

Instructions for Completing the Community Health Action Plan Form

The *Community Health Action Plan* form was initially developed for local health departments and other local community agencies to describe plans for health activities supported by programs in the NC Division of Public Health. It is recognized that many of the programs implemented locally now are supported by funding from other sources. The form should adequately capture implementation information about those programs as well. Local public health departments and community partners are encouraged to focus interventions toward achieving selected objectives that will have a significant impact on the identified needs of the community.

The local public health department is required to select three of the community health priorities identified in the CHA report and develop action plans for each. At least two of the three selected community health priorities must be from the 13 Healthy North Carolina 2020 (HNC 2020) focus areas. Those Action Plans corresponding to the HNC 2020 focus areas shall include, at a minimum, two new evidence-based strategies (EBS) per Action Plan or expand current EBS to new target populations. The EBS shall be identified in the Action Plan and shall include a plan for staffing, training, implementation, and monitoring and evaluation for each EBS. The three Action Plans are due by the first Monday in September following the March submission of the CHA.

When and Where to Submit the Action Plan Documents

The due date for *Community Health Action Plans* is **the first Monday in September following the March submission of the CHA**. It is preferred that the form be sent as an email attachment to Beth Murray at beth.murray@dhhs.nc.gov.

If your agency **can not** submit the Community Health Action Plan forms for review via email attachment, the forms may be mailed on CD/jump drive or as a printed copy to:

Beth Murray
Department of Health and Human Services Division
of Public Health
Local Technical Assistance and Training Branch 5605
Six Forks Road
1916 Mail Service Center
Raleigh, NC 27699-1916

General Guidance

- LTAT is committed to annually updating the *Community Health Action Plan* form and making it available on the NC Division of Public Health website: <http://publichealth.nc.gov/lhd/cha/resources.htm>
- Agencies must use the Community Health Action Plan form in submitting the required number of plans for review.
- The Local Health Department shall submit a total of three action plans. Two of the three action plans should address two different focus areas from Healthy North Carolina 2020. These action plans should include a minimum of two new evidence-based strategies/interventions or expand current evidence-based strategies/interventions to new target populations. It is also acceptable to submit one new and one expanded intervention.
- A separate Community Health Action Plan form should be completed for each of the three action plans in order to support a thorough planning process addressing each health priority.
- For each priority area, review the *Healthy NC 2020 Focus Areas*. Choose one or two of the focus areas that best fit with the chosen priority. These Focus Areas are listed on the form along with a link to the complete *Healthy North Carolina 2020: A Better State of Health* document. Go to the web link and click on the chosen focus area(s) to pick a NC Healthy 2020 Objective that aligns with the chosen priority. Picking the NC Healthy 2020 Objective is the first step toward identifying appropriate strategies/interventions for meeting that goal.

- The Community Health Action Plan review is not meant to provide an all-inclusive look at the county's efforts to implement change but rather to provide feedback about the process used to: create and utilize resources, involve partners and community members, engage policy leaders, evaluate intervention outcomes and provoke movement toward attaining a healthy community.
- Contact the regional Public Health Nursing and Professional Development Unit (PHNPDU) Nurse Consultant assigned to the county with any questions regarding the form or process. The nurse consultant map can be found at: <http://publichealth.nc.gov/lhd/cha/contacts.htm>

Resources for Evidence Based Interventions/Strategies:

- **NC DPH**- Visit "Healthy North Carolina 2020: A Better State of Health" at the following link: <http://publichealth.nc.gov/hnc2020/foesummary.htm>
- Please note the column title *Evidence-Based Strategy*. For each objective there will be a hyperlink "Details". Click onto the hyperlink beside the objective you are interested in and a pdf file will appear on the topic.
- **Population Health Improvement Partners** - "Evidence-Based Resources and Measures": <https://www.improvepartners.org/>
- **Population Health Improvement Partners** - IMAP tool: <https://www.improvepartners.org/imapp/>
- **Population Health Improvement Partners**
 - Laura Edwards RN, MPA serves as Senior Vice President for Strategic Initiatives. She guides DPH efforts to implement the EBS Task Force recommendations and also engages diverse agencies and organizations in the creation of strategic partnerships to organize progress towards meeting the HNC 2020 goals. She is also available to offer education, training, technical assistance and promote access to EBS and HNC 2020 data and information. Email contact: ledwards@improvepartners.org
 - Donna Albertone MS, LPC, CCD serves as the Sr. Director of Organization and Community Development. In her role, she works to build community support and identify diversified sources of support, including a focus on public-private partnerships. This position also works to influence funds to provide community grants to develop the capacity of local leadership to use evidence-based strategies. Email contact: dalbertone@improvepartners.org
 - Joanne Rinker, MS, RD, CDE, LDN, Sr. Director for Community Health Improvement. This role will staff the process to design, implement, and evaluate EBS Trainings and to launch NCIMAPP. Email contact: jrinker@improvepartners.org
- **North Carolina Institute of Medicine**- "Improving North Carolina's Health: Applying Evidence for Success" recommendations http://www.nciom.org/wp-content/uploads/2012/10/EvidenceBased_100912web.pdf

Community Health Action Plan Form with Text Field Specific Instructions:

In order to assist you in completing the form the following sample Community Health Action Plan form was created with the instructions specific to each field embedded into that field. Please use these instructions as a guide as you complete the required Community Health Action Plans for your area. In the actual Community Health Action Plan form, the gray boxes will expand as you type the required information into each field. If you have questions please call your PHNPDU Nurse Consultant.

Insert County Logo Here

Community Health Action Plan 20__ (insert the year the CHA was due)

The local public health department is required to select three of the community health priorities identified in the CHA report and develop action plans for each. At least two of the three selected community health priorities must be from the 13 Healthy North Carolina 2020 (HNC 2020) focus areas. Action Plans corresponding to the HNC 2020 focus areas shall include, at a minimum, two new evidence-based strategies (EBS) per Action Plan or expand current EBS to new target populations. The EBS shall be identified in the Action Plan and shall include a plan for staffing, training, implementation, and monitoring and evaluation for each EBS. The three Action Plans are due by the first Monday in September following the March submission of the CHA, *per consolidated agreement*.

County: Name of County

Period Covered: CHA Calendar Year

Partnership/Health Steering Committee, if applicable: Name of group that spearheaded or partnered with the health department in creating the Community Health Action Plans.

Community Health Priority identified during the most recent CHA for this action plan:

List one priority per Community Health Action Plan form

Local Community Objective: (Working description/name of community objective)

(check one): First time effort New Continuation from previous action plan Ongoing

- **Baseline Data:** *(State measure/numerical value. Include date and source of current information):* Include the data from the 2015 Community Health Assessment that supports this objective.
- **For continuing objective provide the updated information:** *(State measure/numerical value. Include date and source of current information):* Provide the data used to determine this objective is a continuing health need.
- **Healthy NC 2020 Objective** that most closely aligns with focus area chosen below: Go to the Healthy NC 2020 web link and open the focus area chosen below. Pick an objective that most closely aligns with the community objective and include it here.

Population(s)

- I. **Describe the local population at risk for health problems related to this local community objective:** *Describe the local target population that will be impacted by this community objective. Examples of factors placing populations at risk for disparities include race, ethnicity, gender, age, income, insurance status, and geographical location. For example, "There are 20,000 Montreal County citizens who are addicted to drugs. 42% are white, 39% are black, 12% are Hispanic and 7% are "other." 64% are single women under the age of 30 with each of these women averaging 3.5 children. This is concerning given the potential negative social, economic and health impact on these women and their families."*
 - A. **Total number of persons in the target population specific to this action plan:** This is the total number of persons in the at risk population specific to this local community objective.
 - B. **Total number of persons in the target population to be reached by this action plan:** This is the number of persons this intervention is intended to reach/serve.
 - C. **Calculate the impact of this action plan:**
(Total # in B divided by total # in A) X 100% = (b/a x 100 = n%) of the target population reached by the action plan.)

Healthy North Carolina 2020 Focus Area Addressed

Pick the corresponding *Healthy NC 2020* focus area that aligns with your local community objective presented in this Community Health Action Plan.

■ Check below the applicable Healthy NC 2020 focus area for this action plan.

For more detailed information and explanation of each focus area, please visit the following websites:

<http://publichealth.nc.gov/hnc2020/foesummary.htm>

<http://publichealth.nc.gov/hnc2020/>

- | | | |
|---|---|--|
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Maternal & Infant Health | <input type="checkbox"/> Social Determinants of Health |
| <input type="checkbox"/> Physical Activity & Nutrition | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Environmental Health |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Chronic Disease |
| <input type="checkbox"/> Sexually Transmitted Diseases/Unintended pregnancy | <input type="checkbox"/> Infectious Disease/Foodborne Illness | <input type="checkbox"/> Cross-cutting |
| | <input type="checkbox"/> Oral Health | |

Selection of Strategy/Intervention Table

- Complete this table for all strategies/interventions that you **plan to implement**.
- The local public health department is required to select three of the community health priorities identified in the CHA report and develop action plans for each. At least two of the three selected community health priorities must be from the 13 Healthy North Carolina 2020 (HNC 2020) focus areas. Action Plans corresponding to the HNC 2020 focus areas shall include, at a minimum, two new evidence-based strategies (EBS) per Action Plan or expand current EBS to new target populations. The EBS shall be identified in the Action Plan and shall include a plan for staffing, training, implementation, and monitoring and evaluation for each EBS. (Insert rows as needed if you choose more than 2 EBS.)

Strategy/Intervention(s)	Strategy/Intervention Goal(s)	Implementation Venue(s)	Resources Utilized/Needed for Implementation
Name of Intervention: Community Strengths/Assets:	S.M.A.R.T Goals:	Target Population(s): Venue:	Resources Needed:
Name of Intervention: Community Strengths/Assets:	S.M.A.R.T Goals:	Target Population(s): Venue:	Resources Needed:

Interventions Specifically Addressing Chosen Health Priority

<p><u>INTERVENTIONS: SETTING, & TIMEFRAME</u></p>	<p><u>LEVEL OF INTERVENTION CHANGE</u></p>	<p><u>COMMUNITY PARTNERS' Roles and Responsibilities</u></p>	<p><u>PLAN HOW YOU WILL EVALUATE EFFECTIVENESS</u></p>
<p>Intervention: Name of Intervention</p> <p>New Ongoing Completed (As indicated previously.)</p> <p>Setting: Same as venue above.</p> <p>Target population: Same as population above.</p> <p>New Target Population: Y N</p> <p>Start Date – End Date (mm/yy): See Timeframe above.</p> <p>Targets health disparities: Y N A health outcome seen to a greater or lesser extent between populations is a disparity. It can be racial, economic, ethnic, regional, etc.</p>	<p>Individual/Interpersonal Behavior The intervention is aimed at changing something about individual persons or their behavior.</p> <p>Organizational/Policy The intervention is aimed at changing the practices of an organization or an organizational policy.</p> <p>Environmental Change The intervention is aimed at changing something within the community's environment.</p>	<p>Lead Agency: May be the health department or another community agency.</p> <p>Role: The task(s) specific to the lead agency.</p> <p>New partner Established partner</p> <p>Target population representative: Name of culturally or ethnically appropriate representative or advocate.</p> <p>Role: Task(s) specific to the target population representative.</p> <p>New partner Established partner</p> <p>Partner: Agency representative or other interested community member</p> <p>Role: Tasks specific to the agency representative or community member.</p> <p>New partner Established partner</p> <p>Repeat partner information until all partners have been identified. Examples of partner roles include but are not limited to funder, community advocate, surge capacity, policy advocate, planning member, implementation, etc.</p> <p>How will you market the intervention: This can be described as a partner role or the lead agency. Include the means by which you will advertise and promote the evidenced based intervention to the community.</p>	<p>Expected outcomes: Explain how this intervention will help meet the community objective chosen to address the CHA health priority.</p> <p>Anticipated barriers: Any potential barriers? Y N If yes, explain how intervention will be adapted:</p> <p>List anticipated intervention team members: List intervention team member(s) and the agency they represent.</p> <p>Do intervention team members need additional training? Y N If yes, list training plan: Indicate how the team members will be trained to carry out the intervention.</p> <p>Quantify what you will do: Here are a few examples of how to count (quantify) what you are doing: How many intervention participants do you plan to include in your EBS? How many events will occur? What is the number of products that will be produced?</p> <p>List how agency will monitor intervention activities and feedback from participants/stakeholders: Describe safeguards or tools for assuring that intervention activities are provided as planned and that participant and team member comments and concerns are documented.</p> <p>Evaluation: Please provide plan for evaluating intervention: Describe the tools that will be utilized to evaluate the effectiveness of the intervention. Evaluation resources can <u>be found at these links</u>. http://www.centerforhealthync.org/ http://www.cdc.gov/eval/resources/</p>