Item Number	PHAB Reference	Measure	Scale	Documentation/Interpretation
General				
1	1.1.2T/L	Community health assessment (CHA) has been conducted within the past five years.	Yes=4; No=0	A document that includes components of a CHA which is dated within the past five years. CHA is defined as the collection and analysis of community health data. If there is any evidence of data collection and analysis, score YES on this item.
2	5.2.2L	Community health improvement plan (CHIP) has been conducted within the past five years.	Yes=4; No=0	A document that includes components of a CHIP which is dated within the past five years. CHIP is defined as identification of health priorities, objectives, implementation plans, evidence of implementation, and an ongoing evaluation or monitoring plan. If any of the above elements are present, score YES on this item.
3	5.2.2L	The CHIP acknowledges state and national priorities.	Yes=4; No=0	There is some evidence that the CHA/CHIP has acknowledged or thought about the National Prevention Strategy, Healthy People 2010/2020, or state health plan priorities (if available). Consider what was the prevailing national/state document at the time the CHA/CHIP were written. Evidence can include common priorities between the local CHIP and the state or national documents OR a discussion of the consideration of the priorities within the state and federal plans.

4	5.2.1L+	A formal model, local model, or parts of several models are used to guide the CHIPP.	Yes=4; No=0	The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), and the University of Kansas Community Toolbox. Examples of tools or resources that can be adapted or used include NACCHO's Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, Healthy People 2020, County Health Rankings & Roadmaps Action Center, and state health plans (if available).
Work Together				

5	1.1.1T/L+	The health department and other sectors participate in a local/tribal partnership/group to develop a comprehensive CHA of the population served by the health department. These participants are known as stakeholders throughout the remainder of this tool.	0=Public Health (PH) Only and/or No representation of populations that are at higher health risks or have poorer health outcomes (Hi Risk); 1=PH&Hi Risk + 1 other sector; 2=PH&Hi Risk + 2 other sectors; 3=PH&Hi Risk + 3 other sectors; 4=PH&Hi Risk + 4 or more other sector	**Representation of populations that are at higher health risk or have poorer health outcomes should be included** (Individual community members or leaders from organizations that represent these populations, such as a Black Health Coalition, Hmong Association, or other appropriate groups)**.**The collaboration must include various sectors of the community, as appropriate for the community: for example: **Public health** (local and/or state public health agencies); **Health care** (hospitals, clinics, individual health care providers, FQHCs, mental health, dental health); **Local government** (for example elected officials, law enforcement, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, etc.); **For profits** (for example, businesses, industries, and major employers in the community); **Not for profits** (for example, chamber of commerce, civic groups, local Childhood and Women's Death Review organizations, public health institutes, environmental public health groups, groups that represent minority health, etc.); **Community foundations and philanthropists; Education** (academic institutions, K-12 schools, early childhood providers); **Faith-based organizations** (Leaders of houses of worship, Faith at Work, prison ministries, etc.); **Representatives of the state health department and of Tribal health departments** in the health department's jurisdiction.

6	5.2.1L	Broad participation of stakeholders continues and/or exists in the CHIP phase.	0=Public Health (PH) Only and/or No representation of populations that are at higher health risks or have poorer health outcomes (Hi Risk); 1=PH&Hi Risk + 1 other sector; 2=PH&Hi Risk + 2 other sectors; 3=PH&Hi Risk + 3 other sectors; 4=PH&Hi Risk + 4 or more other sector	Stakeholders are defined as persons who serve on a governance or working committee for the CHA or CHIP and/or who work on the implementation of the CHIP. Members of this group may or may not be the same as members of the community health assessment partnership, but the same scale for representation of sectors is used for both the CHA and CHIP phase of the process. Documentation could be, for example, participant lists, attendance rosters, minutes,or membership lists for work groups or subcommittees.

7	None	The stakeholders define a purpose, mission, vision, and/or core values for the CHA and/or CHIP process.	Yes=4; No=0	There is evidence that the stakeholders have clearly defined and collaboratively built consensus about the purpose of the CHA and/or CHIP. Evidence may include a statement of purpose, mission, vision, and/or core values in the CHA or CHIP document or related documents provided by the steering committee. Answer NO if this statement is the purpose, mission, vision, and/or core values of the Health Department, unless it is clear that the stakeholder group has reaffirmed this as the guiding theme for the CHA/CHIP.
8	1.1.2T/L & 5.2.1L	The local community at large has had the opportunity to review and comment on the CHA &/or CHIP.	Feedback was sought and there is evidence it was included in the CHA &/or CHIP=4; Feedback was sought, but not clear how it was used=2; No evidence of seeking feedback=0	There is evidence that feedback was sought and included in the CHA &/or CHIP. Methods to seek this feedback include publishing in the local press with comment or feedback forms, publication on the department website with a comment form, community/town forums, listening sessions, newsletters, discussions or presentations at other organizations' meetings, etc.

9	4.1.1A	Documentation of current collaborations that address specific public health issues or populations.	1 comprehensive partnership that addresses at least 4 health issues or participation in 4 issue-specific coalitions=4;
			
			participation in 3 issue-specific coalitions=3;
			
			participation in 2 issue-specific coalitions=2;
			
			participation in 1 issue-specific coalition=1;
			
			No participation in partnerships or coalitions=0
				The CHA/CHIP or associated documents must document a current, ongoing comprehensive community partnership or coalition with a purpose to improve the health of the community and, therefore, must be engaged in at least four various issues and initiatives. This partnership or coalition may be the same group that developed the community health assessment and community health improvement plan. Alternatively, the health departments must document their involvement in several current ongoing partnerships or coalitions that address specific public health issues.

10	4.2.1A	Engage with members of the community that may be affected by policies and/or strategies proposed in your Community Health Assessment & Improvement Plan.	2 or more examples (at least one with community members) from 2 different policy areas=4; 2 or more examples, but they are either both from the same policy area or neither includes community members=3; 1 example (with community members or people who work directly with them)=2; 1 example that does not include people who are directly affected by the issue=1; no examples=0	The CHA/CHIP or associated documents provide at least two examples of engagement with a particular population that will be affected by a policy or strategy. The focus of this measure is engaging with community members or people who work directly with community members. At least one of the examples must include engagement with community members. The two examples must be from two different health focus or policy areas.

11	4.2.2A	Engage with governing entities, advisory boards, and elected officials that may influence policies or strategies proposed in your Community Health Assessment & Improvement Plan.	2 or more examples in 2 different priority areas=4; 1 example or multiple examples in 1 priority area=2; no examples=0	The CHA/CHIP or associated documents provide at least two examples of educating and/or working with any collaborative member's governing entity, advisory board, and/or elected officials on public health policy or strategy. The two examples must address two different priorities.
12	None	Seek feedback from your stakeholders on what has gone well and/or areas for improvement with the CHA-CHIP process.	Yes=4; No=0	There is evidence that feedback on the CHIPP process was gathered from the stakeholders.
13	None	There is evidence of a democratic or consensus building process among stakeholders.	Yes=4; No=0	There is evidence of a democratic or consensus building process in the operation of the stakeholder group. Examples would include discussion and voting on priorities, action plans, operational issues in the governing/stakeholder group.

Assess Needs & Resources				
14	1.1.2T/L	A variety of data sources are used to describe the community.	4 or more source categories=4; 3 source categories=3; 2 source categories=2; 1 source category=1; no source categories=0	Sources of data in the CHA/CHIP may include 1) federal, state, local, or tribal data, 2) hospitals and health care data, 3) local schools, 4) academic institutions, 5) other governmental data (e.g. recreation, public safety), 6) community non-profits, 7) surveys, 8) asset mapping, 9) focus groups, town hall forums or listening sessions, or 10) other data sources such as the *County Health Rankings*
15	1.1.2T/L	Demographic data are described.	4 or more areas=4; 3 or more areas=3; 2 or more areas=2; 1 area=1; no demographic data=0	Areas of demographic data in the CHA/CHIP may include gender, race, age, income, disabilities, mobility (travel time to work or to health care), educational attainment, home ownership, employment status, immigration status, sexual orientation, etc.
16	None	Data are collected in multiple health factors areas, showing a consideration of the multiple determinants of health. Examples of these areas include Health Behaviors, Clinical Care, Social & Economic Factors, and Physical & Built Environment.	4+ areas=4; 3 areas=3; 2 areas=2; 1 area=1; no health factors data=0	Data measures from multiple determinants of health areas are described.

17	1.1.2T/L	Health issues and specific descriptions of population groups with particular health issues and inequities are described.	Yes=4; No=0	In addition to the general presentation of the data, the CHA/CHIP document must address the existence and extent of health disparities between and among specific populations in the community or areas in the community: populations with an inequitable share of poorer health outcomes must be identified.
18	1.1.2T/L & 5.2.1L	A description of existing tribal or community assets and resources to address health issues is presented.	Yes=4; No=0	The CHA/CHIP or related documents includes a listing or description of the assets or resources that can be mobilized and employed to address health issues. Community assets and resources could be anything in the community that could be utilized to improve the health of the community, including skills of residents, the power of local associations (e.g., service associations, professional associations)and local institutions (e.g., faith based organizations, local foundations, institutions of higher learning), as well as other community factors such as parks, social capital, community resilience, a strong business community, etc. Community assets and resources can be documented in a list, chart, narrative description, etc.
19	1.2.3A	There is evidence of quantitative primary data collection.	Yes=4; No=0	Primary data are data that did not exist before the health department gathered it. The data collection is intended to enhance the knowledge and understanding of the population the health department serves. Data can be obtained from surveys of target groups (e.g., teenagers, the jobless, residents of a neighborhood with higher risks of poor health outcomes).

20	1.2.3A	There is evidence of qualitative primary data collection.	Yes=4; No=0	Data must be collected directly from groups or individuals who are at higher health risk. These data may address social conditions that have an impact on the health of the population served, for example, unemployment, poverty, lack of accessible facilities for physical activity, housing, transportation, and lack of access to fresh foods. Examples of data collection methods include open ended survey questions, forums, listening sessions, focus groups, storytelling, group interviews, stakeholder interviews, key informant interviews, etc.
21	1.1.2T/L	There is evidence of secondary data collection.	Yes=4; No=0	Secondary data collection includes data published or collected by other parties such as other governmental agencies (law enforcement, EPA, OSHA, Bureau of Labor Statistics, and workers' compensation bureaus). It may include graduation rates, census data, hospital discharge data, Behavioral Risk Factor Surveillance System data, and academic research data.
22	1.2.3A	Sources of data are cited.	All of the time=4; Most of the time=3; Some of the time=2; Rarely/Only a few times =1; None of the time=0	The source and year(s) of data are cited.

23	1.3.1A	Local data are compared to other agencies, regions, state, or national data.	2 or more examples=4; 1 example=2; no examples=0	There are at least two examples of comparison data that compare data from similar data sources over similar timeframes.
24	1.3.1A	Trends in local data are reported.	2 or more examples=4; 1 example=2; no examples=0	There are at least two examples of displaying trends in a data element that include at least three points of data.

25	1.1.2T/L	There is evidence of ongoing monitoring, refreshing, and adding of data and data analysis	2 or more examples=4; 1 example=2; no examples=0	Documentation of gathering of information, collection of data, conduct of community dialogues, and/or identification of community assets specific to populations and/or geographic areas in the community where health inequities and poorer health indicators were identified in the community health assessment. Additional data analysis is expected to be neighborhood or community specific in order to understand health inequities and the factors that create them. Geographic information analysis of socioeconomic conditions would be appropriate information to include in an annual update or supplement. A complete revision or overhaul of the community health assessment, is not required, but for a continuous effort to better understand the health of the population through the collection of information and data. Examples of community dialogue include organizing town meetings, conducting focus groups, participating in other local organizations' community meetings (e.g., church community meetings, school public meetings, community association meetings or assemblies, etc.), conducting open forums, and conducting group discussions with specific populations (e.g., teenagers, young mothers, residents of a specific neighborhood, etc.).
26	1.3.1A	Data are analyzed from multiple sources, including aggregated primary and secondary data, and conclusions are drawn.	Yes=4; No=0	The analysis of data from multiple data sources demonstrates an understanding of how multiple factors affect health issues. Data must be compiled, analyzed, and conclusions drawn. The sources of the data used must also be provided. Documentation could be reports, memos, GIS maps, or other written documents.

Focus on What's Important				
27	5.2.1L	Information from the community health assessment is provided to the stakeholders who are setting priorities.	Yes=4; No=0	Evidence that the stakeholders who are setting priorities have been given the information from the assessment phase. This may include a list of data sets or evidence that participants used the community health assessment.
28	5.2.1L	Completed CHA and/or CHIP that includes issues and themes identified by stakeholders in the community.	Yes=4; No=0	Evidence that stakeholder discussions were held to identify issues and themes. Community members' definition of health and of a healthy community must be included.
29	5.2.1L+	A process is identifed and agreed upon by the stakeholders to select priorities.	Yes=4; No=0	A description of the process identified and agreed upon by the stkeholders to develop a set of priority health issues.
30	5.2.1L	Community health priorities were selected using the process established and agreed upon by the stakeholder group as decribed in Measure #29.	Priorities were selected using the process identified in Measure #29=4; Priorities were selected, but there was no clear description of what the process was for selecting priorities=2; No priorities were set.	Evidence that participants developed a set of priority community health issues, based on a process agreed upon by the stakeholders.

31	5.2.2L	There is consideration that the social determinants of health, causes of higher health risks and poorer health outcomes of specific populations, and health inequities were considered and are included in the priorities.	Yes=4; No=0	At least one of the priorities identified in the CHIP addresses an area that causes higher health risks or poorer health outcomes in a specific population or health inequities within the community.
32	5.2.2L	CHIP contains measurable objectives with time-framed targets.	Measurable objectives and time-framed targets=4; measurable objectives with no time-framed targets OR Time-framed targets, but objectives are not measurable=2; no objectives=0	The CHIP or an associated work plan has measurable objectives and time-framed targets.
Choose Effective Policies & Programs				
33	1.4.1A & 5.2.1L	Data is used to inform public health policy, processes, programs, and/or interventions.	2 or more examples=4; 1 example=2; no examples=0	At least two examples must show how data from at least two different data sets are used to support the selection of specific intervention strategies (policies, processes, programs).

34	5.2.2L+	CHIP identifies improvement strategies that are evidence-based, promising practices, or may be innovative to meet the needs of the community.	All of the time=4; Most of the time=3; Some of the time=2; Rarely/Only a few times =1; None of the time=0	Strategies identified in the plan are evidence-informed, promising practices, or innovative strategies. Innovative strategies are considered evidence-informed if they have a clear foundation and reasoning and a clear evaluation plan to monitor results. Guidance is provided by the National Prevention Strategy, Guide to Community Preventive Services, Healthy People 2020, What Works for Health and / or state health plan (if available).
35	5.2.2L	CHIP must contain policy changes.	2 or more examples and at least one addresses social and economic conditions that influence health equity=4; 1 example that does address health equity=3; 2 examples, but neither address health equity=2; 1 example that does not address health equity=1; No examples=0	At least two examples of policy changes to accomplish identified health objectives are included in the plan. Policy changes should include those that are adopted to alleviate the identified causes of health inequity. Policy changes may address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, and zoning, for example. Policy change can be at a legislative level or a systems change within an institution such as a school district or worksite.

Act on What's Important				
36	3.1.2A	Documentation of implemented health promotion strategies.	2 or more examples and at least one addresses chronic disease prevention=4; 1 example that addresses chronic disease prevention=3; 2 examples, but neither address chronic disease prevention=2; 1 example that does not address chronic disease prevention=1; No examples=0	At least two examples of health promotion strategies that correspond to health priorities in the CHIP are implemented**.** At least one of the strategies must address the prevention of chronic disease.
37	5.1.2A	Engage in activities that contribute to the development and/or modification of public health policy.	2 or more examples=4; 1 example=2; no examples=0	There is documentation that LHD and/or partners have contributed to deliberations concerning public health policy and practice with those who set policy and also contributes to stakeholder or community involvement in development and/or modification of public health policy. Documentation must include at least one of the three following items for each example: 1) impact statement or issue brief; 2) distribution of correspondence, emails, briefing statements, or reports on policy impacts; 3) A presentation of evaluations or assessments of current and/or proposed policies.

38	5.2.3A	Implement elements and strategies of the CHIP, in partnership with others and according to timelines within the plan.	All of the strategies implemented=4; Most of the strategies implemented=3; Some of the strategies implemented =2; Few of the strategies implemented=1; None of the strategies implemented=0	Documentation supports evidence of implementation of the plan, including strategies used, partners involved, and the status or results of action taken. The % of strategies implemented is based on the timeframe identified within the plan (i.e. it would be the % of those items that should be done by the date of the review). If there are no timelines in the plan, % of all strategies will be used for this measure. If the plan was published within the past 12 months, score 4 if there is evidence that implementation is underway.
39	5.2.2L	CHIP identifies individuals and organizations that have accepted responsibility for implementing strategies	Yes=4; No=0	The CHIP includes designation of individuals or organizations that have accepted responsibility for implementing strategies outlined in the CHIP. (Does not need to be formal MOU/MOA)
40	5.3.1L	The Community Health Improvement Plan and Process (CHIPP) includes priorities and action plans for entities beyond just the local health department.	Yes=4; No=0	There is evidence that other agencies will take responsibility for leadership of and/or specific steps in the implementation plan. If there is only a CHA, this is scored NO.
41	11.2.4A	Seek resources to support implementation of the strategies identified in the CHIP.	2 or more examples=4; 1 example=2; no examples=0	There are at least two examples of grant applications (funded or unfunded) or documentation of leveraging funds to obtain additional resources to support the CHIP priorities.

Evaluate Actions				
42	None	CHIP contains a plan for measurable health outcomes	Yes=4; No=0	CHIP or a companion document indicates how outcomes will be measured.
43	5.2.2L	CHIP contains a process for tracking actions taken to implement strategies.	Yes=4; No=0	The tracking process must specify the strategies being used, the responsible partners involved, and the status of the effort or results of the actions taken. Documentation could be, for example, a narrative, table, spread sheet, or a combination. This may look like a work plan that includes the status of the implementation of the work plan.
44	5.2.4A	Review and revise as needed the strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners.	The CHIP has been reviewed and revised (or revisions were not necessary based on the review)=4; The CHIP was reviewed, but not revised=2; No review or revision=0	An annual evaluation report is provided that documents progress on performance indicators and health indicators and revisions in the plan. (Health indicators may take several years to show measurable progress.) If the plan has been adopted within the year, a report of a previous plan may be provided or detailed evaluation plans may be submitted.
Communicate				
45	1.1.3T/L+	The CHA document(s) are electronically available to the public via a website.	Yes=4; No=0	CHA is posted online.
46	1.1.3T/L+	The CHIP document(s) are electronically available to the public via a website.	Yes=4; No=0	CHIP is posted online.

47	1.1.3T/L	Ensure that the CHA is accessible to partners, agencies, and the general public.	Yes=4; No=0	There is evidence that the CHA and/or CHIP were promoted to the public. Evidence can include the document itself or summaries of the findings published in newspapers, outlined in the department's newletter, linked to from the Department's Facebook page, or published on the department's website. Reports that the document or findings were published is acceptable for a YES.
48	3.1.2A	Documentation that health promotion strategies are communicated to the public in your community.	Yes=4; No=0	Uses social media strategies such as Facebook or Twitter to promote health promotion strategies OR evidence of using traditional strategies like marketing via advertising, posters, billboards, brochures, etc.