having steering committees (one for CHA and one for CHIP) with key stakeholders from the community ensures that there is more ownership among partners. It also helps ensure there is more effective outreach when collecting data for the CHA and identifying priorities and activities for the CHIP. This can be complemented by an accreditation committee (if applicable) within the T/LHD to ensure there's alignment between the national standards and measures and CHA/CHIP efforts.

Data for Community Health Assessments

Q: Where can I get existing data?

A: Existing data – known as secondary data – means the information is collected by another organization. Secondary data is usually free or low cost and may already be analyzed for you. Local level data is often the hardest to find, as many data sources are only available at the regional, state, or national level. However, even if you find a data source that is not available at the county level, it may be available at the local health departmental level or it may be possible to combine the data across multiple counties.

You can access this information from websites or by contacting these organizations directly. For example, you can request data directly from NDHHS (see question about partnering with state agencies to get community level data) or some Nebraska T/LHDs also noted they work with local hospitals and clinics to get aggregate data from their electronic health records (EHRs). The table below has some common websites that provide access to data, dashboards, and/or reports with data available at a county or regional level. One recommendation is to start by reviewing data from the County Health Rankings. These rankings are based on a variety of national and state data sources and provide an overview of how Nebraska counties compare to one another. Please note that the Resource Inventory (pages 7-9 and Appendix A) offers more detailed information about these data sources and aggregators, as well as *many* others, including instructions on how to use the websites to gather information.

Data Source/Site	Website URL
County Health Rankings & Roadmap	https://www.countyhealthrankings.org/
American Community Survey (ACS)	https://www.census.gov/programs-surveys/acs
Behavioral Risk Factor Surveillance System (BRFSS) local-level information	https://www.cdc.gov/places/ or https://dhhs.ne.gov/Pages/Nebraska-Public-Health-Atlas.aspx
Kids Count	https://datacenter.kidscount.org/
mySidewalk	https://www.mysidewalk.com/
Nebraska Opportunity Map	https://www.neopportunitymap.org/
Nebraska Risk and Protective Factor Student Survey	https://bosr.unl.edu/projects/sharp/nrpfss/
Nebraska Vital Statistics	https://dhhs.ne.gov/Pages/Vital-Statistics.aspx
Web-based Injury Statistics Query and Reporting System (WISQARS™)	https://www.cdc.gov/injury/wisqars/index.html

Q: How can we partner with state agencies to get community level data?

A: Data can be requested from most state agencies by contacting them. Although it may vary by agency or program, it is typically best to request data as soon as you know you need the data to begin the request process with the state. While some programs have specific forms to complete, a good starting point for obtaining NDHHS data is to email dhhs.publicrecords@nebraska.gov. To obtain data from the Nebraska Department of Education (NDE) – complete this form: https://nep.education.ne.gov/request.html. The Resource Inventory (page 10 and Appendix B) provides additional information and includes a data use agreement example.

Q: Why aren't we able to get some secondary data for our community or service area?

A: Even if you request data from an entity or find a source that has local level data available, information may not be available for your specific community or service area. In reports or dashboards, this may be indicated by an asterisk (*) or footnote. This is typically because when there is not enough data or the data is from a small community, it can be unethical to share it publicly. This is primarily due to issues with:

- **Confidentiality**. When collecting data, the people who participate are often assured of confidentiality, meaning their responses cannot be traced back to them. In a small community, it can be easier to identify who the data is from, so the data is only released at a regional or state level to protect their confidentiality.
- **Representation**. If you end up having data from only a small number of people from an area or from a certain group, it may be used to make inaccurate conclusions.

While you may not have data available for the specific geographic area you are hoping for, you can look for data that covers a larger geographic area. For example, if data isn't available for one county, you may see if it is available for a group of counties combined, or your local health department level. Another potential option for some datasets is accessing county-level data that is combined across years, which allows for the number of people to increase. The Resource Inventory (pages 28-29) includes additional guidance for how to deal with small populations.

Q: Do we need to collect our own data?

A: Not necessarily, though most T/LHDs in Nebraska do because of how vital community-level data and feedback is. Collecting primary data allows T/LHDs to better understand the population by hearing directly from community members on topics that are pertinent at the local level. In addition, both primary (data collected by you) and secondary (data collected by others) data is required to meet national standards and measures. It also gives a more well-rounded view of a community or service area. It's typically best to collect data on information you already have doesn't answer your question (either because it doesn't exist, isn't accessible, or doesn't provide the level of detail you need) or there is additional information you would like to know. For example:

- You may have data about various health conditions or health status from BRFSS or YRBS, but it would be helpful to know community member attitudes about priorities.
- BRFSS or YRBS data may indicate that a certain health condition is a problem, but you want to know what the root cause is to better understand how to prevent or address it.
- You may have data on a topic of interest available at the state level, but you may want to collect data on that topic with a representative sample of people within your service area to better understand local needs.

If you decide to collect and analyze your own data, the Resource Inventory (pages 12-39) provides detailed information on this topic.

Q: We know we need to collect data, but how do we decide what method (surveys, interviews, focus groups, etc.)?

A: Although collecting your own data takes time, money, and expertise, there are many options to meet different levels of resources. Nebraska LHDs and tribal entities utilize a variety of data

collection methods when carrying out their CHAs, including surveys (online, mail, phone), focus groups, and key informant interviews. How you collect data generally depends on the types of questions you want to ask and the resources available. The Resource Inventory (pages 12-15) provides details on the pros and cons of each approach, but below are some general considerations.

	Survey	Interview	Focus Group
If you want to generalize across a population	✓		
If you want to go in depth (explain "why")		✓	✓
Large # of participants	✓		
Small # of participants		✓	✓
Limited time	✓		✓
Limited funding	✓		
Complex information		✓	✓

It is also important to keep in mind that if you are collecting data, you do not need to start from scratch. There are many tools available related to CHAs/CHIPs (see Community Toolbox), or you can take advantage of resources like the NALHD Qualtrics Library, which includes pre-built surveys. The MAPP 2.0 file package also includes supplemental resources, and their Community Status Assessment guide lists indicators for different issues (pages 37-42).

Q: How do we successfully implement our data collection efforts (surveys, interviews, focus groups, etc.)?

A: Gathering data can be a challenge, especially when trying to collect data from the general public. As one Nebraska LHD explained, *"We do press releases and we continually put it on our Facebook page and we have our staff email people and our community partners, we have them help solicit responses; but just getting people to take the survey is always a challenge."* Employing best practices, such as using surveys that are a reasonable length, collecting data from a representative sample by using a sample frame and sending reminders, using incentives, and have tools in multiple languages are a few ways to address challenges in collecting data. The Resource Inventory (pages 15-21) and Community Toolbox provide additional information about best practices for data collection, including guidance on how to ensure high quality data is collected.

Q: How do we ensure our data represents our community or service area?

A: Since you cannot realistically get data from every person in your community or service area, it is important to find ways to collect or analyze data so that it can be as reflective of your population as possible. This allows your community to make more informed decisions about the problems and priorities that should be addressed through the CHIP.

The first step is understanding what your population looks like, including subpopulations. One Nebraska LHD stressed that some subpopulations may be specific to a service area, and it is important to have that context when knowing what type of data to collect or analyze. As an example, a tribal elder may be defined or viewed as someone 55 and older rather than 65 and older, so data may need to be gathered or analyzed differently to reflect that distinction.

To help ensure data represents your community or service area:

- If you are collecting your own data, aim to **get data from different groups and demographics within your community**. Some Nebraska LHDs and tribal entities feel that it can be challenging to collect data from some sub-groups. Lincoln-Lancaster County Health Department reported in 2023 that they addressed this challenge by doing a minority oversample of their community health survey, enlisting the help of cultural centers, having their data collection tools available in multiple languages, and conducting focus group in multiple languages. The Resource Inventory (pages 15-18) includes additional suggestions for how to best obtain data from various groups.
- If you collected data that is not reflective of the population, you can **use a process called data weighting**. This means that you are balancing out the representation of groups that are underrepresented or overrepresented within the data to make your results more representative of your community or service area. For example, if 90% of those who completed your survey were white women, but they only make up 30% of your community's population, you could use weighting to ensure their voice is not overrepresented. Refer to the Resource Inventory (page 30) for more information.

Q: How can we look at our data to identify key differences or disparities?

A: When exploring disparities, it is important to learn 1) where there are differences; 2) the magnitude of those disparities; and 3) why they might be occurring. To do that effectively, your organization may need to look at multiple measures and/or sources, as you likely cannot identify that information through just one measure. Quantitative data (numbers) can be used to compare health outcomes between populations (which could be by sex, age, race/ethnicity, education level, etc.) or different geographic areas. This is done by looking for differences between groups that are statistically significant – meaning that we are confident that the difference is likely not due to random chance. Qualitative data can also help explore disparities, particularly related to the potential causes.

In addition to looking at common demographics, it is also important to explore Social Determinants of Health (SDOH). SDOH are about the environments people live in, including their economic, physical, social, and service conditions - such as what they have access to, who they interact with, and how they are supported by social systems. Healthy People 2030 organizes them into five domains:

1. Economic Stability
2. Education Access and Quality
3. Healthcare Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

These domains (and the Healthy People 2030 resources) can be used to organize objectives and/or consider what optimal health would look like within each domain. The Community Status Assessment in the MAPP 2.0 outlines the way SDOH affects one's community. To understand if SDOH are experienced differently in a community, you should collect data about different groups and compare them. Doing this may look different, depending on the community. For example, indigenous communities often perceive health as a holistic concept that encompasses not only physical well-being but also mental, emotional, and spiritual health, reflecting their

deep-rooted cultural traditions and connections to the land. This holistic perspective aligns closely with the understanding of SDOH, which recognizes the broader societal and environmental factors influencing well-being. Indigenous communities have endured historical traumas such as residential schools, land seizures, and suppression of cultural practices, resulting in intergenerational impacts on mental, emotional, and spiritual health. Recognizing and acknowledging these unique historical and social contexts within SDOH is essential for developing culturally informed health practices that encompass and respect these perspectives.

A common challenge among LHDs is having a service area that covers multiple counties, so it's not uncommon to *"have a pretty wide variety of issues among our counties."* To address this, some LHDs identify differences between their counties. Some Nebraska LHDs even separate out their CHAs and/or CHIPs by county and have county-level CHAs and/or CHIPs. LHDs that produce county-level CHAs and/or CHIPs, may also produce a CHA/CHIP for the LHD area, which identifies both differences and similarities across counties within their LHD.

The Resource Inventory (page 31) includes additional information on analyses by different groups, as well as general information on data analysis including a summary of tools that can be used (pages 22-39).

Q: We've gotten all our data compiled – now what?

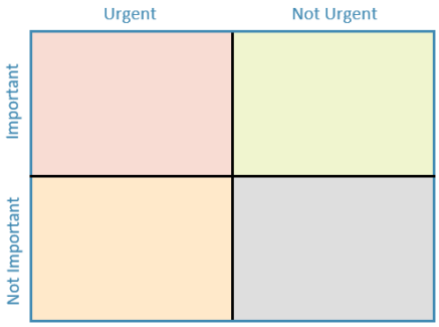
A: Sharing the results of the CHA is crucial, primarily because that data should be used by partners who represent the community to select priorities for their local area. While the Resource Inventory (page 43) offers additional guidance and examples for sharing your CHA, there are two key things to keep in mind:

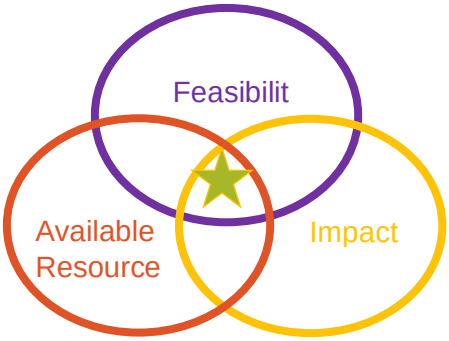
- **Know your audience.** Presenting results or providing progress updates within a tribal entity may look different, for example considering cultural sensitivities (e.g. sacred spaces and rituals; respect for elders and traditional leaders; linguistic preferences), and traditional communication channels. Tribal communities often prioritize consensus-building and collective decision-making. Therefore, involving community members in the interpretation of CHA results and the selection of priorities is essential. Data may also need to be simplified or sufficiently explained, as some individuals may not be as comfortable with or experienced in interpreting statistics.
- **The need for transparency**. Any report or presentation should include a section that describes what data was used, including sample sizes, response rates, demographics of respondents, limitations on data interpretations, and even an appendix with the survey tool or other materials for reference.

Developing & Implementing Your Plan

Q: How do we choose priorities?

A: The **first thing to do when identifying priorities is to review the results from the CHA**. The data – and particularly the information collected from community members – can help provide a sense for what the key priorities should be. A variety of processes can be used to select priorities. For example:





- Tools like the Eisenhower Matrix (see image) can guide decisions using limited resources based on importance and how urgent the topic is.
- Other processes encourage communities to consider what can be addressed (feasibility), where there are resources, and what will have the greatest impact (see image).
- The Evidence Based Public Health approach goes a step further to consider current research and evidence based practices in addition to resources and population characteristics, needs, and preferences.
- Common methods include simple voting by the stakeholders involved, group discussion, and ranking/weighing methods. These are outlined in the Resource Inventory (page 40-41 and Appendix B) and in the Prioritization Guide developed for NDHHS to select health status priorities for the State Health Improvement Plan (SHIP).

Each priority selection method comes with benefits and challenges, so using multiple approaches can be helpful to maximize benefits and minimize costs if time and resources allow. The MAPP 2.0 Handbook (starting on page 136) and Community Toolbox both describe ways to choose priorities that best serve the needs of the community.

When selecting priorities, Nebraska T/LHDs also noted that it's important to consider…

- **Who should facilitate the selection of priorities.** Many T/LHDs hire someone external to facilitate the discussion so that they can 1) participate rather than lead the discussion and 2) further emphasize it's meant to be a community plan, not a T/LHD plan.
- **How many priorities are appropriate**. PHAB requires that at least two priorities are selected and, on average, Nebraska T/LHDs select four. Some T/LHDs are shifting to focus on fewer priorities to narrow their focus and hopefully have a bigger impact.
- **Who is involved in the selection process.** The goal for this is to include partners who reflect the broader community. It is especially important to include partners of underrepresented groups, particularly if there is a goal of improving health equity.

Q: How do we keep the CHIP realistic?

A: CHIPs generally cover activities for a three-to-five-year time period, so it is important to keep the action items and outcomes realistic. Given many of the priorities identified by Nebraska T/LHDs are relatively broad and difficult to tackle, there are various approaches communities could take to keep the CHIP realistic:

- **Limit the number of priorities**. Some Nebraska T/LHDs are narrowing their CHIPs to only address one to three priorities, and in doing so they noted it's best to ultimately select ones that *"are tangibly reportable on"* so they can monitor progress.
- **Rethink the timeframe for CHIP priorities**. Often the priorities selected for the CHIP are complex problems that cannot be adequately addressed within a 3-to-5-year CHIP cycle. Rather than starting from scratch every 3-5 years, communities could set priorities that they would commit to working on for 10 or more years. To meet the 3-5 year CHIP requirement, partners could reconvene every 3 – 5 years to review progress and updated CHA data to reconfirm the priorities and/or add any emergent issues.
- **Identify priorities and outcomes that can be measured.** This means ensuring that data is available to track your progress, which was a challenge many Nebraska LHDs noted with their previous priorities.
- **Develop a logic model for key priorities.** This allows your community to think through the short, medium, and long-term outcomes for the CHIP time period.

Q: How do we keep people engaged?

A: Many T/LHDs in Nebraska find it challenging to keep people engaged with the CHIP implementation, in part since partners may feel the T/LHD should be the one to lead or carry out the CHIP. Various approaches may work for different communities and for different entities:

- **Have a variety of community partners involved in CHIP implementation**. At least two Nebraska LHDs noted that having a broader workgroup for implementation helps keep things moving forward. Often the key partners – such as hospitals – end up having other priorities that take them away from CHIP efforts. There should be *"partner ownership in addition to community ownership."*
- **Provide project management or facilitation training**. Offer opportunities for partners and stakeholders to enhance their skills and better understand project management and facilitation efforts. This may help keep partners involved and give them a better understanding of how to implement CHIP efforts.
- **Identify and recruit implementation teams/leaders.** While it helps to have a variety of partners involved, there are individuals who will need to lead and coordinate efforts to keep efforts moving forward. Ideally it's helpful to find individuals who are not only committed to the work, but can potentially do the work as part of their job. This can make it more likely that the work will be carried out.
- **Set expectations from the start**. While working on CHIP efforts may be part of your role with a T/LHD, that may not be the case for your partners. Clarifying roles and responsibilities upfront helps partners see where they fit in the process. One method to help figure out different levels of expected

CHIP Priority 1 RACI Chart				
	T/LHD Staff #1	T/LHD Staff #2	Partner #1	Partner #2
Task 1	R	A	I	C
Task 2	R	I	A	R
Task 3	C	A	R	I
Task 4	A	R	I	R

engagement is a RACI chart. RACI stands for **R**esponsible, **A**ccountable, **C**onsulted, and **I**nformed. The image shows how you might use one to identify who does the work (responsible), who makes sure the work gets done (accountable), who should provide feedback (consulted), and those who primarily receive updates (informed). Partners can be engaged at different levels, and a RACI chart (or similar project management tool) can help.

- **Coordinate funding with partners to support implementation.** Leveraging funds from a variety of partners can help people feel more committed to carrying out the work – particularly if it directly relates to their organizational priorities. That could mean providing resources to partnering organizations, or having those organizations financially support the implementation efforts.
- **Use the CHA/CHIP to help organizations identify or set funding priorities.** Particularly if there are limited resources to carry out CHIP activities, having set priorities and goal can help organizations look for new funding opportunities. Nebraska T/LHDs felt a benefit of doing the CHA/CHIP is knowing what funding to seek out, which could also pertain to other organizations. *"For example, hospitals can divert their investments based on the needs in the community."*
- **Meet regularly with the steering committee**. One tribal entity noted they meet quarterly to show what changes are happening and to keep all partners updated. To further keep people engaged, they have different partners present at each meeting to ensure they stay engaged.

Q: How do we share our CHIP and progress made as we implement it?

A: What you share and how may depend on the needs of your organization as well as the resources available. The PHAB Standard & Measures for Reaccreditation includes guidance on data and progress sharing. The MAPP 2.0 Handbook recommends several methods of sharing the results of a CHA/CHIP (starting on page 129). If possible, an online data dashboard is best, but information could also be shared on a webpage or through various documents (such as a report, executive summary, or fact sheet). You can also utilize partners to share the CHA/CHIP and any related updates. Nebraska T/LHDs have also found effective ways to share out the CHA/CHIP efforts:

- Turn some of the key milestones – such as submitting the application for reaccreditation or completing the CHA/CHIP – into a community event. That can help the community rally around the effort and remind partners that it's not just a T/LHD priority or activity.
- Do a presentation to the community when the process is finished. It's also presented to any board of directors/board of health.

Q: How do we integrate sustainability as we're implementing the plan?

A: There is a planning and monitoring approach described in the MAPP 2.0 handbook to ensure the progress of your CHA/CHIP is sustainable. This approach, referred to as action planning, is explained in detail in Step 7 under "Develop Continuous Quality Improvement Action Planning Cycles".

- Action planning follows a plan-do-study-act cycle (page 158) that monitors progress towards objectives and goals, while also allowing for modifications as needed.
- Within this cycle, the SMARTIE (Specific, Measurable, Achievable, Relevant, Timebound, Inclusive, Equitable) method is used to create objectives that result in

successful completion of a goal. The MAPP 2.0 Handbook describes what to include in SMARTIE objectives (page 159) and provides a worksheet to help you lay out goals that will support the achievement of each priority issue (page 161).

- Once SMARTIE objectives are set, develop a logic model to identify the pieces of your plan and determine what can be tracked to measure the outcomes. Having short-, intermediate-, and long-term metrics in place creates more opportunities to assess and adjust to keep progress moving forward. For guidance on developing a logic model for each goal, select the link to Worksheet 3 titled "Measuring What Matters in Public Health" (page 162) in the MAPP 2.0 Handbook.
- Next, use the logic models you created to determine how you will evaluate your progress by tracking the short-, intermediate, and long-term outcomes. Create a central document to track implementation activities. Make it accessible to partners who will have their own implementation activities and outcome data to report. The MAPP 2.0 Handbook has a list of indicators for tracking (page 163) that you could refer to when creating your own evaluation.
- The final step is to develop the action plan. This plan translates your objectives into specific activities that you and your partners will carry out. The MAPP 2.0 Handbook provides a comprehensive 90-180 day Implementation worksheet (page 163) to help you organize this process. As objectives are carried out, use the established outcome metrics to monitor progress over time. Use the plan-do-study-act cycle to make adjustments as needed to keep the progress of your CHA/CHIP moving forward.

There is not just one way to make sure your CHA/CHIP is sustainable, but most methods point to having specific and measurable goals, regular reassessments and evaluations, continuous data collection, and consistent input from partners and stakeholders to address obstacles and narrow objectives to focus your resources. Other available tools that outline these strategies for sustainability are listed below:

- The MAPP 2.0 emphasizes the importance of forming relationships by engaging the appropriate stakeholders. Nebraska T/LHDs noted having a community team that works on the process with the health department is essential for not only developing the CHA, but also creating a sustainable CHIP. In time, this may create sustainability through alignment of priorities and leveraging funds among partnering agencies.
- The Community Toolbox includes a detailed section on planning for sustainability which includes a wealth of information. Marketing to secure financial support, using different funding strategies, and utilizing existing resources are just a few of the methods listed in this section.
- The Program Sustainability Assessment Tool (PSAT) developed by the Center for Public Health Systems Science can be a useful resource to refer to when assessing and factoring in the sustainability of the CHA/CHIP. This tool recommends evaluating capacity every 3-5 years to identify what is feasible to maintain. It is okay to eliminate elements of your program that are no longer pointed towards future goals. It is also okay to build off existing program goals and objectives that are working, instead of starting over with a new program every time you do a reassessment.