Summary of Local Health Department Planning Documents: Best Practices and Trends

August 2024

Public Health®
Prevent. Promote. Protect.

NACCHO℠
National Association of County & City Health Officials

Summary of Local Health Department Planning Documents: Best Practices and Trends

Developed for NACCHO by Sinai Urban Health Institute

NACCHO[SM]
National Association of County & City Health Officials

Sinai Chicago | Sinai Urban Health Institute

Authors

Jackie Jacobs, MPH
Britney Smart, MPH
Alyn Dougherty, MPH
Jesus Valencia, MPH
Maureen Benjamins, PhD

Acknowledgments

This report was produced with funding from the Centers for Disease Control and Prevention (CDC), Office for State, Tribal, Local, and Territorial Support, under grant number 6 NU38OT000306-05-05. The contents of this resource are those of the authors and do not necessarily represent the official position of or endorsement by the CDC.

This report was authored by Sinai Urban Health Institute with contributions from NACCHO staff: Anna Clayton, MPH; Ashley Edmiston, MPH; Tim McCall, PhD; Joi Lee, and Krishna Patel, DrPH.

NACCHO thanks the local health departments who submitted their plans for this analysis. We greatly appreciate their contribution to this work.

Table of Contents

Executive Summary *4*
Key Findings **4**
Introduction *5*
Methodology *6*
Sample **6**
Analysis **6**
Themes **6**
Plan Types *9*
Strategic Plans *10*
Development **10**
Content **12**
Priority Areas 12
Solutions 13
Community Health Improvement Plans *14*
Development **14**
Content **16**
Goals and Objectives 16
Priorities 17
Strategies 19
Quality Improvement Plans *20*
Development **20**
Content **21**
Lessons Learned *24*
References *25*

Executive Summary

The National Association of City and County Health Officials (NACCHO) contracted Sinai Urban Health Institute (SUHI) in September 2023 to complete an environmental scan of Local Health Department (LHD) planning documents. To become accredited by the Public Health Accreditation Board (PHAB), LHDs are required to have a Strategic Plan (SP), a Community Health Improvement Plan (CHIP), and a Quality Improvement Plan (QIP). The plans are designed to guide LHD work and outline actionable steps to ensure the health, wellness, and safety of those residing in their jurisdictions. NACCHO serves nearly 3,200 LHDs, of which approximately 344 are PHAB accredited and, therefore, eligible for this environmental scan. SUHI analyzed a sample of 91 plans from 31 LHDs to answer the following research questions:

1) What goals, priorities, and strategies are included in LHD strategic plans (SP), community health improvement plans (CHIP), and quality improvement (QIP) plans across the country?
2) How are SPs, CHIPs, and QIPs similar and different across LHDs?

Key Findings

Frameworks. Nearly all LHDs use at least one framework in their planning documents, with the Plan-Do-Study-Act (PDSA) or Plan-Do-Check-Act (PDCA) framework and the 10 Essential Public Health Services being the most prevalent. The PDSA/PDCA framework involves planning a change, implementing it, studying or checking the results, and acting on what is learned to refine processes. The 10 Essential Public Health Services framework outlines the 10 critical public health activities that all communities should undertake.

Development Process. LHDs use various methods to collect, analyze, and synthesize data to guide their plans and track progress. Many LHDs used data from Community Health Needs Assessments (CHNA) to inform their plans' goals, objectives, and priorities. The plans also indicated a heavy emphasis on community engagement; however, LHDs differed in their approaches. Some administered a survey to residents, while others included community residents in their committees and workgroups.

Priorities. Across the 31 LHDs, 15 priorities were specified: Access to Care, Aging, Behavioral Health, Chronic Diseases, Environmental Health, Infectious Disease, Local Health Department Operations, Maternal and Infant Health, Nutrition and Physical Activity, Prevention, Public Health Preparedness, Social Determinants of Health, Social Wellness and Community Cohesion, Violence, Youth and Adolescent Health. There were distinctive patterns in the priorities highlighted in SPs and CHIPs. The most prevalent priority area for SPs was LHD operations. LHDs recognized the importance of improving their internal administrative, workforce, and technological capacity to meet their residents' needs. In the CHIPs, behavioral health, which is inclusive of mental health and substance use, was the most frequently listed health priority. This was followed by social determinants of health, access to care, chronic disease, nutrition, and physical activity. Public health preparedness was only considered a priority area for one LHD. QIPs were distinct from SPs and CHIPs; they served as a guide for selecting and developing QI projects, and their central objective was to achieve a culture of

quality. QIPs frequently described governance structures like QI committees, leadership teams, and health department staff. They also provided detailed overviews of monitoring and evaluation, training, and communication plans.

Introduction

In September 2023, the National Association of City and County Health Officials (NACCHO) released a Request for Proposals for an "Environmental Scan and Summary of Local Health Department Planning Documents." The overall purpose of this initiative was to provide local health departments (LHD) with information about trends seen across LHD plans. The project focused on the three key plans that LHDs use to guide their organizational strategies and activities: strategic plans (SP), community health improvement plans (CHIP), and quality improvement plans (QIP). Sinai Urban Health Institute (SUHI) was selected to conduct the environmental scan and document analysis. Specifically, the analysis sought to answer the following research questions:

> 1) What goals, priorities, and strategies are included in LHD strategic plans (SP), community health improvement plans (CHIP), and quality improvement (QIP) plans across the country?
> 2) How are SPs, CHIPs, and QIPs similar and different across LHDs?

As a basis for the study, NACCHO solicited plans from all PHAB-accredited LHDs (n=344). A representative sample was then selected, resulting in 93 plans from 31 LHDs. These plans were then assessed using a framework analysis. The following report provides a summary of the sampled plans, trends by LHD characteristics, and lessons learned to support LHDs as they develop or update their planning documents.

Methodology

This environmental scan employed a document review and framework analysis to examine strategic plans (SP), community health improvement plans (CHIPs), and quality improvement (QIPs) from a subset of LHDs.

Sample

In January 2021, NACCHO contacted all 344 PHAB-accredited LHDs to request their most recent SP, CHIP, and QIP for analysis. In total, documents were received from 109 LHDs. All documents were stored securely on Google Drive and SUHI's internal storage system, with a standard naming convention for easy identification. Using urbanization and region data from the 2022 NACCHO Profiles Study[1], a representative sample of 31 PHAB-accredited LHDs was selected for analysis. For this analysis, the 4-category region variable (Midwest, Northeast, West, and South) from the US Census was used. Urbanization was a 2-category variable distinguishing LHDs who serve a majority rural or urban population. LHDs selected for this analysis were predominantly from urban cities (90%) and the Midwest (42%) and served medium-sized jurisdictions (65%). Plans were also more likely to be written or revised in 2022 or 2023 and came from LHDs with approximately 366 full-time employees.

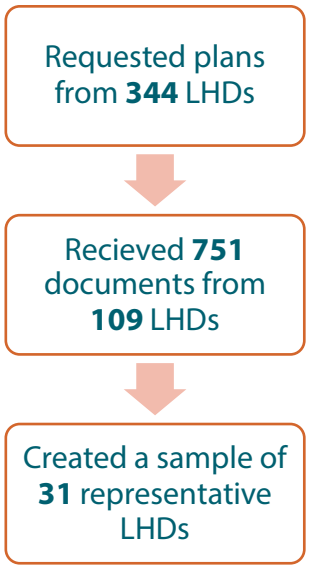

Figure 1. Sample selection process

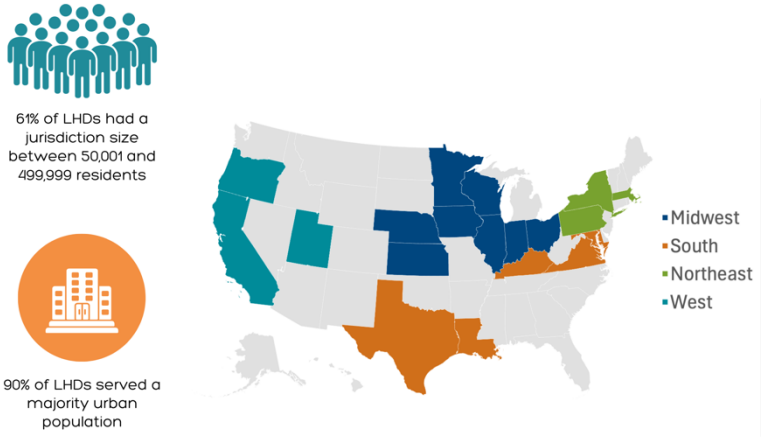

Figure 2. LHD sample at a glance

Analysis

A framework analysis was conducted. First, research staff reviewed a subset of documents (three of each SP, CHIP, and QIP) to gain familiarity with their content and structure. Next, a coding framework was developed to systematically categorize and code relevant themes and elements within the documents. This framework was iteratively refined as the analysis progressed. The final coding framework was applied to a final selection of documents from 31 LHDs (i.e., 93 individual documents). Twelve of 93 documents were double-coded. Finally, coded data was systematically analyzed to identify common themes, patterns, and variations across the sampled LHDs. Matrices and tables were generated to organize and summarize findings, facilitating comparisons across documents and LHD characteristics.

Themes

As documents were analyzed, themes emerged into two main categories: plan development and content. The development section includes findings on frameworks applied, approaches

to collecting and analyzing data, and partners engaged during plan development. Content includes findings on health and operational priorities, goals and objectives, strategies, and solutions. Due to confidentiality, all plans included in the analytic sample are de-identified in the findings.

Table 1. Plan Priorities, Focus Areas, and Examples in Strategic Plans and Community Health Improvement Plans

Priority	Focus Areas	Example Strategies
Access to Care	Creating or increasing access to receiving health care services and resources.	Primary Care Dental Care Community Health/FQHCs
Aging	Health and wellbeing of older adults.	Aging and Connection Aging Support
Behavioral Health	Mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms.	Tobacco Prevention and Cessation Addiction Treatment Suicide Prevention Mental Health
Chronic Diseases	Prevention and/or maintenance of chronic diseases prevalent in the community.	Diabetes Prevention and Management Stroke Obesity
Environmental Health	Addressing the environment, including climate change.	Air Quality Environmental Health
Infectious Disease	Prevention of illnesses and/or further spread of illnesses caused by a pathogen or toxic product from an infected host. One included this priority under other under their Maternal and Child Health priority.	Infectious Diseases (HIV) Infectious Diseases Sexual Health Prevent Communicable Diseases
Local Health Department Operations	Improving the internal operations of the local health department.	Public Health Practice Build Community Capacity
Maternal and Infant Health	Improving the health and wellness of child-bearing individuals and infants.	Sexual Health Family Health
Nutrition and Physical Activity	Individual and community opportunities to improve nutrition and engage in physical activity.	Healthy Eating Active Living Healthy Behaviors
Prevention	Detecting and preventing health issues before it is diagnosed or before it becomes challenging to manage. Some plans included this priority under other health priorities such as access to care, mental health, substance use and chronic disease.	Prevent Chronic Disease Access and Affordability to Care Upstream Prevention

Priority	Focus Areas	Example Strategies
Public Health Preparedness	Preparing for public health emergencies, both manmade and natural.	Public Health Preparedness
Social Determinants of Health	Addressing the social factors that affect individual and community health.	Poverty Housing Stability Health Equity and Social Determinants of Health
Social Wellness and Community Cohesion	Strengthening relationships and increasing sense of belonging.	Healthy Relationship Promotion
Violence	Preventing or addressing community violence, domestic violence, unintended injuries, and other traumatic and adverse events.	Social Determinants of Community Violence Violence Prevention
Youth and Adolescent Health	Priorities focused on health issues specifically affecting youth and adolescents. Some plans included this priority under other health priorities such as mental health, substance use, bullying, chronic disease, and more.	Pediatric Asthma Substance Use Prevention Access to Childcare

Plan Types

According to NACCHO[2], public health performance improvement aims to influence positive change in a public health department's capacity, processes, and population health outcomes using clear and aligned planning, monitoring, and improvement activities.
The plans included in the analytic sample (SPs, CHIPs, and QIPs) aim to improve public health performance. Figure 3 shows each plan's definition and purpose.

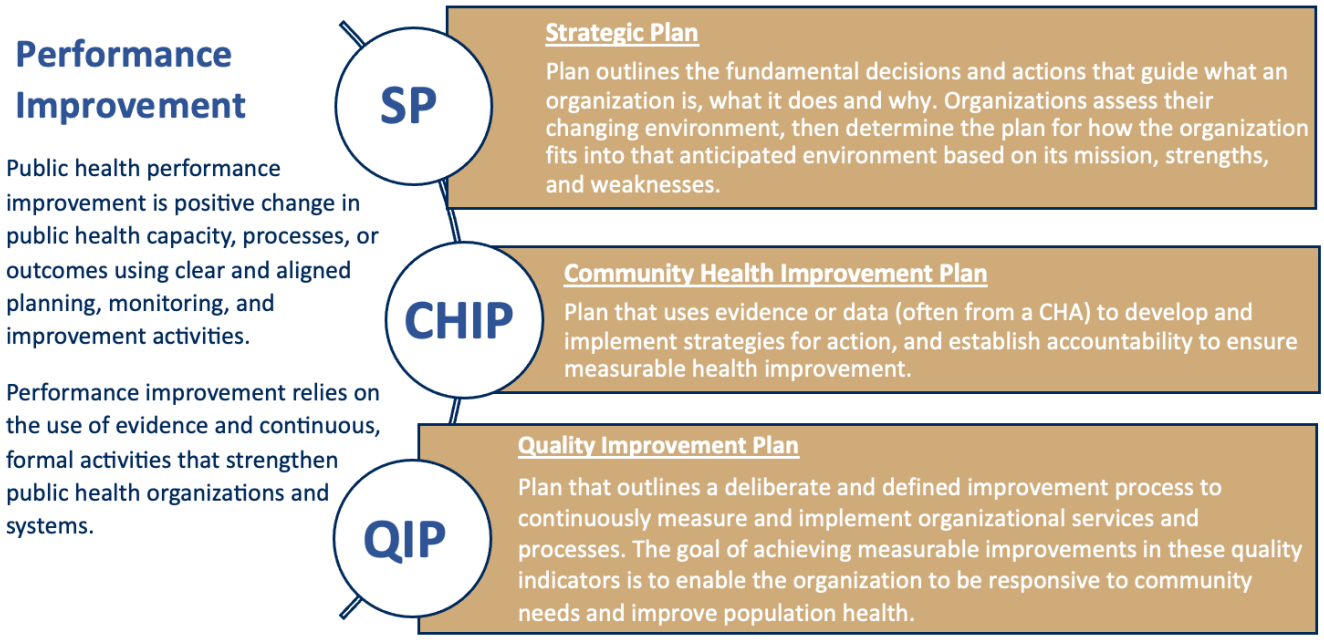

Figure 3. Performance Improvement Plan Definitions

As described by NACCHO, CHIP priorities are designed to have a community impact and inform SPs, whereas SPs are designed to improve internal LHD operations, which then aid the implementation of CHIP objectives and foster community health. Meanwhile, the QIPs provide concrete steps for facilitating continuous improvement of LHD operations and strategies for improving community health, making it a how to guide for implementing both the SPs and QIPs. See Figure 4 for a visual representation of how plans are designed to relate to each other.

Community Health Improvement Plans informing Strategic Plans: Twenty-three LHDs described developing their SP based on CHIP priorities and associated goals and objectives. Application of this alignment varied. Illustrative examples of this alignment include plan crosswalk tables and the listing other plans' priorities, goals, and objectives.

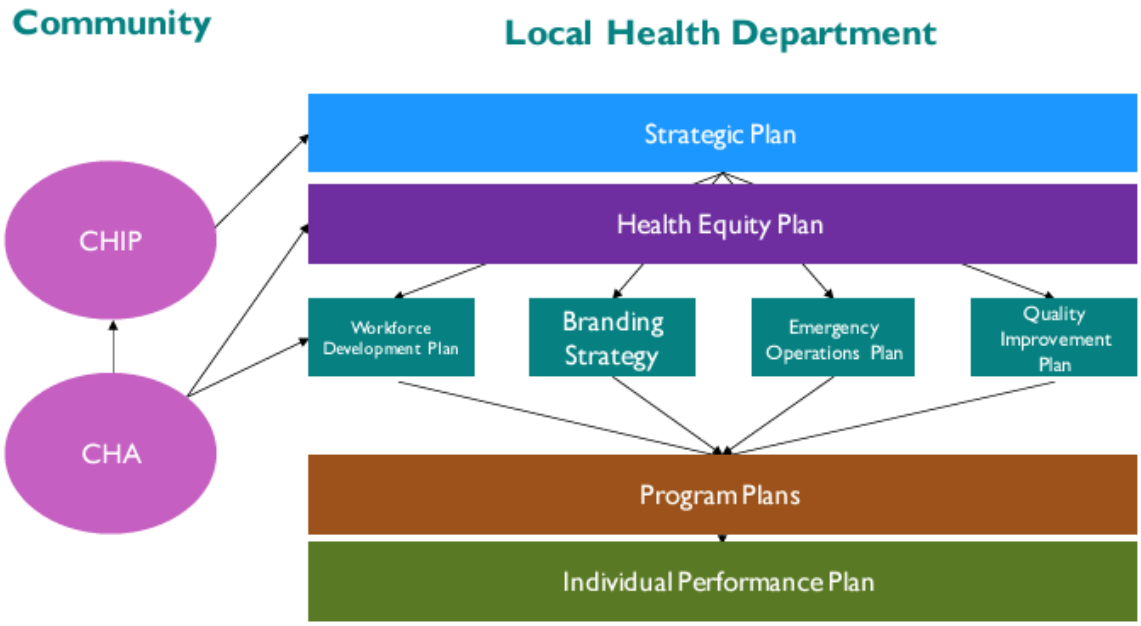

Figure 4. Performance improvement plan relationships. Graphic adapted from work by Marni Mason, Susan Ramsey, and ASTHO

Strategic Plans informing Quality Improvement Plans: Twenty-one LHD QIPs referenced their SP to guide the development of their QIPs, but the connection between these plans was rarely made explicit. LHDs that were more explicit in the connection included a header or matrix that indicated which SP priorities or key improvement indicators aligned with the QIP projects selected. Meanwhile, the other LHDs only indicated that QIPs would be aligned with their SP and other performance improvement plans (existing or in development).

Other Plans Referenced: Other plans, both internal and external, were often referenced, including Healthy People 2030, state-level plans, workforce development plans, and local initiatives.

Strategic Plans

Development

Frameworks: Frameworks were infrequently used to guide the development of SPs (in contrast to CHIPs and QIPs). The few LHDs that employed frameworks in their SPs often referenced Plan-Do-Study-Act/Plan-Do-Check-Act, 10 Essential Public Health Services, the Health Impact Pyramid, or Collective Impact.

***Data*:** LHDs used document reviews, interviews, focus groups, and surveys to inform the development of their SP. Document reviews included a review of previous strategic plans, organizational background materials (i.e., mission, vision, values), and internal policy

documents. LHDs also collected qualitative data through interviews and focus groups, which took place with internal staff and external partners. Surveys gathered staff feedback on workplace satisfaction and insights into strategy recommendations. Of note, several plans collected data to inform a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis and subsequently used this to structure the content of their SPs.

Partners: In addition to internal staff, many LHDs worked with external partners and collaborators to develop their SP. Internal LHD staff were expected to be active participants in the planning process. Often, there was an executive committee comprised of leaders and managers from the LHD and workgroups consisting of staff who provided insight on specific topics/areas of interest. Nine LHDs worked with an external facilitator to guide their planning process. External facilitators were often private consultants with experience leading planning processes and facilitating convenings. They were often responsible for leading workgroups and retreats to help LHD staff members identify the needs of their communities, synthesize ideas, and establish clear priorities and goals. Six LHDs collaborated with health professional associations such as the Network of Behavioral Health Providers (NBHP), the Hospital Council of Northwest Ohio, and the Rural Nebraska Healthcare Network. Although less frequent compared to CHIPs, some LHDs worked with community partners during their SP development process. These LHDs leveraged existing councils and community-based organizations to get community member insights on the issues that impacted their daily lives.

Table 2. SP development collaborators and partners at a glance

Internal Collaborators[+]	# of SPs
Executive Leadership (e.g. directors, assistant directors)	12
Strategic Planning Committee (Staff and Supervisors)	10
Epidemiology/Disease Surveillance	6
Administration & Finance	4
Social Services	4
Human Resources	3
Quality Improvement/Strategic Management	3
Clinical Services	2
Marketing	2
Technical Writer	1
External Partners	**# of SPs**
Board of Health	15
Consultants/External Facilitators	9
City/Local Government	3
External Partners	**# of SPs**
CBOs	3
Hospitals	3
Community Residents	3
Other LHD	1

[+] Includes leadership titles and departments represented that were engaged in SP development.

Content

Priority Areas

As shown in Figure 5, SPs had a wide range of priorities. Across SP, 14 different priorities were identified, with the most prevalent being LHD Workforce and Operations, followed by Social Determinants of Health.

***LHD Workforce and Operations**:* All 31 LHDs strategic plans prioritized the improvement of their workforce by fostering staff satisfaction, advancement, and success through various initiatives such as training, professional development activities, and the creation of a culture of continuous learning. LHD strategic plans emphasized the importance of a qualified and diverse workforce, promoting a positive organizational culture, and utilizing frameworks for workplace mental health and well-being to ensure a healthy, supportive work environment. They aimed to equip staff with the necessary tools, evaluate data systems, and increase capacity to obtain grants while acknowledging challenges, such as responding to the COVID-19 pandemic.

Social Determinants of Health (SDoH): Thirteen of the 31 LHDs mentioned SDoH as a priority area in their SP. LHDs recognized that various facets of SDoH, such as socioeconomic status, poverty, and housing, were significant contributors to poor health outcomes and that addressing SDoH would improve several health issues. The SPs also discussed the importance of training the LHD workforce to recognize the significance of SDoH and to effectively work alongside communities to address them.

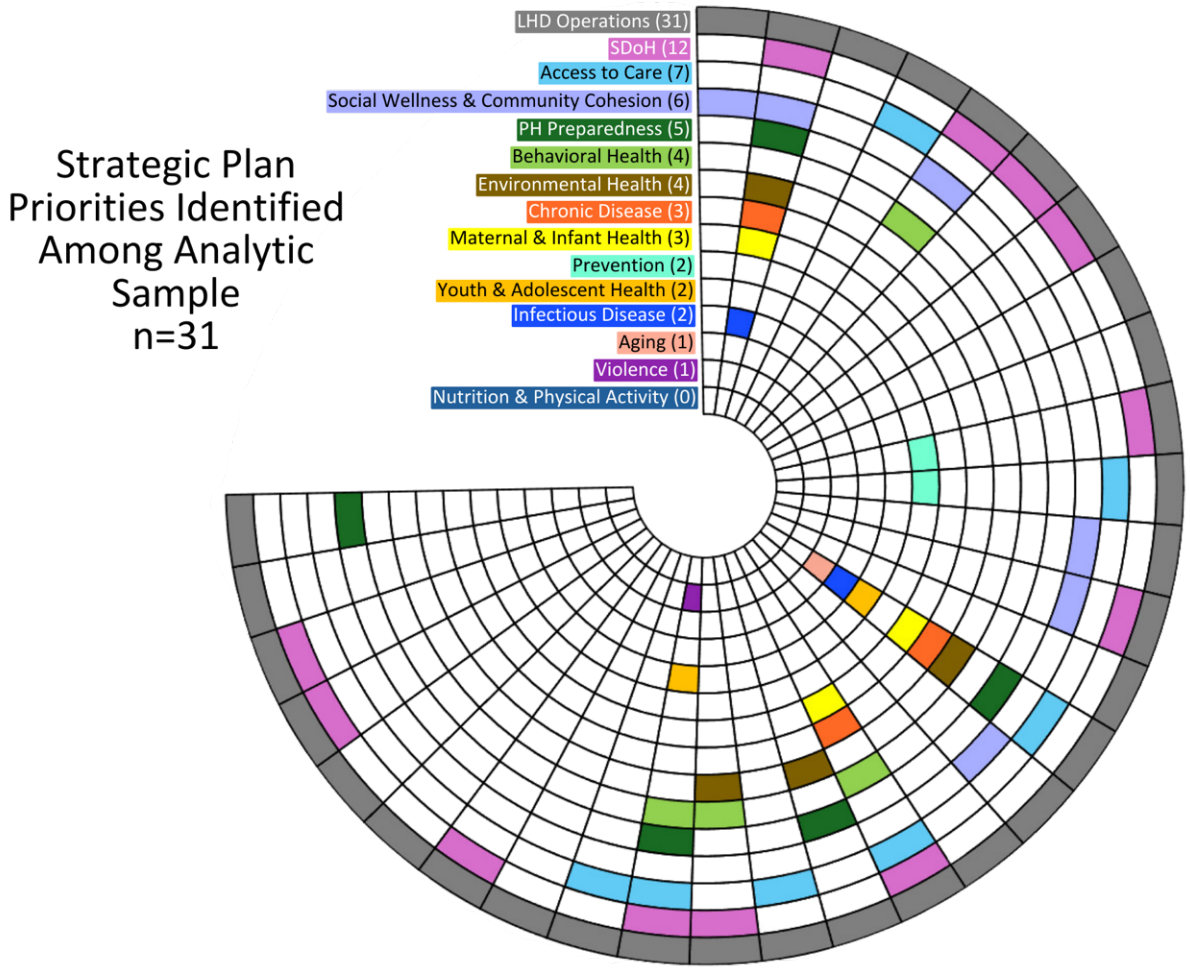

Figure 5. Strategic plan priorities in the analytic sample

Solutions

The most prevalent solutions identified in the SPs were collaboration and partnerships, policies, and increasing programming, resources, and services.

Collaboration and Partnerships: A handful of LHDs discuss the potential for collaboration and partnerships within their SPs. Partnerships were most often referenced as a solution for addressing SDoH. LHDs mentioned the importance of leveraging internal partners' expertise to address the challenges they face. They also discussed the value of developing external working relationships with other city departments, as well as public and private community partners, to accomplish their shared goals. While some plans emphasize the need for more authentic partnerships with community residents and organizations, specific details on how to best collaborate were rarely included.

Communication: LHDs saw internal and external strategic communications as a key opportunity to improve engagement and educate individuals about current programs and initiatives. Many plans discussed redesigning websites, establishing a communications strategy, and improving the marketing of outreach events. They acknowledge a broad goal of elevating public awareness of public health issues while combating misinformation through culturally competent messaging. Internally, LHDs sought to strengthen communication by crafting internal communication plans.

Strategies	Lead
• Implement a communications plan to (a) inform key stakeholders in City government on the Health in All Policies approach, and (b) garner support for cross-departmental equity work • Disseminate health, equity and social determinants of health-related data to City department heads and decision-makers • Explore/identify/support opportunities to use health impact assessments as a tool for Health in All Policies • Pursue collaboration with other City departments on equity-related efforts • Build relationships with non-City partner organizations working in the community on social determinants of health (e.g. housing, transportation, etc.) to inform and partner on equity-related efforts	Manager of Strategic Performance and Partnerships, Manager of Strategic Initiatives, Executive Team

Figure 6. Example from LHD strategic plan, strategies used to address priority areas

Internal Processes: The SPs highlighted how LHDs aimed to address internal operation challenges by investing in staff development and upgrading technology. Initiatives to boost employee engagement and well-being included employee spotlights, staff wellness programs, and improved recognition benefits. Technology improvements were broader and included enhanced data collection, utilization, and sharing capacity. LHDs expressed that optimizing technology support would promote more effective remote work for staff and more improved use of data to promote equity.

Community Health Improvement Plans

Development

Frameworks: A variety of frameworks were used throughout the development of CHIPs, including Mobilizing for Action through Planning and Partnerships (MAPP) 1.0 and MAPP 2.0, the Health Impact Pyramid, 10 Essential Public Health Services, Collective Impact, the Community Health Assessment Framework. MAPP v1.0 was the most common framework used (13 LHDs); one LHD used MAPP 2.0 (pictured in Figure 7). LHDs used MAPP to structure their teams for the CHIP

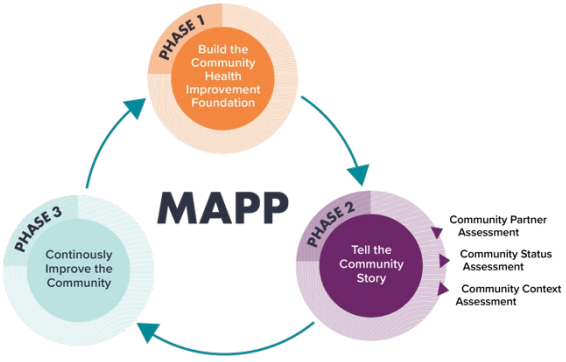

Figure 7. NACCHO's MAPP 2.0 framework

planning process. They often created different steering committees and workgroups to tackle different components of MAPP (e.g. health priority planning teams, MAPP core team). There were also 8 LHDs that employed the use of more than one framework. For example, one LHD applied the Strategic Doing framework towards the development of their MAPP 1.0 action cycle. Another LHD applied MAPP 1.0 to their CHIP's development, and the Health Impact Pyramid to their health prioritization process. There were ten LHDs that did not disclose a guiding framework for their CHIP development. See Table 2 for more details on the frequency of plans used in the sample.

Table 3. Frequency of CHIP frameworks used in analytic sample

Framework	Description	Frequency
Mobilizing for Action through Planning and Partnerships (MAPP)	MAPP is a community-driven planning framework developed by NACCHO. It has 6 key phases, (1) Organizing and Engaging Partners, (2) Visioning, (3) The Four Assessments, (4) Identify Strategic Issues, (5) C Formulate Goals and Strategies, and an Action Plan, and (6) Action Cycle.	14
The Health Impact Pyramid	A 5-tier pyramid provides a framework for improving public health and shows the relative impact of creating interventions on specific tiers on the health of the overall population.	4
10 Essential Public Health Services	The 10-essential public health services provide a framework for understanding core public health activities.	4
Framework	**Description**	**Frequency**
Collective Impact[3]	Collective impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change.	1
Community Health Assessment Framework[4]	Nine-step guide for hospitals and health systems to collaborate with their communities and strategic partners to conduct a community health assessment (CHNA) and meet community health needs assessment (CHNA) requirements.	1

Data: Using a data-driven approach to develop CHIPs can encourage measurable outcomes and realistic goals. Across the sample, LHDs used a variety of data sources to inform their CHIP: surveillance data, surveys, focus groups, key informant interviews, document reviews, and meetings. Many of these data collection methods were tied to MAPP 1.0 assessments, including the Community Themes and Strengths Assessment, Local Public Health System Assessment, and Forces of Change Assessment.

Partners: Collaboration with partners was consistently identified as part of the CHIP development process. Partners included representatives from the LHD, local universities and colleges, local hospitals and healthcare providers, community-based organizations (CBOs), hospital associations, service providers, and community residents. Often this collaboration was in the form of LHDs creating steering committees, health priority committees, and workgroups in their planning process. Steering committees were most often comprised of LHD employees, CBO leaders and representatives, educators and administrators from academic institutions, and government representation. In many instances, partners were members of health priority committees and coalitions and responsible for identifying appropriate strategies to include as goals and objectives. Similarly, several LHDs engaged partners in community health assessment data collection efforts, and health topic prioritization processes (e.g. community town halls and listening events). While some community residents were engaged in health priority steering committees, they were most often engaged in data collection and prioritization. In some cases, LHDs included partners as CHIP authors. Lastly, three LHDs engaged an outside consultant to co-lead CHIP development. For a list of all external partners, see Table 4.

26

LHDs formed a committee with community partners for CHIP developement.

Table 4. CHIP external partners at a glance

External Partners	# of CHIPS
CBOs	28
Hospitals & Healthcare Providers	26
Community Residents	16
Academic Institutions	15
Public Officials & other Government Departments	13
Other LHDs	9
Health Professional Associations	8
Insurance Agencies	7
Board of Health	5
Faith-Based Organizations	4
Local Businesses	4
Consultant/Development Facilitator	3

Content

Goals and Objectives

Goals were often high-level and visionary, whereas objectives were more concrete and followed aspects of SMART/IE (specific, measurable, actionable, realistic, and time-bound/

inclusive, equitable). Many objectives were timebound or specific, but not both. LHDs emphasized community engagement and partnership building, equity, and innovation as key strategies within their goals and objectives.

Priorities

All CHIPs identified specific priorities to concentrate on throughout the implementation of their plans. Behavioral health was the most common priority area across all CHIPs analyzed. Other common CHIP priorities aimed to address social determinants of health (e.g. housing stability, poverty), chronic disease, access to care, and nutrition and physical activity. It's worthwhile to note that some CHIPs varied in the specificity of their health priorities. While some LHDs focused on broader topics like health equity, social determinants of health, and healthy behaviors, others were incredibly specific in their priority areas, focusing on pediatric asthma, smoking, or a specific population, for example. Despite many CHIPs being developed during or after the recent Covid-19 pandemic, rarely was public health preparedness identified as a priority. See Figure 8 for all CHIP priorities identified among the 31 plans analyzed.

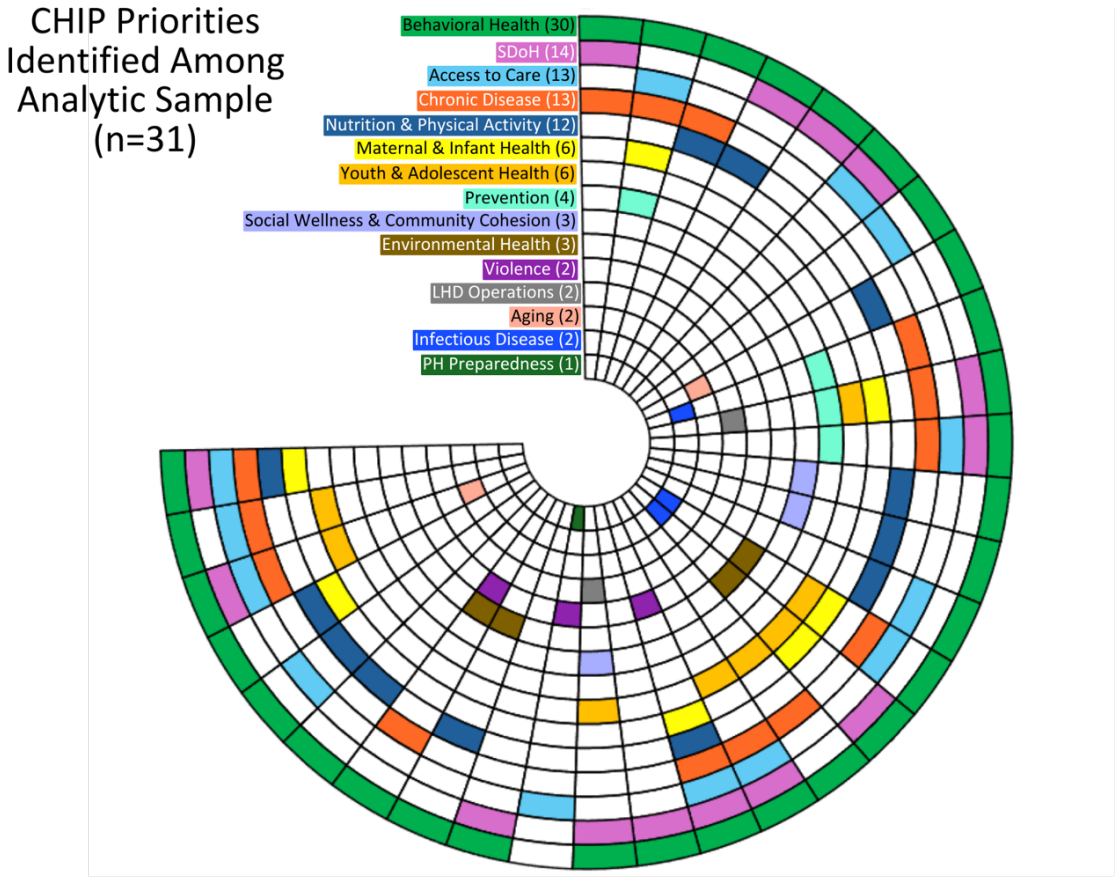

Figure 8. Priorities identified in analytic sample of CHIPs

Behavioral Health: All but one of the LHDs selected a behavioral health topic as one of their health priorities. CHIPs commonly reported the selection of this priority was driven by issues of stigma and trauma, lack of access to mental health providers and substance uses treatment facilities, and lack of knowledge about behavioral health challenges from the community. Stigma and trauma were the most identified issues tied with priorities addressing mental health. CHIPs often indicated that stigma resulted from misinformation about mental illness within the community, especially among minoritized communities, as well as concern for perceived or anticipatory stigma if seeking treatment. Trauma on the other hand was fueled by a variety of sources including adverse child experiences, public health emergencies (e.g. Covid-19 and natural disasters), and racism and discrimination. Several CHIPs identified lack of both mental health and substance use treatment providers, or a lack of navigating healthcare to reach these services, as being major problems for community access. Additionally, lack of knowledge (e.g. misinformation about mental health diagnoses, unable to identify substance abuse behaviors) among community members contributed to lack of care utilization and perpetuation of stigma.

Social Determinants of Health (SDoH): Fourteen CHIPs included SDoH as one of their health priorities. As mentioned previously, LHDs' varied in their specificity of how priorities were defined. While some LHDs included "Social Determinants of Health" as a broad priority, others named specific aspects of SDoH like housing stability and economic mobility. CHIPs often reported problems driving SDoH challenges as lack of affordability, lack of services and resources (especially after a public health emergency response), and stigma. Eight of the fourteen CHIPs focused their SDoH priorities on housing and economic concerns due to lack of affordable housing options and a lack of services and resources to assist in locating affordable options when available. The six remaining CHIPs named SDoH as a broader priority due to historical stigma and generational trauma against minoritized communities.

Access to Care: Thirteen CHIPs identified access to care as one of their health priorities. Access to care mainly focused on primary care access, but some focused on mental and dental care access too. Lack of access to these resources within their community was identified as a driver of this priority. Lack of access included lack of capacity/providers, challenges navigating the healthcare system, and cost (for both insured and uninsured populations). Additionally, racism and discrimination were noted in some CHIPs as drivers preventing Black, Latine and LGBTQ+ community members from seeking care.

Chronic Disease: Thirteen CHIPs identified chronic disease as one of their health priorities. CHIPs varied in how they outlined their approach to addressing chronic diseases (e.g. diabetes, lung cancer, breast cancer, stroke, and hypertension). Contrary to the previous three priorities discussed, there were few problems described as driving this priority outside of high prevalence of chronic disease in the community. Only one LHD indicated providers had issues with limited patient face-to-face time and insurance reimbursement structures that disincentivized their work.

Nutrition and Physical Activity: Twelve CHIPs identified nutrition, physical activity, or a combination of both as one of their health priorities. Similar to chronic disease, there were

few examples of issues driving the selection of this as a priority. For example, three LHDs indicated a lack of access to healthy foods as an issue, but only one described that lack of access being due to transportation barriers, non-accessible locations to access healthy food, and ineligibility to qualify food access social services.

Strategies

Twelve (12) unique strategies were identified across the analytic sample, but the most common strategies identified were increasing the number of and availability of resources and services, increasing awareness, leveraging collaboration and partnerships, and influencing policy. When stratifying by jurisdiction size, LHDs with smaller jurisdictions often identified community engagement as a strategy. While most LHDs identified strategies for each of their objectives, there was one whose strategies were pending while they waited for additional data.

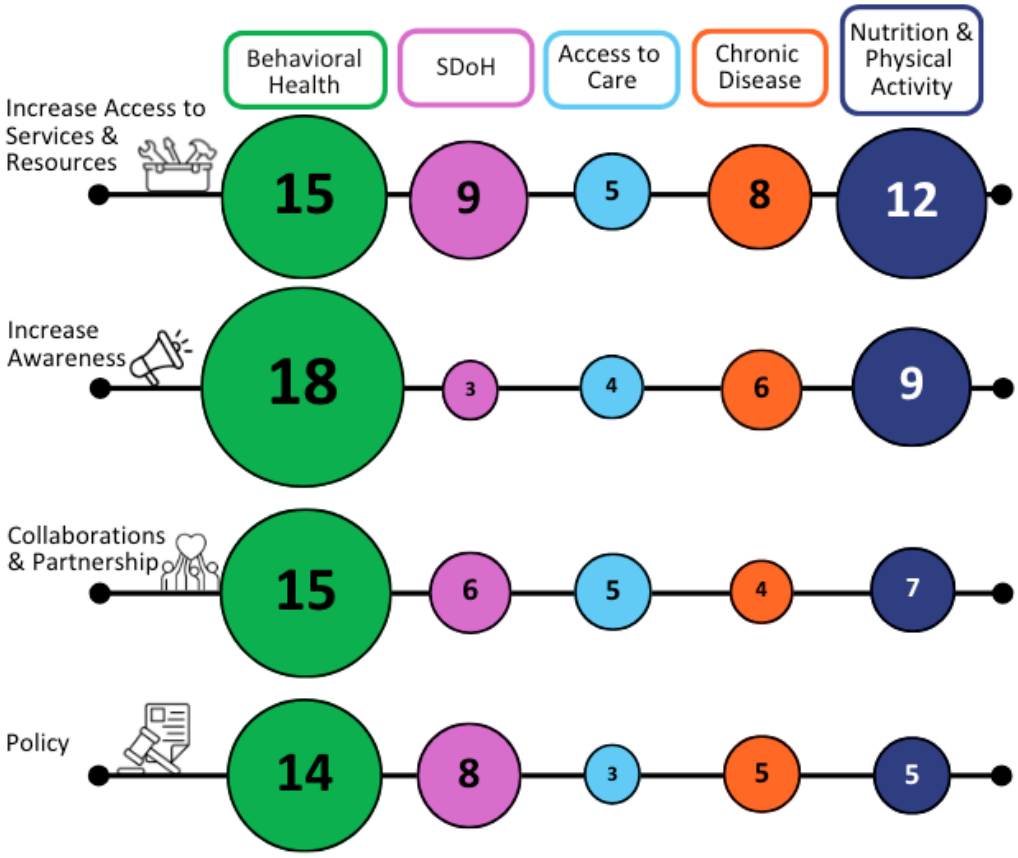

Figure 9. Frequency of CHIPs using identified strategies at a glance

Increase Access to Services and Resources: This strategy was applied broadly across 30 CHIPs. It included strategies that would create or increase resources and services relevant to the specific priority. For example, CHIPs addressing behavioral health described strategies for increasing naloxone distribution locations, establishing crisis intervention protocols, and promoting low to no-cost cessation classes. CHIPs addressing nutrition and physical activity, and chronic disease, commonly used similar strategies like promoting community fitness classes, increasing healthy food access at farmers' markets, and bolstering chronic disease

screenings. CHIPs addressing housing stability and transportation as part of SDoH priorities often proposed increasing affordable housing and services to finding affordable housing and improving transportation accessibility and community reach.

Increase Awareness: Twenty-three CHIPs proposed increasing awareness as a strategy. Developing and implementing awareness campaigns was the most common strategy identified with this strategy. Those prioritizing behavioral health were the most common to implement awareness campaigns (e.g. vaping risks, available mental health services, stigma, and binge drinking). LHDs addressing nutrition and physical activity priorities also employed awareness campaigns to promote increasing fruit/vegetable consumption, reducing sugary beverage consumption, and promoting regular physical activity. While LHDs were clear what their awareness campaigns message was, and sometimes which audience they aimed to prioritize, no details were shared for how these campaigns would be implemented.

Collaborations and Partnerships: Twenty-seven CHIPs included collaborations and partnerships as a strategy. Some LHDs had established relationships with partners while others indicated a desire to cultivate new collaborations. Some collaborations identified were established multi-sector coalitions, while others were individual organizations and agencies (e.g., CBOs, schools, parks departments, other city departments). However, few CHIPs explicitly stated who their partners were. Among the 15 CHIPs that included behavioral health as a priority, only six stated a specific partner.

Policy: Twenty-six CHIPs included advocating, supporting, or changing policy as a strategy. It was more common for LHDs to include advocating for/supporting policies at the state or jurisdiction level (e.g., vaping and tobacco-free locations, educating policymakers on housing as SDoH). Whereas LHDs that described changing existing policies within their own jurisdiction's agencies and organizations (e.g., changing department policy for equitable data gathering practices, modifying background check policy for substance use prevention peer-support staff in schools).

Quality Improvement Plans

Development

***Framework*:** Almost all QIPs analyzed (27 of 31) referenced or used a framework to develop their QI protocol or to align their QI plan with organizational priorities. Frameworks referenced include the Kaizen Approach; Plan-Do-Study-Act (PDSA)/Plan-Do-Check-Act (PDCA); 10 Essential Public Health Services; Specific, Measurable, Actionable, Realistic, Timebound, Inclusive, and Equitable (SMARTIE); and Turning Point Performance Management.

Table 4. Frameworks identified in QIPs

Framework	Description	Frequency
Plan-Do Study Act (PDSA) or Plan-Do-Check-Act (PDCA)	Methodology for implementing and testing small changes in workflows and protocols.	22
Turning Point Performance Management	A system for measuring performance, allocating resources, and providing insights on whether a program is working or there are changes needed to boost efficacy.	9
10-Essential Public Health Services	Provides a framework for understanding core public health activities.	2
Kaizen Approach	Approach to quality improvement which posits that small ongoing and incremental change can result in significant improvements.	1
Specific, Measurable, Actionable, Realistic, Timebound, Inclusive, and Equitable (SMARTIE)	Framework for creating goals and objectives.	1

Content

QIPs were designed to describe LHDs' QI goals and objectives and to outline systems and processes for doing QI projects. The QIPs discussed various methods for gathering data to gauge performance, including customer satisfaction assessments. Overall, the sample QIPs consistently included five components: purpose and scope, methodology, evaluation and monitoring, training, and communication.

Purpose and Scope: Many QIPs had a defined section that discussed the purpose and scope of their QIP. Within this section, they often described their goals and objectives, which for most LHDs was to attain a "Culture of Quality" to ensure that they were meeting the needs of the residents effectively. Within this process, they used tools like *NACCHO's Organizational Culture of Quality Self-Assessment* to evaluate their current quality improvement efforts and identify what phase of QI they were currently in. Almost all LHDs referenced NACCHO's *Roadmap to a Culture of Quality* as a method to guide their progress.

Methodology: LHDs used their QIPs to outline protocols and procedures for how QI happens within their organizations. Overall, the process for selecting QI projects involved several key steps to ensure alignment with strategic goals and performance measures. This included reviewing project checklists, completing project aim worksheets, and presenting proposals to divisional team representatives for review. Priority was given to projects that aligned with strategic plan goals and performance measures. Additionally, QI project tracking was emphasized, with revamped documentation and simplified submission forms to guide teams through the process. Furthermore, input from various stakeholders, including staff, community partners, and service recipients, was solicited to identify areas for improvement. Performance measurement data, community health needs assessments, customer satisfaction feedback, and quality assurance activities were all utilized to inform project selection and ensure continuous improvement in service delivery.

Figure 10. Methods for submitting QI projects at a glance

Evaluation and Monitoring: LHDs also outlined their systems for consistently and iteratively monitoring and evaluating their progress. Several described their performance management system and included example tools in their appendices.

REQUIRED QI TRAINING

Title	Training Objectives	Mode	Length
New Employee Orientation (NEO)			
NEO Part 2: Intro to QI *Core Competencies:* *Tier 1: 5.1, 8.2, 8.6, 8.5*	• Define principles of a culture of quality improvement • Understand the foundational elements of a quality culture and staff roles • Review HD PMS and QI Systems • Show QI website and how to get involved	Classroom/ virtual	1 hour
Introduction to QI: The PDSA Cycle *Core Competencies:* *Tier 1: 2.7*	• Define and describe an AIM statement • Introduce QI concepts • Review the Plan-Do-Study-Act process • Introduce a few tools (flow charts, 5 whys) and where to find more information	Online	20-30 min
NEO: Fundamentals of a Quality Culture (renaming) ***Development 2022*** *Core Competencies:* *Tier 1: 2.3, 2.7, 3.7, 7.8, 8.2, 8.6*	• Review the Turning Point PMS framework • Describe Performance Management System (PMS) functions and staff roles • Understand how the FCHD is a data-informed, learning organization (e.g., use of performance data, importance of benchmarking)	Classroom	2 hours
All Staff Refresher Training (required every 3 years)			
QI in Action at the FCHD or Staying Current in QI ***Development 2023*** *Core Competencies:* *Tier 1: 2.7, 3.2, 7.6, 7.7, 7.9*	• Understand continuum of QI from individual performance improvements through formal QI initiatives and systems change • Review resources available to support local and division-wide QI efforts • Learn strategies for recognizing potential QI projects and how to get started • Practice using QI tools in FCHD-specific process improvement scenario	Classroom	TBD - no more than 4 hours
Mid-Managers' Role in QI ***Development 2023-24*** *Core Competencies* *Tier 1: 2.7, 3.2, 7.6, 7.7, 7.9*	• See above elements of QI in Action training • Specific roles of the manager in supporting and promoting QI	Classroom	TBD - no more than 4 hours

Figure 11. Example from LHD Plan: Required QI training

Training: Thirty of the 31 LHDs discussed the importance of training within the QI journey. Several provided examples of QI modules that would be included in their new employee orientation and their annual required education.

Communication: The vast majority of LHDs emphasized the importance of communicating QI progress to external and internal audiences. Some methods mentioned included:

- Employee newsletters
- Posting QI progress on websites and social media
- Sharing results and best practices by participating in state webinars, conferences, and workshops

Lessons Learned

Several patterns emerged from the analyses, highlighting potential areas for LHDs to consider when revising or creating new plans.

Social Determinants of Health and Equity as a Lens: While the vast majority of LHD plans defined and/or acknowledged the value of a ***Social Determinants of Health (SDoH)*** and/or ***health equity*** lens, their integration varied. Some plans briefly mentioned these concepts, providing a definition of SDoH without any meaningful application to their plan, while others made them key priority areas. LHDs that made SDoH a priority area proposed strategies such as Health in All Policies, regular dissemination of health, equity, and social determinants of health data to political decision-makers, and building relationships with community-based organizations working in housing, transportation, etc. Addressing SDoH has the potential to influence the fundamental causes of poor health outcomes, by targeting the root causes of inequities. Like SDoH, the phrase "health equity" was used across all LHDs but was not frequently well integrated. LHDs that fully integrated health equity emphasized the historical context for health inequities and leveraged community-engaged methods for identifying not only problems but also strategies. For instance, using data to identify areas with greatest disparities and developing targeted strategies to address specific challenges. At the national level, SDoH and healthy equity are priorities, as evidenced by their inclusion in Healthy People 2030's priority areas. Substantial research has shown that addressing social needs and promoting health equity are essential for improving health outcomes.[5]

Evidence-Informed Programs and Initiatives: Within all LHD plans, and CHIPs in particular, LHDs worked to identify potential strategies to the most prevalent issues they or their residents faced. While strategies spanned the gambit of the 10 Essential Services of Public Health, evidence-informed programs and initiatives implemented during the planning period have the potential to boost the efficacy of their efforts. LHDs that cited evidence-based practices were able to create more detailed and comprehensive action plans with clear next steps. Learning from existing evidence also allowed for LHDs to more easily identify ways to tailor strategies to suit the needs of their constituents.

Additional Resources: There are two priority areas that should be highlighted, ***Behavioral Health*** and ***Emergency Preparedness****, due to their high and low frequency across plans, respectively.* Most LHDs identified Behavioral Health as a pressing concern for their communities, but few addressed root causes. Most proposed downstream strategies such as setting up new detox centers, offering smoking cessation programs, expanding the mental health workforce, or increasing awareness of trauma through media campaigns. However, fewer plans included upstream strategies like providing substance use education in schools, screening at-risk populations, and advocating for policies around alcohol purchasing. In contrast, Emergency Preparedness was only listed as a priority area in a single LHD plan which is surprising considering the COVID-19 pandemic has brought to the forefront the importance of investing in LHDs emergency preparedness. LHDs may need additional support in the coming years to identify ways to bolster their ability to respond to rapidly emerging health issues.

References

1. Cunningham, M., Patel, K., McCall, T., et al. (2024). 2022 National Profile of Local Health Departments. National Association of County and City Health Officials. Washington, DC. Accessed on July 30, 202. https://www.naccho.org/resources/lhd-research/ national-profile-of-local-health-departments
2. Performance Improvement. NACCHO. Published 2024. Accessed July 26, 2024. https://www.naccho.org/programs/public-health-infrastructure/performance-improvement
3. What is collective impact? Collective Impact Forum. Published 2024. Accessed July 26, 2024. https://collectiveimpactforum.org/what-is-collective-impact/
4. Community Health Assessment Toolkit. AHA Community Health Improvement. Published 2024. Accessed July 26, 2024. https://www.healthycommunities.org/resources/community-health-assessment-toolkit
5. CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.