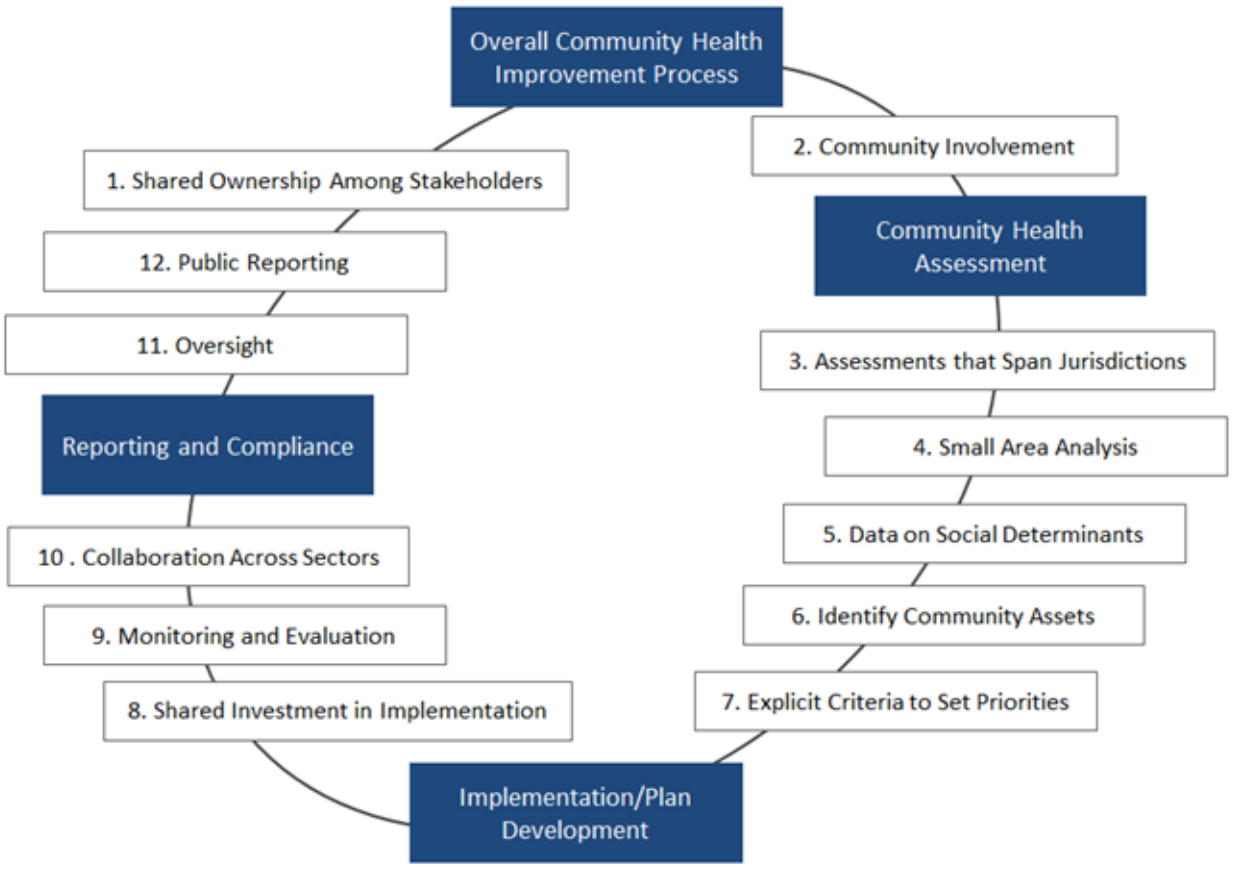
SOME RECOMMENDED PRACTICE AREAS FOR ENHANCING COMMUNITY HEALTH IMPROVEMENT



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Preface

"Had I not been awake I would have missed it,

A wind that rose and whirled …

It came and went so unexpectedly

And almost it seemed dangerously…

A courier blast that there and then

Lapsed ordinary. Not ever

After. And not now."

--Poet Seamus Heaney, "Had I not been awake"

The winds of change are blowing in the field of community health improvement. Courier blasts from the Affordable Health Care Act, and accreditation standards for local/state/tribal health departments, call for improved approaches in community health assessment, implementation, and reporting.

Some see danger—burden, loss of control—in this whirl of shifting oversight. But, should we avoid "lapsing ordinary," we can be awake to this opportunity to enhance the collaborative practice of community health improvement.

Our shared vision for the work of community health improvement (CHI):

- Widespread and effective use of community health improvement methods
- Collaboration that meets the needs of diverse stakeholders and communities
- Improvement in population health and health equity

Achieving a collective impact:

To have a *collective impact* on population health requires a common agenda and shared commitment among those multiple organizations that can affect conditions under which health and well-being occurs (Kania and Kramer, 2011). It requires a prepared workforce—including those from health and human service organizations, business, government—and others who can implement recommended practices to improve community health. Such efforts benefit from intermediary or support organizations that can provide training and technical assistance for effective implementation. A common measurement system can help assure access to continuous information for quality improvement and accountability.

Enhancing collaborative practice –some assets, challenges, and gaps:

The timing is right for enhancing collaborative action for health improvement. The Affordable Health Care Act calls for non-profit hospitals to engage with others, such as health departments, in this work. Many

local health departments will also be involved as part of their requirements for accreditation. Local United Ways and other stakeholders are taking part in similar efforts—in the same communities, often at the same time.

A scan of the field of community health improvement (CHI) reveals a rich array of methods for fulfilling the core functions of assessment, planning, implementation, and evaluation (Institute of Medicine, 1988, 1997, 2003; Turnock, 2009). This report distills practice guidance from prominent models including the Catholic Health Association (2011), the National Association of County and City Health Officials (NACCHO/CDC) MAPP Framework (2001), and the Association for Community Health Improvement (ACHI) (2002); as well as other approaches used by government agencies, United Way, and other stakeholders.

Despite the rich array of practice models, there are significant challenges for collaborative efforts to achieve collective impact. Each model offers its own distinct language to characterize different phases and steps. Evidence is limited for effects of particular CHI models and specific practices, such as engaging community members or setting priorities, on indicators related to planning, implementation, and outcome.

There are critical gaps in practice. Different models show varying attention to attributes that enhance CHI efforts. Sometimes collaboration is limited, with virtually all stakeholders from health organizations and few representing other key sectors. Uncoordinated assessments by different lead organizations, such as hospitals or the local health department, may use different geographic areas that minimize their utility for other stakeholders in the community. Attention to data on social determinants is often missing, restricting the understanding needed to address root causes of health disparities. Where there is monitoring, lack of common measures and transparency may limit community engagement in making sense of the findings.

Key features of promising community health improvement efforts:

Current knowledge and experience suggests seven key features of community health improvement efforts that have the potential to improve population health and health equity. Such efforts:

- **Have a common agenda**—Collective impact requires a shared vision for what the group hopes to accomplish and how they will work together to do so (Kania and Kramer, 2011). This is necessary to resolve differences in interests that can lead to resistance and missed opportunities for different organizations to make their unique contributions.
- **Enhance collaboration across sectors and levels**—Emerging evidence and expert consensus suggest that widespread behavior change and improved health outcomes requires changing the environment through multiple sectors, beyond health organizations to education, business, and government, for instance ; and at multiple ecological levels, beyond individuals to whole communities (Institute of Medicine, 2003). This work requires collaboration—sharing risks, resources, responsibilities, and rewards—among people and organizations with different interests.
- **Assure community participation**—Engagement of community members and other stakeholders in planning and sense making is seen as essential to understanding, implementing and sustaining CHI efforts (Institute of Medicine, 2003). Meaningful participation extends beyond physical presence of community members to include their active engagement in generating ideas, contributing to

decision making, and sharing responsibility for taking action (NIH, *Principles of Community Engagement*, 2011).

- **Use comprehensive approaches to improving population health/equity**—Emerging evidence also suggests that comprehensive interventions, not single programs, are required to improve health outcomes at the population level (Institute of Medicine, 2003; Task Force on Community Preventive Services, *The Community Guide*, accessed via web August 17, 2011).
- **Use evidence-based approaches**—Good practice requires attention to the evidence base—what works and under what conditions—in setting priorities for implementation (Anderson et al., 2005; Brownson et al., 1999; Task Force on Community Preventive Services, *The Community Guide*, accessed via web August 17, 2011).
- **Address social determinants of health**—Social justice requires attention to those broader determinants, such as income inequality and social exclusion, that are associated with marked disparities in health outcomes among some groups (e.g., African Americans, Hispanics, Native Americans) (Braveman et al., 2011; World Health Organization, 2008). Addressing social determinants involves taking action to improve conditions that produce differential exposures (e.g., to stress, toxins), vulnerabilities (e.g., education), and consequences (e.g., limited access to health services for uninsured).
- **Use performance monitoring**—There is an old adage in public health, "You get what you inspect, not what you expect" (Foege, 2011). A shared measurement system helps focus attention on the group's agreed-upon indicators of what success would look like (Kania and Kramer, 2011). Monitoring and evaluation of implementation and outcome is recognized as a core process in community health improvement (Fawcett, Schultz, et al., 2010; Halverson et al., 1998; Institute of Medicine, 1997; Kania and Kramer, 2011; Kindig, 1997; Turnock, 2009).

Context of this report:

A CDC working group (see Acknowledgments) identified 12 practice areas, such as assuring shared ownership and using small area analyses, to fill gaps and enhance core features of community health improvement efforts. This report aims to enhance the work of community health improvement by outlining guidance for implementing these 12 recommended areas of practice.

Our University of Kansas team developed guidance to help support implementation of these recommended practice areas. For each practice area, we provide: a) key steps and recommended (illustrative) implementation, b) a full example reported by a practitioner with experience in the field, and c) other supports (e.g., adaptation of this practice for resources and context, questions for reflection, and sources). This guidance is intended to support effective implementation, not to prescribe a one-size-fits-all approach. These practices need to be adapted for context, situation, and available resources. But, without clear specification of core tasks and recommended implementation, there is inadequate support and no basis for accountability.

These 12 recommended areas of practice reflect emerging evidence and expert consensus of what it takes to implement community health improvement efforts. Table 1 illustrates how the 12 practice areas, taken together, contribute to the core functions and key features of community health improvement.

Table 1. A crosswalk of the 12 recommended practice areas and their contribution to key features of community health improvement efforts.

RECOMMENDED PRACTICE AREAS	FEATURE OF COMMUNITY HEALTH IMPROVEMENT ADDRESSED BY PRACTICE						
	Common Agenda	Collaboration across sectors/levels	Community participation	Comprehensive approaches	Evidence-based approaches	Address social determinants	Performance monitoring
1. Assuring Shared Ownership	✓	✓	✓	✓			
2. Assuring Involvement of Community Members	✓	✓	✓			✓	
3. Assessments that Span Jurisdictions		✓	✓			✓	✓
4. Small Area Analysis	✓		✓			✓	✓
5. Information on Social Determinants	✓	✓	✓	✓		✓	
6. Information on Community Assets		✓	✓	✓			
7. Criteria to Set Priorities	✓	✓	✓	✓	✓		✓
8. Shared Investment of Stakeholders	✓	✓	✓	✓			
9. Monitoring and Evaluation		✓	✓	✓	✓		✓
10. Collaborating Across Sectors	✓	✓	✓	✓	✓		
11. Oversight Mechanisms			✓		✓		✓
12. Formal Reporting			✓				✓

Aim of this report:

This report offers practical guidance for implementing each of the 12 recommended practice areas. It:

- Reflects the phases and steps of prominent models, using language that is ecumenical
- Fills gaps in implementing community health improvement efforts
- Outlines key steps for implementation, harmonizing activities across practice areas

Our aim is to offer a high-level view of best practices but not be overly academic. We put forth core tasks and recommended implementation, recognizing that the different contexts do not lend themselves to a single prescription. We sought a balance of challenge and feasibility, prompting fuller implementation of key practice areas but without being overly burdensome. We call for enhanced accountability, outlining specific approaches for performance monitoring and oversight while recognizing that the work of community health improvement is a shared responsibility.

This report is version 1.0 of a practice guide. We hope that it supports implementation, stimulates critical reflection, and advances efforts to improve conditions for community health and well-being. Together, we can write the next version of guidance for enhancing the work of community health improvement.

SOURCES:

Anderson, LM, Brownson, RC, Fullilove, MT, et al. Evidence-based public health policy and practice: promises and limits. *Am J Prev Med*. 2005;28:226-230.

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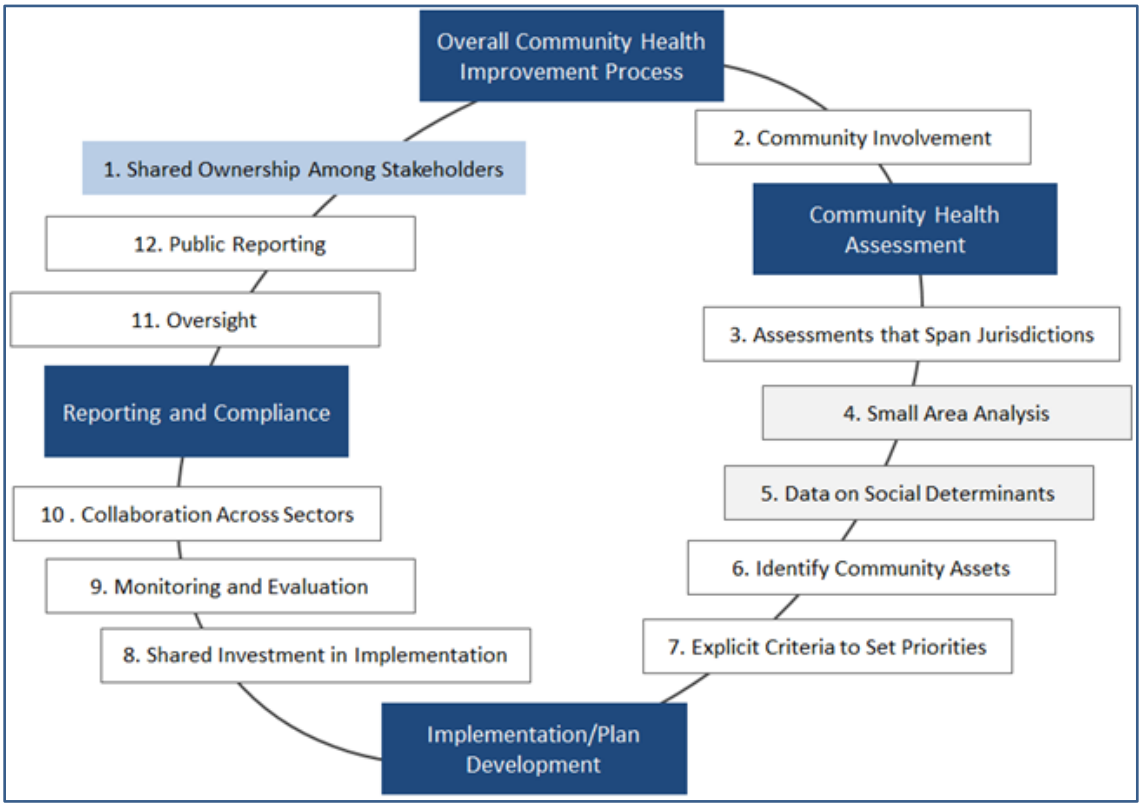
Turnock, B. (2009). *Public health: What is it and how it works*. (4th ed.). Sudbury, MA: Jones and Bartlett Publishers.

World Health Organization, Commission on Social Determinants of Health—Final Report (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organization.

Recommended Practice Area 1:
Assuring Shared Ownership of the Process among Stakeholders



PURPOSE/OVERVIEW: The aim of this practice area is to assure ownership among diverse stakeholders of the entire process—from community assessment through planning and implementation for community health improvement. It involves establishing governance structures and formal agreements that enable diverse stakeholders to work together collaboratively.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify key stakeholders in the assessment and planning process
   - Engage the leadership/board from the hospital, local health department, United Way/human service agencies, government, school district, business, faith community, concerned citizens; (if present) the community advisory board of local community health coalition(s)
   - Ensure representation from diverse sectors that can help address community health issues and from populations most affected by them such as members/advocates from populations experiencing health disparities; e.g., African Americans, Latinos, Native Americans; women, people with disabilities; etc.

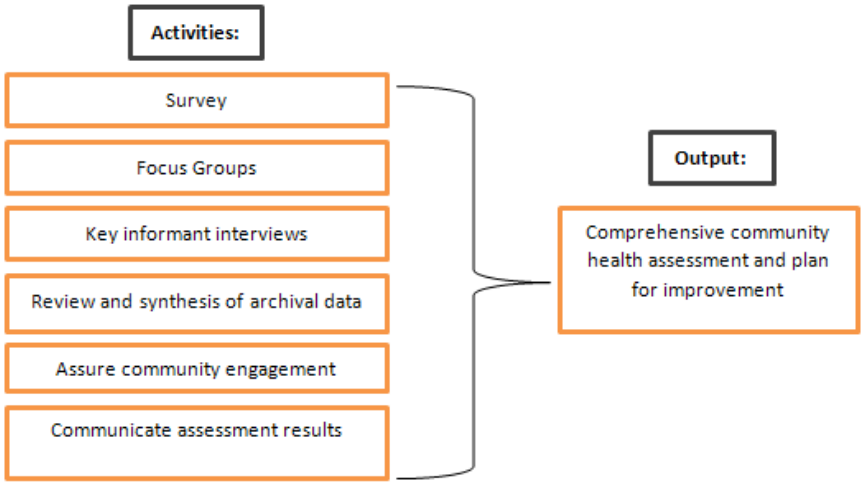
2. ___ Implement planning activities to enhance working relationships among stakeholders
   - Create a coordinating entity for the community health improvement process
   - Facilitate planning retreats or other opportunities to build trust, relationships, communication, and collaborative engagement among stakeholders

3. ___ Determine stakeholders' interests (and offers) for this process

- Facilitate a dialogue about this with key stakeholders including what they see they may gain or lose from being involved
- EXAMPLE:
    - Hospital—Interests: Necessary assessment data and basic plan at low cost; Offers: Staff to assist
    - Local health department—Interests: Better targeting of programs to those who most need them, better understanding of community assets, help meet criteria for accreditation; Offers: Data from BRFSS and other assessments, connections with populations experiencing health disparities
    - United Way— Interests: Data for community planning and priority setting with member agencies; Offers: Information about community needs and assets for addressing them
    - Local community health coalition—Interests: Attention to community concerns and social determinants of health (e.g., education, jobs, housing); Offers: Community voice in decision making

4. ___ Convene and engage key stakeholders in establishing a shared vision for the community health improvement process
    - Engage key stakeholders in establishing a shared vision statement that reflects their dreams for the initiative

5. ___ Identify key outputs from the assessment/planning process and activities needed to produce them
    - Develop a logic model or framework that includes a picture of what the group is doing and what should result from it. For example:



6. ___ Identify human and financial resources needed for CHI work and secure commitments
    - Secure financial commitments from partners for needed coordination, data collection, etc. (e.g., for coordinator to facilitate engagement and follow up on agreed-upon actions)
    - Apply for additional funding, if appropriate, to local health foundation
    - Engage those who have trusting relationships with communities with health disparities (e.g., community leaders, elders, clergy)

7. ___ Establish a working agreement among key stakeholders about their roles and responsibilities in this shared work of assessment, planning, and implementation

- Depending on the context, there may be a continuum of formality to the agreements. For instance, once trust and relationships have been established, the group may develop a formal agreement (e.g., signed Memorandum of Agreement) to support the community health improvement efforts
- Outline the key roles and responsibilities of organizations/individuals in implementing the agreed-upon activities (i.e., who will do what activities, with whom, by when, with what outputs or deliverables)

8. ___ Assure the readiness of key organizations/individuals to fulfill their responsibilities; build capacity as needed
   - Ensure needed training, coaching, and practical tools to support those doing the work

9. ___ Establish the governance and organizational structure for making decisions, managing, and supporting the CHI work
   - Form one community advisory board with diverse membership (e.g., including leadership from the hospital, local health department, United Way, Community Advisory Board of local community health coalition, community members, etc.)
   - Establish rules for decision making
   - Clarify when representatives can speak for their organizations, and when they need to obtain approval from more senior leadership
   - Establish management team and coordinator role
   - Assure needed technical support (e.g., from university/consulting partners)

10. ___ Assure opportunities for community members and representatives from stakeholder organizations to participate fully and ongoing in assessment, planning, and implementation
    - Arrange for community forums/listening sessions and meetings with staff of key agencies
    - Establish comment/feedback period for draft plans for assessment and implementation
    - Communicate adjustments in plan based on feedback

11. ___ Indicate how stakeholders' involvement will be sustained from initial assessment through implementation of the plan for community health improvement
    - Implement a plan for how the group will assure meaningful roles, appropriate responsibilities, adequate resources, minimal risks, and rewards/recognition for those doing this work.

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of assuring shared ownership of the process among stakeholders:

Project Access Dallas – Dallas, Texas

In 2002, key community partners convened to address the issue of uninsured patients' access to health care. These partners included the Dallas County Medical Society, the Dallas/ Ft. Worth Hospital Council, HealthTexas Provider Network (the Baylor Health Care System's employed physician organization), and Central Dallas Ministries (now CitySquare). Invitations were extended to all of the area's hospital systems, the medical school, and local city/county government officials as well as other non-profit leaders.

Numerous stakeholders for this important community issue were identified and quickly became engaged. Hospitals were concerned about the costs associated with high ER utilization. Volunteer physicians -- frustrated by rendering free assessments only to have patients unable to afford needed laboratory tests or specialty care-- were eager to help design a better system. Charity clinics were concerned about helping vulnerable populations access needed specialty care, labs, and procedures. All of these stakeholders were brought to the table, and named lack of access to timely primary & specialty physician care (and prescription access) as a cause of unnecessary suffering among impoverished and uninsured members of the community.

In order to identify the human and financial resources needed for implementation, a local strategy firm donated the services of a young MBA professional to assist in the development of a viable business plan. This detailed plan and budget was approved by each of the four key community partner stakeholders, and ultimately helped prepare the initiative for successful implementation efforts.

Establishing memoranda of agreement among key stakeholders to clarify roles and responsibilities was helpful to their shared work of assessment, planning, and implementation. Governance was shared by the four key convening entities through an established Executive Committee. The Dallas County Medical Society became the fiscal home for the initiative. When 3 years of federal grant funding was received, MOAs were further utilized to divide up the work. CitySquare was responsible for the community health navigation, and HealthTexas Provider Network agreed to provide medical direction and claims management, while hospitals entered into agreements to provide outpatient and inpatient volunteer services to enrollees.

A distinguishing feature of the initiative is its focus on reciprocity. Charity clinics needing labs or specialty services for a patient must agree to provide primary care for that patient. In return, local hospitals provide needed ancillary and outpatient services. In all, this reduces costs to local hospitals by reducing ED utilization rates and avoiding preventable hospitalizations while improving the quality of care to those in need.

Since 2002, this unique collaboration has grown to include more than 2,000 physicians, 16 hospitals, nine charity health clinics, 11 ancillary service support organizations, two national laboratory service organizations, and more than 40,000 nationwide pharmacies—all toward the ultimate goal of providing compassionate care for the uninsured in Dallas.

Source: Interview, Dr. James Walton, Project Access Dallas

ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider what is already available and how responsibilities can be shared among existing staff of key stakeholders. For instance, assessment might make effective

use of secondary data that has already been collected such as using census data and information provided by partners as part of their existing reporting requirements.

QUESTIONS FOR REFLECTION: Who are key stakeholders and what are their interests in this process? How will they share resources and responsibilities for their work together? How will we assure participation from diverse sectors that can help address community health issues, and from populations most affected by them? Who owns the resulting assessment and plan for implementation?

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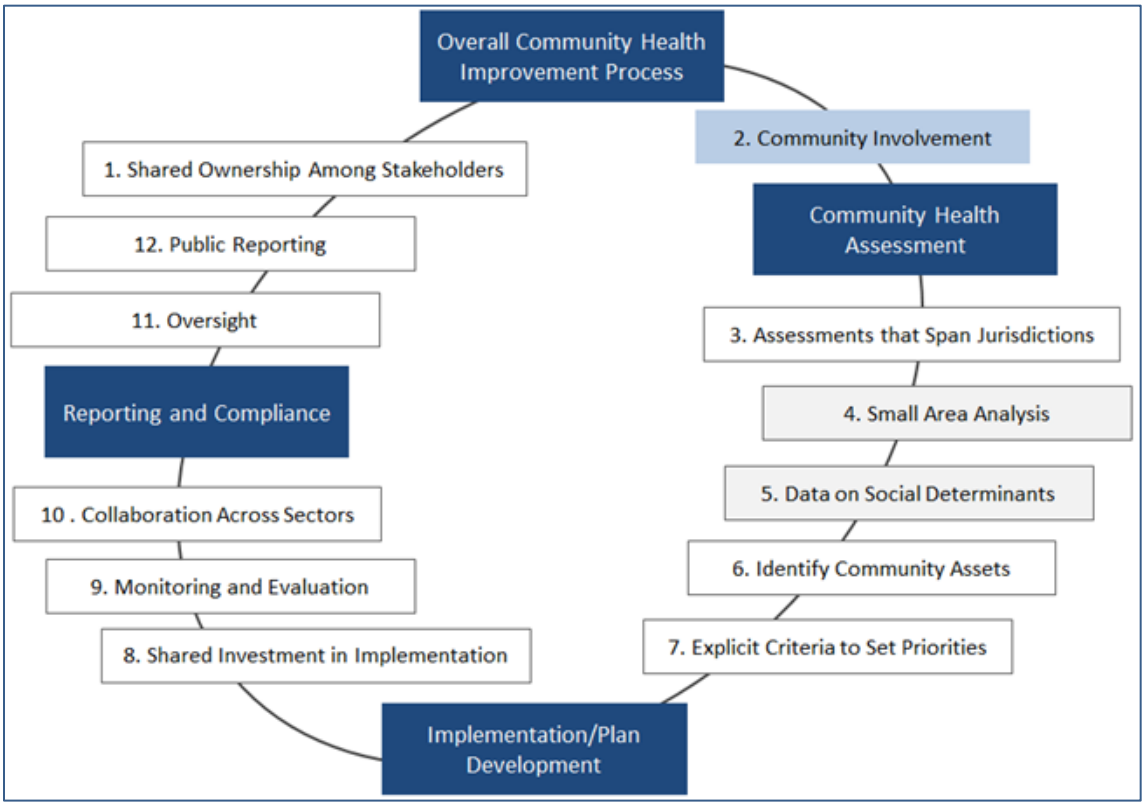
1. Association for Community Health Improvement. Step 1: Plan and Prepare for the Assessment. *Community Health Assessment Toolkit.*
2. National Association of County and City Health Officials. (2001.) Phase 1: Organize for Success / Partnership Development. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
3. Centers for Disease Control and Prevention. (2010). Action Step 1: Assemble The Community Team. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
4. Association for Community Health Improvement. Step 1: Establishing the Assessment Infrastructure. *Community Health Assessment Toolkit.*
5. Voluntary Hospitals of America (1994). Phase I: Internal and External Assessment. *Community Health Assessment: A Process for Positive Change* (77-80). Texas: Voluntary Hospitals of America, Inc.
6. U.S. Department of Health and Human Services. Phase I: Mobilize the Community. *Planned Approach to Community Health: Guide for the Local Coordinator.* Atlanta, GA: U.S. Department of Health and Human Services, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

Recommended Practice Area 2:
Assuring Ongoing Involvement of Community Members



PURPOSE/OVERVIEW: This practice area seeks to involve community members throughout the entire CHI process—from community assessment through planning and implementation. It involves establishing opportunities for decision-making and other meaningful roles and responsibilities for community members in the CHI initiative.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify those community members and groups, including those experiencing health disparities, who have a stake in community health improvement
   - Identify those to be engaged, including:
     - Community members: Those living in the geographic area, receiving and providing health/ human services from organizational stakeholders (e.g., hospitals, local health department, United Way agencies)
     - Those interested members/advocates from groups experiencing health disparities (e.g., African Americans, Latinos, Native Americans, women, people with disabilities)

2. ___ Invite members of the community to participate through connectors
   - In addition to public announcements, personally invite community members through connectors—those with trusting relationships and credibility with members of diverse communities

3. ___Make community participation and involvement easier
   - Enhance access by arranging meetings at times and places convenient for community members, with language/physical access, transportation, child care, and other necessary accommodations

4. ___ Make community participation and involvement more rewarding
   - Assure that the "6 Rs" are incorporated into the group's meetings and activities, including:
     - Recognition—Recognize people for their contributions
     - Respect—Respect and consider people's values, culture, ideas, and time
     - Role—Give each person a clear and meaningful role through which they can contribute(e.g., participating in community advisory board meetings, chairing sub-committees, providing voice about relevance to community concerns)
     - Relationships—Provide opportunities for people to establish relationships and build networks
     - Reward—Ensure that that the rewards of participating in the group outweigh the costs
     - Results—Work to achieve results that are linked to outcomes of importance to the community

5. ___ Assess and enhance the cultural competence of the community health improvement initiative
   - Assess how well the organization's programs, policies, and practices incorporate and accommodate local values and customs
   - Modify current planning or intervention strategies to better reflect the local customs and values of those to be engaged
   - Design proposed activities with the assistance of people from diverse cultures within the community to enhance their appropriateness and effectiveness
   - Ensure that all participants, including those from groups experiencing disparities, have the power and voice to express their concerns without fear of public disapproval or loss of services

6. ___ Learn from community members about their interests during the community assessment, planning, and implementation efforts
   - Facilitate a dialogue with community members about what they think they may gain or lose from the CHI effort (e.g., addressing community concerns and improving conditions that affect health, community voice in planning and decision making)

7. ___ Assure open communication of draft plans/findings and opportunities for review and feedback from the whole community
   - Arrange for community forums/listening sessions in the community and meetings with staff of key agencies
   - Establish comment/feedback period for draft plans for assessment and implementation
   - Communicate adjustments in plan based on feedback

8. ___ Indicate how community members' involvement will be sustained from initial assessment through implementation of the plan for community health improvement

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of assuring ongoing community involvement throughout the process:

Three Rivers District Health Department – Carroll, Gallatin, Owen, and Pendleton Counties - Kentucky

"Sometimes, when you don't have a whole lot of resources, you find out your greatest strengths are people themselves. We need each other desperately." – Melody Stafford, Three Rivers District Health Department

In rural northern Kentucky, the Three Rivers District Health Department knows that community participation is essential to bringing about meaningful change. This four county area, population 44,000, has been implementing the Mobilizing for Action through Planning and Partnerships (MAPP) process to assess and address local community issues. Even in their framing of their local partnerships as related to "health and safety," they were thinking of what would attract the most community member involvement.

Health Department staff invited concerned community citizens and people from numerous sectors of the community to be involved with their assessment and improvement efforts. More than sixty people attended the first meeting to kick off their process, and included judges, field representatives for congressmen, representation from the local faith communities, the hospitals, primary care center, board of health members, chiropractors, police, mayors, judges, the school superintendents, family resource representatives, youth service representatives, adult education, EMS workers and other concerned citizens. Although many area residents lack access to cable television or Internet connections, energetic and resourceful Health Department staff members were effectively able to engage people. They advertised in local newspapers, church bulletins, and through venues such as the county extension service, dentists' offices, pharmacies, local businesses, hospice, the county sheriff, jailors, banks, and area technical colleges. Staff shared that their ability to allocate funds in their budget for food was also very helpful for convening people (they met over the lunch hour over catered sandwiches). At the first meeting, their sign-in sheet allowed people to indicate interest in joining the partnership on health and safety, and then staff followed up with those people (e.g., using postcards and phone calls). Health Department staff members have also gathered support and membership for the partnerships by going and making presentations to many local community groups, including the rotary club, chambers of commerce, the schools, and local faith groups.

Since that successful launch, the Coalition has strategically engaged members and collaborated with other existing local partnerships. The Coalition has worked within each County to identify top health concerns. They sent out local surveys asking county residents (which asked them to identify the three most important things for a healthy county, the three top risky behaviors, and the top three health concerns). $100 gift cards served as incentives for participation and each of the four counties received responses ranging from 600 to 1,000 returned surveys. This community input identified unique priorities for each county, including reducing tobacco use, reducing obesity, decreasing motor vehicle fatalities, and increasing access to care, and has been essential to improvement planning efforts.

The health education staff of the Health Department facilitates the local health and safety partnerships in each of the four counties. This provides institutionalized support for ensuring the staff time needed to facilitate these important community-driven processes.

Source: Interview, Melody Stafford, Three Rivers District Health Department

ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider identifying priority activities and sharing responsibilities for them among existing staff of key stakeholders.

QUESTIONS FOR REFLECTION: How can community members be engaged and contribute fully to this process? How will we assure meaningful opportunities for community members to be involved? What are community members' interests, and how will they be addressed in their roles and responsibilities? How will we make it easier and more rewarding for community members to participate in the effort, including those from groups experiencing health disparities?

SOURCES:

1. Community Tool Box, *Toolkit #8: Increasing Participation and Membership.* KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/dothework/tools_tk_content_page_226.aspx
2. Centers for Disease Control and Prevention. (2010). Action Step 1: Assemble The Community Team; Action Step 2: Develop Team Strategy; Action Step 3: Review All Five CHANGE Sectors; Action Step 8: Build the Community Action Plan; EVALUATION AND REASSESSMENT. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-9, 10, 11-13, 39-42, 43-45). Atlanta: U.S. Department of Health and Human Services.
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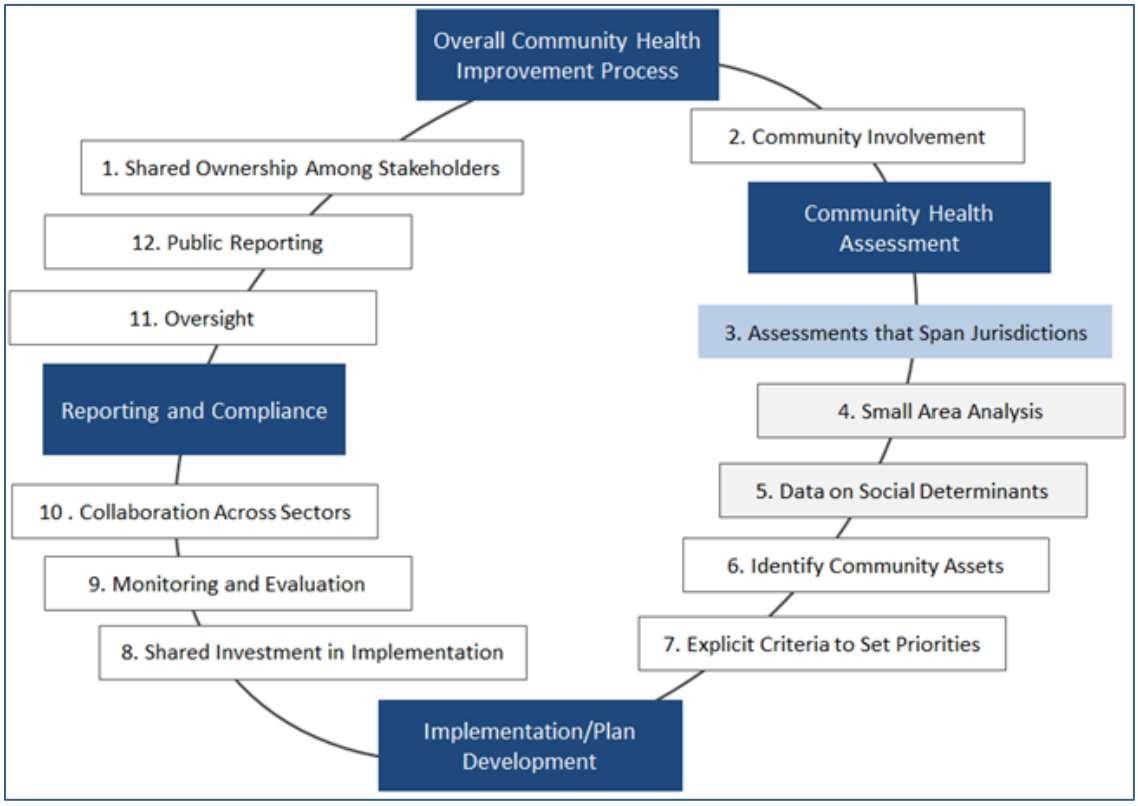
Recommended Practice Area 3:
Arranging Assessments that Span Jurisdictions



PURPOSE/OVERVIEW: This practice area involves adjusting the geographic parameters or area covered in the community assessment to fit the responsibilities/ interests of key stakeholders (e.g., hospitals, local public health agencies, United Way/human service agencies, community health centers, and other stakeholders).

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify intended uses of the data and consider implications for jurisdictions to be included in the assessment
   - Clarify potential uses of the data—e.g., inform the local health department's efforts; meet the local hospital's need for a community health assessment; identify priority health objectives; identify determinants to be addressed; meet reporting requirements for board/funder
   - Consider implications for jurisdiction—e.g., narrow focus on organization's reporting area; broader focus on levels at which social determinants influence health outcomes

2. ___ Specify the geographic areas served by key stakeholders and related overlap/disconnect
   - Identify specific geographic areas of responsibility (distinct and overlapping) for key stakeholders; EXAMPLES: Specific region, county, tribal area, city/town, school district, zip code, census block, MSA, Congressional district, multi-county rural area, particular neighborhoods in urban area, hospital service

area, hospital referral region (i.e., regional health care markets, or more distant places where patients are referred for tertiary medical care)

3. ___ Identify available/potential data sources and the geographic areas that they represent
   - Potential sources include:
     - Census data (see below)
     - BRFSS (CDC Behavior Risk Factor Surveillance System)—State-level data, with periodic oversampling to represent adults in the County
     - Hospital records, for catchment area of a specific hospital
     - YRBS (CDC Youth Risk Behavior Survey) data representing school-aged youth in the school district
     - Crime/safety data from law enforcement officials by zip code/precinct within city/county
     - Department of Education
     - CMS databases
     - PRAMS (CDC Pregnancy Risk Assessment Monitoring System)
     - Data from city/town/county planning office

4. ___ Identify potential community health goals and target populations and implications for defining the region to be covered in this community health assessment
   - EXAMPLE:
     - To address incidence of HIV/AIDS or IV drug use in our rural community, rates in nearby urban area must also be examined
     - To address health care access among Latinos, the urban metropolitan area must be considered
     - To address the social determinant of income inequalities may require regional data to inform regional planning for economic development

5. ___ Characterize aspects of the defined community and broader context that affect community health status and efforts to improve it
   - Provide information on:
     - Demographics of the community (census data)—population size; age (by age groups); income/poverty/S.E.S. (Socio-Economic Position); racial/ethnic composition; nativity/immigrant status; education/literacy; employment/workforce; transportation (e.g., walkability); housing (e.g., owners, renters); crime/safety
     - Moderating factors and social determinants related in health/disparities—income inequality; racism/discrimination; access to health care/insurance; social norms for health behaviors; social capital (i.e., trust, social connectedness); food insecurity (e.g., food stamp utilization)
     - Community context—organized group with history of working together on shared mission to promote health; new or expanded/reduced resources to address community health issues; community leadership and champions, new or expanded leadership, loss of/change in leadership; political commitment (i.e., will to act and keep acting) to change conditions; those engaged have power, authority, and jurisdiction to make the changes that are needed

6. ___ Engage the Community Advisory Board in making a formal decision about the geographic area that will define “community” for this community health assessment. For example:
   - Convene the Community Advisory Board
   - Specify the county or city, hospital service area, etc. to be included
     - For a rural context, this might include multiple counties, with targeted assessments for towns with health disparities
     - For an urban context, this might include one city, with targeted assessments for neighborhoods/census tracts with health disparities

7. ___ Assess the fit of the proposed geographic area with available/potential data sources for the community health assessment
    - Use a small sub-committee to gather and analyze data
    - Determine a core set of indicators and determine sources for the core needed data
    - Note the overlap/gap between the proposed geographic area (e.g., city) and existing/potential data sources (e.g., data only available for county level or hospital catchment area)

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of arranging an assessment that spans jurisdictions:

Health District of Northern Larimer County – Fort Collins, Colorado

Every three years since 1995, the Health District of Northern Larimer County has worked with local partners to conduct a robust community health assessment to identify the area's highest priority health needs. However, the Health District is a geographical subdivision of the state of Colorado that only covers the northern two-thirds of Larimer County. Through changing the jurisdiction of their assessment, the Health District has been able to also meet the needs of the broader county. Dr. Bruce Cooper, the Health District's Medical Director, noted that collaboration with several different partners, such as Larimer County Health and Human Services, United Way, the Larimer County Hospital, and the Centers for Disease Control and Prevention (CDC) enabled the assessment to be administered at the full county level.

The Health District uses multiple assessment methods, including focus groups, interviews, and surveys. In the past, survey administration was designed to reach a representative sample of the Health District's adults. By obtaining supplemental resources from partners, Larimer Health District was able to administer additional surveys in order to also provide a representative sample for the southern part of the county.

For the most recent health assessment conducted in 2010, Larimer County also worked closely in a unique partnership with the Vector-Borne Disease division of the CDC. Sue Hewitt, Health District of Northern Larimer County Coordinator of Research and Evaluation, notes that this collaboration was cost-effective for both organizations. A couple of CDC questions regarding West Nile virus were incorporated into the Larimer County health assessment survey, and combining the resources allowed the surveys to be disseminated to a wider geographical area than either would have been able to reach separately.

Dr. Cooper noted that this year, the health district has been working closely with the hospital in planning the next survey, and given the hospital's broader geographical boundaries, there is the possibility of combining the Larimer County survey with a similar survey from an adjoining county to establish an even broader geographic representation for the next assessment, due to take place in 2013.

Sources: Interview, Dr. Bruce Cooper, Health District of Northern Larimer County Medical Director
Interview, Sue Hewitt, Health District of Northern Larimer County Coordinator of Research and Evaluation

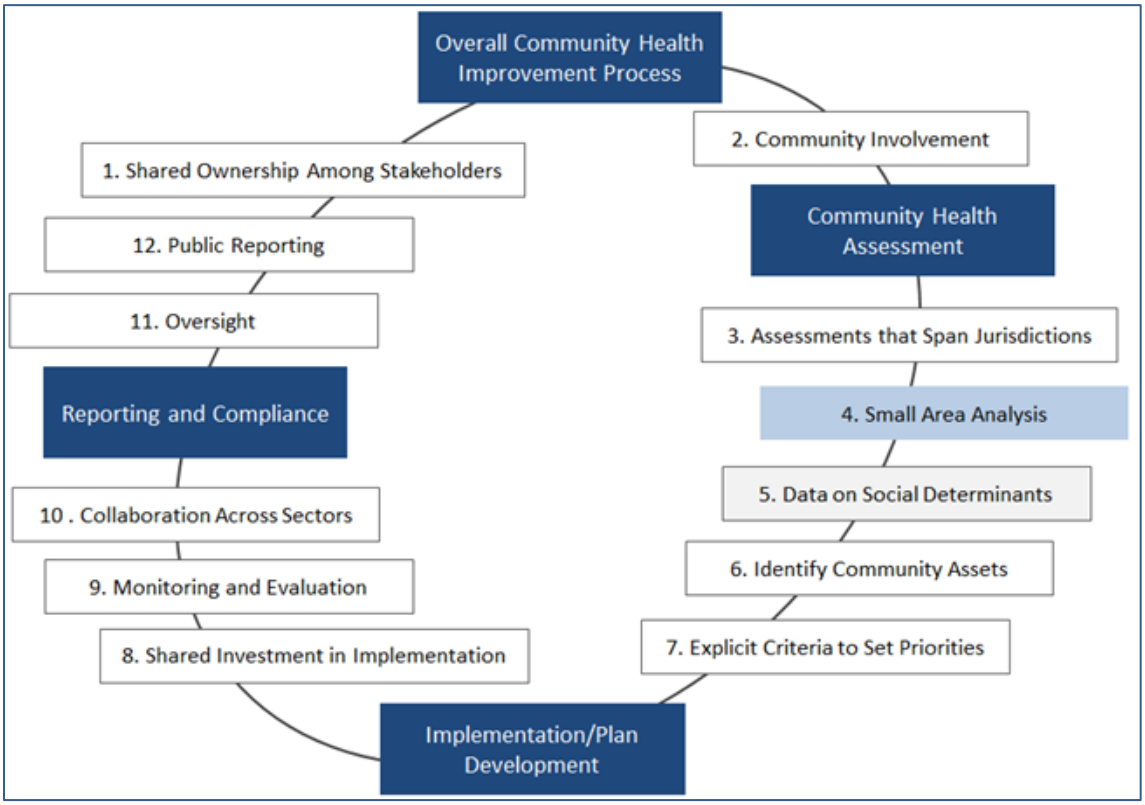
ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider selecting a geographic area that fits most key stakeholders and for which there are existing/potential data sources.

QUESTIONS FOR REFLECTION: How do we define the geographic parameters for this community health assessment? How well does this proposed geographic area fit the data needs of key stakeholders and the community's goals and priority populations? How will key stakeholders and the community have an opportunity to influence decisions about the geographic community to be covered by this assessment?

SOURCES:

1. Association for Community Health Improvement. Step 2: Determine the Purpose and Scope of the Community Health Needs Assessment. Community Health Assessment Toolkit.
2. National Association of County and City Health Officials. (2001.) Phase 3: Four MAPP Assessments, Community Health Status. Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool. Washington, DC: National Association of County and City Health Officials.
3. Association for Community Health Improvement. Step 2: Defining the Purpose and Scope. *Community Health Assessment Toolkit.*
4. National Association of County and City Health Officials. (2008). Task 4: Define the Goals of the Assessment. *Protocol for Assessing Community Excellence in Environmental Health*.
5. Substance Abuse and Mental Health Services Administration. Step 1: Identify the goals of the needs assessment. *Community Needs Assessment Guide*. U.S. Department of Health and Human Services.

Recommended Practice Area 4:
Using Small Area Analysis to Identify Communities with Health Disparities



PURPOSE/OVERVIEW: The overall goal of this practice area is to use small area analysis to help identify communities with disproportionate unmet health needs in particular places (e.g., at the level of sub-county, neighborhood, zipcode, or census tracts). It involves using mapping of the incidence/prevalence of health concerns by zip code or neighborhood and sharing of hospital utilization data to help identify specific groups and places experiencing health disparities.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify intended outcomes and decisions related to health disparities that will result from the smaller-area analyses
   - These may include intended outcomes of being able to:
     - Set priorities for eliminating specific health disparities in particular populations and places (e.g., reduce disparities in incidence/prevalence of diabetes among Latinos or infant mortality among African Americans in particular neighborhoods)
     - Reduce rates of cancer in particular areas
     - Pinpoint potential factors/determinants of health disparities to be addressed by the effort (e.g., differential exposure to stressors, environmental toxins, etc.; differential vulnerabilities associated with lower education, income, power; differential consequences associated with limited access to health services)
     - Make decisions about allocation of resources to address these priority concerns among populations/places experiencing health disparities

2. ___ Identify smaller geographic areas and particular populations in which there may be greater disparities in health outcomes
   - Depending on context, this may include:
     - Specific towns within a county
     - Specific urban neighborhoods of concentrated poverty
     - Particular populations experiencing health disparities (e.g., African Americans, Latinos, Native Americans; low-income women and children)

3. ___ Characterize aspects of the defined community and broader context that may affect health disparities in these places and populations
   - This will likely include information about:
     - Demographics of the community (census data), for example:
       - Population size
       - Age (by age groups)
       - Income/Poverty/S.E.S. (Socio-Economic Position)
       - Racial/ethnic composition
       - Nativity/Immigrant status
       - Education/Literacy
       - Employment/Workforce
       - Transportation (e.g., walkability)
       - Housing (e.g., owners, renters)
       - Crime/safety
     - Environmental conditions that affect priority issues, for example:
       - Density of fast food and tobacco retailers
       - Existence and comprehensiveness of smoke free policies
       - Land use policies
     - Moderating factors and social determinants related to disparities, for example:
       - Income inequality
       - Racism/discrimination
       - Access to health care/insurance
       - Social norms for health behaviors
       - Social capital (i.e., trust, social connectedness)
       - Food insecurity (e.g., food stamp utilization)
     - Context, for example:
       - Organized group with history of working together on shared mission
       - New or expanded/reduced resources to address health disparities
       - New or expanded leadership, loss of/change in leadership
       - Political commitment (i.e., will to act and keep acting) to change conditions
       - Those engaged have power, authority, and jurisdiction to make needed changes

4. ___ Identify potential data sources for the prospective smaller area analyses
   - Data sources may include:
     - Census data
     - BRFSS (Behavior Risk Factor Surveillance System)—State/County-level data, with rare oversampling to represent adults in particular smaller areas
     - YRBS (Youth Risk Behavior Survey) data representing school-aged youth in the school district, with potential sub-analyses by high school catchment area
     - Crime/safety data from law enforcement officials, with data available at zip code level
     - Department of Education
     - CMS databases

- PRAMS (CDC Pregnancy Risk Assessment Monitoring System)
- Data from city/town/county planning office
- Hospital utilization data

5. ___ Engage the Community Advisory Board in deciding the smaller geographic areas for sub-analyses of community health concerns and related disparities
   - Assure opportunities for community members and those responsible for implementation to participate in this decision
   - Specify particular areas (e.g., zip codes, census tracts, towns, neighborhoods of concentrated poverty) to be examined, in light of feasibility and importance to addressing health disparities

6. ___ Assess the fit of the proposed smaller geographic area with available/potential data sources for the sub-analyses
   - Note the overlap/gap between the proposed geographic area (e.g., zip codes) and existing/potential data sources (e.g., data only available at county level or for hospital catchment area)

EXAMPLES OF THIS PRACTICE AREA: Below are examples from the field of using small area analyses to identify places and populations experiencing health disparities:

Example 1: Contra Costa Health Services – Contra Costa County, California

Contra Costa Health Services uses small area analysis to identify health disparities (differences in health outcomes in different groups of people) within the county. They have found that Contra Costa communities with the highest percentage of low-income and non-White residents — San Pablo, Richmond, North Richmond and Pittsburg/Bay Point — experience higher death and disease rates than the county overall for many chronic and communicable diseases, injury, and maternal and child health issues. African Americans have a higher age-adjusted death rate from all causes combined than county residents overall and than Whites, Latinos and Asians.

Data collected in recent years highlights some local health disparities.

- In Contra Costa, the hospitalization rate for asthma for African American children is almost five times that of White children.
- Latinas have a rate of births to teens more than twice that of the county overall.
- Most of the homicide deaths in Contra Costa occurred among African Americans.
- People living in San Pablo, Oakley, Richmond, Antioch, Brentwood and Pittsburg, as well as African Americans and men overall, are more likely to die from heart disease compared to the county overall.
- African Americans and Latinos, as well as people living in San Pablo, Richmond and Pittsburg, are more likely to die from diabetes compared to the county overall.

Contra Costa has created a 5-year plan to reduce health and health care disparities. This includes its own Reducing Health Disparities efforts to improve its service delivery system to address health disparities (e.g., through culturally and linguistically appropriate services), and efforts to partner with local community and public agencies (e.g., education, housing, transportation, community development, land use planning) to address physical and social environmental factors that underlie health inequities.

Source: McKetney, Chuck. Health Disparities in Contra Costa. Retrieved from:
http://www.cchealth.org/groups/rhdi/pdf/health_disparities_in_cc.pdf
http://www.cchealth.org/health_data/hospital_council/2010/pdf/06_health_inequities.pdf

Example 2: The Hot Spotters - Camden, New Jersey

Jeffrey Brenner, a physician in Camden, New Jersey, used hospital utilization data and geomapping to identify "hot spots" in the community – places that had disproportionately high hospital utilization rates. He color-coded city blocks by the hospital costs of residents and found hot spots, including two blocks that included Abigail House nursing home and Northgate II low-income housing tower. Between 2002 and 2008, 900 people in these two areas accounted for 4,000 hospital visits and approximately $200 million in health-care bills. One patient had 324 admissions in five years. Brenner was interested in improving the quality of care for those individuals who were cycling in and out of the hospitals. "Emergency-room visits and hospital admissions should be considered failures of the health-care system until proven otherwise," Brenner stated. Brenner located these hot spots of hospital utilization as a strategy for better understanding possible interventions to promote health equity, improve health care, and reduce health-care costs in the community.

Source: Gawande, Atul. (2011) The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? The New Yorker. Retrieved from: http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=1

ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider selecting smaller areas for analysis that focus on communities of concentrated poverty as identified in census data.

QUESTIONS FOR REFLECTION: How well do the data from the community health assessment help identify concentrations of unmet needs among specific groups in particular places (e.g., zip codes/census tracts)? How well do the data analysis and display by these smaller areas (e.g., mapping of the incidence/prevalence by zip code) help detect and communicate disparities? What factors should influence decisions about the smaller geographic areas selected for this analysis (e.g., feasibility, importance to addressing health disparities)?

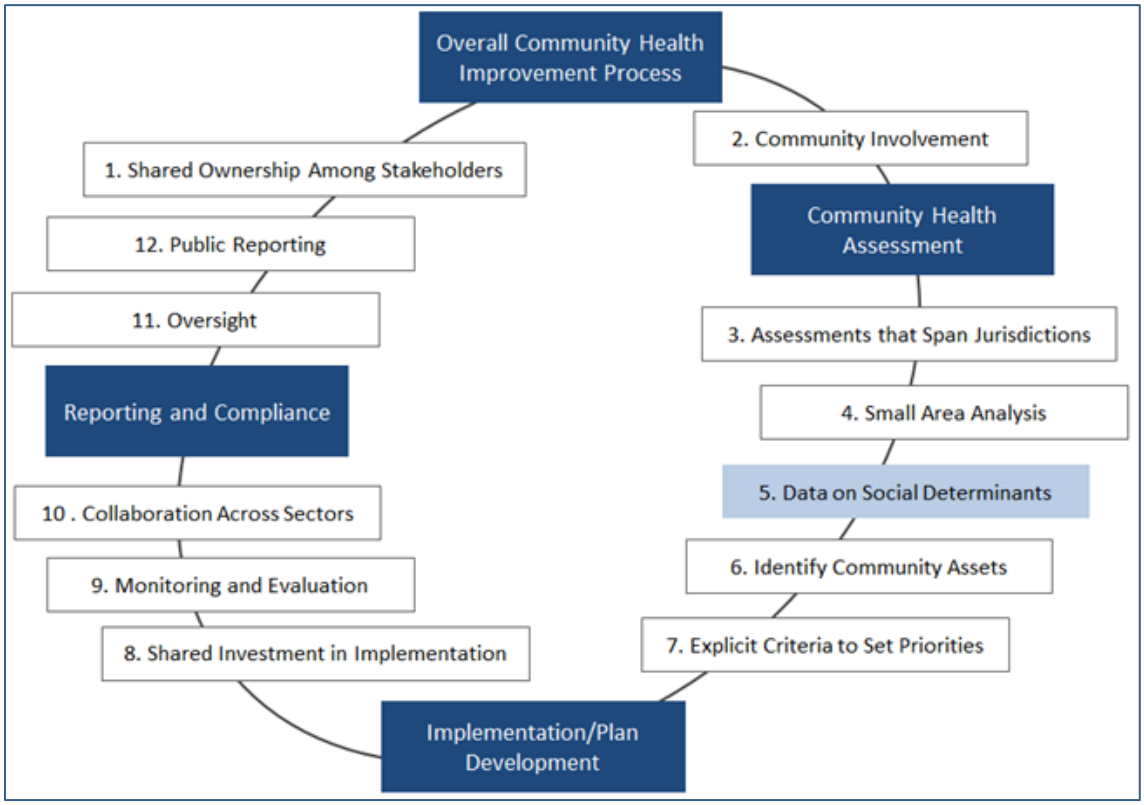
SOURCES:

1. Association for Community Health Improvement. Step 2: Determine the Purpose and Scope of the Community Health Needs Assessment. *Community Health Assessment Toolkit.*
2. Catholic Health Association. (March 2011 Draft). CHNA Step 2: Determine the Purpose and Scope of the Community Health Needs Assessment. *Assessing and Addressing Community Health Needs*.
3. National Association of County and City Health Officials. (2001.) MAPP Framework—All Phases: Phase 1: Organize for Success / Partnership Development; Phase 2: Visioning; Phase 3: Four MAPP Assessments; Phase 4: Identifying Strategic Issues; Phase 5: Formulating Goals and Strategies; Phase 6: Action Cycle. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
4. National Association of County & City Health Officials. (2008). Task 4: Define the Goals of the Assessment. *Protocol for Assessing Community Excellence in Environmental Health*.
5. Substance Abuse and Mental Health Services Administration. Step 1: Identify the Goals of the Needs Assessment. *Community Needs Assessment Guide*. U.S. Department of Health and Human Services.
6. Bay Area Regional Health Inequities Initiative. (2008). *Health Inequities in the Bay Area*. Retrieved from: http://www.barhii.org/press/download/barhii_report08.pdf.
7. Alameda County Health Department. (2006). *Alameda County Health Status Report, Chapter 1: Demographic*

and Social Profile, and Chapter 2: Health Inequities. Retrieved from: http://www.acphd.org/AXBYCZ/Admin/DataReports/00_chsr2006-final.pdf.

8. Gawande, Atul. (2011) The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? *The New Yorker.* Retrieved from: http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=1

Recommended Practice Area 5:
Collecting and Using Information on Social Determinants of Health



PURPOSE/OVERVIEW: The aim of this practice area is to collect and use information on social determinants of health -- those conditions (e.g., education, income inequalities) that contribute to health disparities or inequities in health outcomes among particular groups. This involves examining associations between social determinants (e.g., education, income, housing) and the incidence/prevalence of specific health conditions, as well as taking action to improve social determinants. It may involve geo-mapping to depict these associations in particular places; that is, displaying information by zip code or neighborhood about the incidence/prevalence of particular health conditions (e.g., asthma) and social determinants (e.g., quality of housing/ education/ income level).

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Develop a health equity value orientation in the Community Advisory Board
   - Build awareness and understanding of social determinants of health and upstream (e.g., policy) approaches to health improvement
   - Focus goals on fairness within the health system and environment and its contribution to health (dis)advantage, health gaps, and social gradients of health outcomes (e.g., related to income inequality)
   - Assure access to training on how social determinants produce health disparities, as well as strategies for addressing them

2. ___ Identify key stakeholders' interests related to social determinants of health (SDOH) and criteria for success
    - Example Interests of Key Stakeholders:
        - Hospitals might question whether addressing education, income, housing, etc. is within their mission
        - Policy makers might care about the cost-benefit of investing in improving SDOH
        - Practitioners might ask what the biggest barriers to implementing SDOH interventions will be
    - Some Potential Criteria for Success:
        - Meeting milestones in the process (e.g., completing assessment of SDOH, selecting priority strategies for addressing differential exposures, vulnerabilities, and consequences)
        - Achieving policy changes related to priority goals (e.g. expanding opportunities for better housing, mentoring for low-academic achievers)

3. ___ Engage the Community Advisory Board in making a formal decision about the social determinants to be examined within the community health assessment

4. ___ Identify key social determinants measures to be obtained
    - This will likely include information about:
        - Demographics of the community; determinants related to disparities

5. ___ Identify available/potential data sources for the prospective SDOH and analyses
    - Use social indicator data, such as on transportation or discrimination by social grouping, from CDC's online social determinants of health maps
    - Use morbidity and mortality data for communities most negatively affected by SDOH
    - Use data on behavioral factors such as BRFSS (Behavior Risk Factor Surveillance System) and State/County-level data, with occasional oversampling to represent adults in particular smaller areas

6. ___ Gather data and organize information on social determinants
    - Map current policies and environmental conditions and their implications for differential exposures (e.g., housing/land use policies related to exposure to toxins, access to bike/walking trails, etc.), vulnerabilities (e.g., school policies that affect educational achievement, labor laws that affect worker safety and wages), and consequences(e.g., access to health and human services)
    - Assess resource flows and available resources and political will for addressing determinants
    - Review policies that could address identified social determinants

7. ___ Synthesize evidence about social determinants for populations experiencing health disparities
    - Distill the most important findings from the SDOH assessment into a set of clear conclusions and recommendations for taking action
    - Assess the strength of the evidence about associations between social determinants and health
    - Make recommendations for addressing SDOH with consideration to what changes are more politically feasible and likely to be cost-effective in the long, medium or short term. [Note: to address social determinants, such as income inequalities, might require data at regional level to inform regional planning for economic development]

8. ___ Assure opportunities for community members and those responsible for implementation to participate in reviewing the information

- Arrange for community forums/listening sessions in the community and meetings with staff of key agencies to review the information
- Present data on SDOH and arrange for systematic reflection on what we are seeing, its meaning, and implications for adjustment
- Communicate adjustments in plan based on feedback

9. ___ Plan and implement a communications campaign about social determinants and their effects on health disparities
    - Consider the long-term goals of improving population health and health equity, as well as community readiness and context
    - Implement core components of a communications campaign regarding SDOH (e.g., key messages for key audiences, channels of communication, etc.)
    - Integrate communications plan with CHI implementation plan

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of collecting and using information on social determinants of health:

Alameda County Health Department – California

In order to address the social conditions that lead to poor health, Alameda County is participating as one of the Joint Center for Political and Economic Studies, Health Policy Institute (HPI) National Place Matters Initiative.

Alameda County public health officials recognize that "the odds of being healthy can depend very much on which community you live in" (Health Inequities in the Bay Area Report, 2008). Alameda County has been closely tracking inequities in health, and using data on social determinants of health to inform community health improvement efforts. In-depth analysis of available census data has shown, in fact, that there is a 15-year difference in life expectancy between a child born in West Oakland and a child born in Oakland Hills. The neighborhood into which a child is born can also predict whether he is likely to graduate from high school, or the likelihood of developing medical conditions such as asthma.

Examining mortality and morbidity census data by race and ethnicity shows gross, and growing, disparities. In fact, retroactive analysis has shown the gap between life expectancy for whites and blacks has increased since 1960.

Former Surgeon General David Satcher and his colleagues calculated that between 1991 and 2000, nearly 177,000 deaths were prevented because of advances in medical technology. Matt Beyers, Epidemiologist with the Alameda County Health Department, calculated that if we were to eliminate the disparity between African Americans and whites, we would have avoided over 886,000 deaths.

Alameda County also examines the "social gradient," which, in keeping with trends nationally, shows that the more income and wealth people have, the more likely they are to live longer, while people with less income and wealth can expect to live comparatively shorter lives.

Public health officials in Alameda County use these compelling data in reports and presentations to raise awareness about these inequities and the importance of addressing conditions for health at a fundamental level, and underscores the need for capacity-building to address these systemic issues. These data point to the multiple and interrelated solutions that must be put in place to begin addressing these inequities, including social policies that affect education, housing, land use decisions, and economic development. It also points to needed modifications to the physical environment that influence health, including reducing exposure to toxins, increasing the availability of open space and healthy foods, decreasing the prevalence of

stores specializing in fast foods, alcohol and tobacco, and encouraging residential patterns that promote interaction across boundaries of race and class.

Sources: Mia Luluquisen, Alameda County Health Department; Matt Beyers, Epidemiologist, Alameda County Health Department, Health Inequities in the Bay Area Report, 2008

ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application area in low-resource contexts, consider using only available census data to identify SDOH.

QUESTIONS FOR REFLECTION: What data can help us see broader conditions that affect disparities in health outcomes? From what sources can we obtain such data? How do social determinants produce disparities in health outcomes, and what can we do to address them?

SOURCES:

1. Centers for Disease Control and Prevention. (2010). *Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf
2. HIllemeier, M., Lynch, J., Harper, S. & Casper, M. (2003). Measuring Contextual Characteristics for Community Health. *Health Services Research*. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360969/
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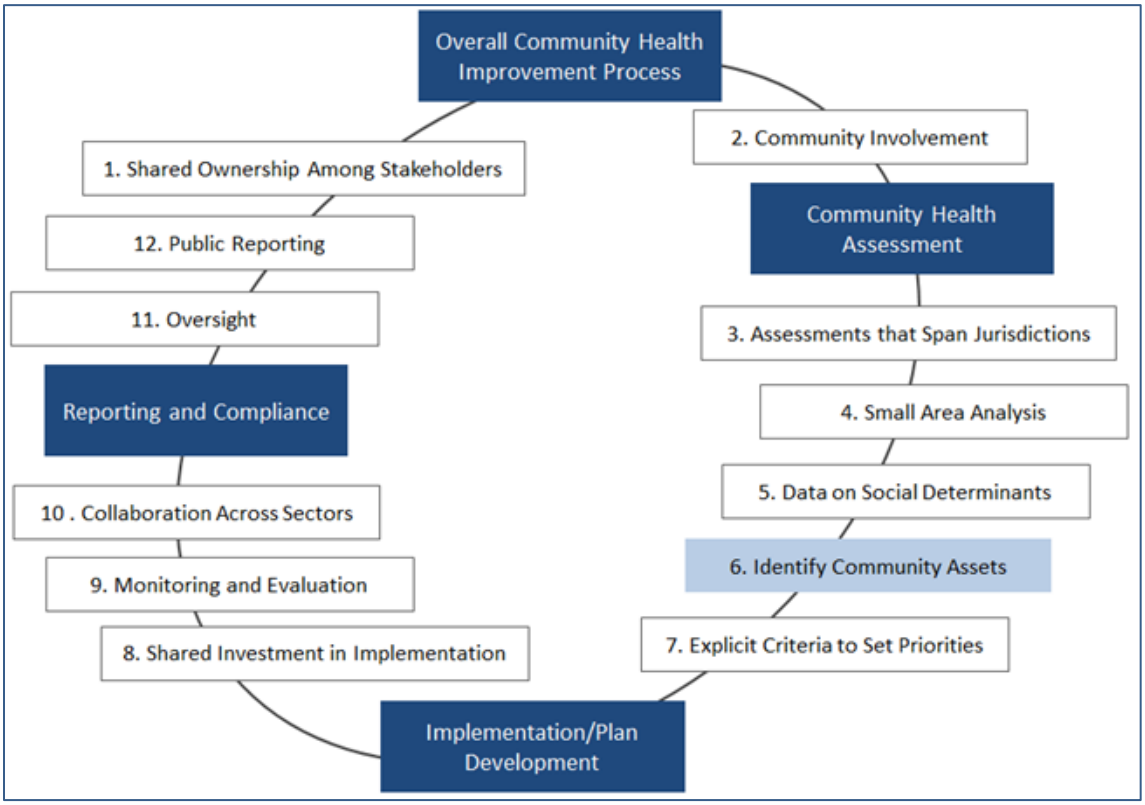
4. Ramirez, L.K., Baker, E.B., & Metzler, M. (2008). *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*. Social Determinants of Health Workgroup at the Centers for Disease Control, U.S. Department of Health and Human Services.
5. Alameda County Public Health Department. (2010). *Rebuilding Neighborhoods, Restoring Health: A report on the impact of foreclosures on public health*. Retrieved from: http://www.acphd.org/AXBYCZ/Admin/DataReports/rebuild_restore_fullrpt_sep2010.pdf.
6. Alameda County Public Health Department. (2006). *Youth Health and Wellness in Alameda County*. Retrieved from: http://www.acphd.org/AXBYCZ/Admin/DataReports/00-youth2006-final.pdf.
7. Bay Area Regional Health Inequities Initiative. (2008). *Health Inequities in the Bay Area*. Retrieved from: http://www.barhii.org/press/download/barhii_report08.pdf.
8. U.S. Centers for Disease Control and Prevention Racial and Ethnic Approaches to Community Health (REACH). (2007). *The Power to ReduceHealth Disparities: Voices from REACH Communities*. Retrieved from: http://www.cdc.gov/nccdphp/dach/chhep/pdf/voices_101007.pdf

Recommended Practice Area 6:
Collecting Information on Community Assets



PURPOSE/OVERVIEW: The aim of this practice area is to collect information on community assets to better understand and enhance resources that can contribute to community health improvement. This involves posing questions to key informants from relevant sectors of the community to identify, communicate, and enhance aspects of individuals, organizations, and agencies that can contribute to the effort.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify the geographic place and/or community of interest for which assets are to be identified, for example:
   - Community of Place
     - Hospital catchment area
     - City/ county
     - Neighborhood
   - Community of Interest/Experience
     - Those at higher risk for particular health outcomes (e.g., children; older adults)
     - Those experiencing health disparities

2. ___ Clarify the purpose and context for the assessment

- Indicate what the group will do with the resulting map of community assets (e.g., prompt use and detect gaps in existing assets)
- Indicate what types of assets will be assessed (e.g., capabilities and service offerings of key individuals, organizations, and agencies)
- Indicate who can do the work of documenting and mapping assets (e.g., part-time coordinator, staff of partner agencies, student interns)
- Acknowledge constraints (e.g., time, money)
- Indicate available resources for this task (e.g., current/prior inventories of services or other assets)

3. ___ Identify information to be gathered about assets. For example:
   - Individuals/ organizations/ agencies that contribute to the health and well-being of the community (e.g., clinics, service agencies, recreational facilities)
   - Environmental conditions that affect priority issues (e.g., access to affordable healthy food options existence and comprehensiveness of smoke free policies, land use policies promoting physical activity)
   - Services (activities, capabilities) particularly important for community health improvement (e.g., health screenings, economic development)
   - Assets particularly important to achieving priority health objectives. For example:
     - Farmers' markets—promoting healthy nutrition
     - Parks—physical activity
     - Schools—promoting educational achievement
     - Youth organizations and Faith Communities—promoting healthy youth development

4. ___ Review documents for information about assets
   - Obtain and review existing service directories and online databases to gather information about community assets
   - Document key information about each asset, for example:
     - Name of Individual/ Organization/Agency
     - Services Offered/Eligibility requirements
     - Capabilities
     - Evidence of quality (if available)
     - Contact information

5. ___ Conduct interviews and/or focus groups with key informants in each relevant sector of the community to gather information about community assets
   - Key sectors may include:
     - Health organizations (e.g., local health department, hospitals, safety net clinics)
     - Government (e.g., city management, parks and recreation, law enforcement, etc.)
     - United Way/human service agencies (e.g., youth organizations)
     - Schools/education
     - Business (e.g., Chamber of Commerce)
     - Faith communities

6. ___ Develop and maintain a publically-available directory of assets for community health improvement, in printed and/ or online forms

7. ___ Use the identified information for community health improvement
   - Draw upon these assets when developing an implementation plan for improvement – these assets will likely be critical partners for your efforts
   - Promote widespread use of relevant services and capabilities

- Identify gap areas for needed development (e.g., places without access to low-cost nutritious food) and make plans for improvement
- Collaborate across organizations and sectors to share, enhance, and sustain key assets

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of identifying and collecting information on community assets:

Greater Rochester Health Foundation – Rochester, NY

In 2008, the Greater Rochester Health Foundation released an RFP for Neighborhood Health Status Improvement grants. The Foundation funded four community groups to engage in asset-based, grassroots efforts to improve the health status of residents in their communities. Barbara Zappia of the Greater Rochester Health Foundation shared that in areas high in poverty, it is easy to identify problems. The purpose of the assets-based approach was to support communities in working from their strengths. "Every community does have assets," Zappia shared. "Find them and you're empowered to do something!"

Grantees receive ongoing technical assistance from the Asset-Based Community Development Institute, and use the continuous "Assess – Plan – Do" model for their work. During the first year of the project, grantees conducted research to identify community assets including institutions, organizations, people, and physical assets. Project team members conducted focus groups where community members already congregated. Team members visited block clubs, churches, youth centers, and also interviewed residents on the street.

During the second year, grantees engaged in planning for implementation. During the third year, community members prioritized issues and implemented plans for change. Health Promotion Project grants (mini-grant awards of up to $500 each) were awarded to implement community-determined projects (e.g., cleaning up a vacant lot to make a community garden) that built upon existing assets. Approximately 30 awards have been distributed to date, which have encouraged community-member involvement and attracted new partners.

Grantees use various methods for communication. A rural grantee uses large community meetings as an ongoing venue to share and receive information. Some of the urban communities utilize existing block clubs for dissemination of information. One grantee, Project HOPE, is supporting a resident-led Neighborhood Summit involving residents of the neighborhood, service providers, elected officials, and others who care. This Summit will serve as a venue for information sharing and planning for implementation of future efforts.

Sources: Interview, Barbara Zappia, Senior Program Officer, Greater Rochester Health Foundation, Asset-Based Community Development Institute website, http://www.abcdinstitute.org/stories/rochester/

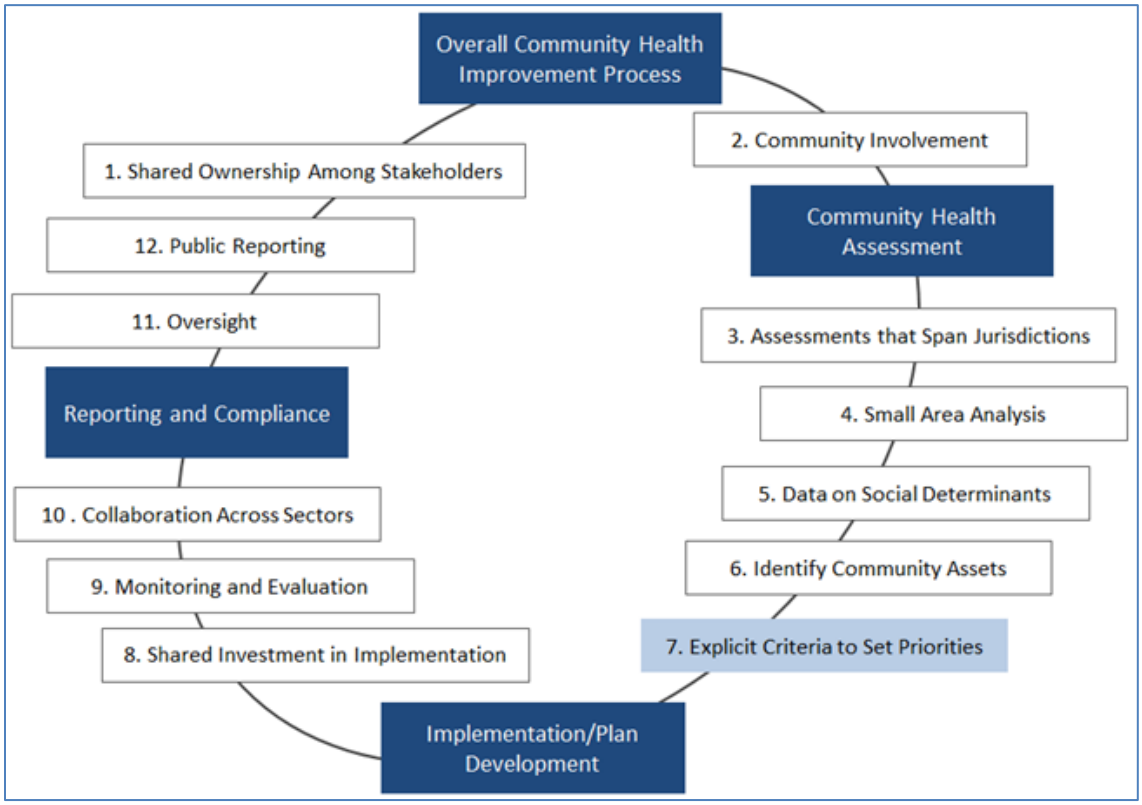
ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application in low-resource contexts, consider using interviews and/or focus groups with a smaller number of individuals from key sectors. Instead of interviewing everyone, consider distributing to some participants a draft list of community assets and asking people to fill in the gaps.

QUESTIONS FOR REFLECTION: What community assets—of individuals, organizations, and agencies—can contribute to community health improvement? What are the opportunities for identifying and gathering data on community assets?

SOURCES:

1. Community Tool Box, *Chapter 3, Section 8: Identifying Community Assets and Resources*. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/sub_section_main_1043.aspx
2. Kretzmann J.P., McKnight J.L. (1993): *Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago: ACTA Publications.
3. McKnight, J. & Kretzmann, J. (1996). *Mapping Community Capacity*. Evanston, IL: Institute for Policy Research, Northwestern University. Retrieved 6 August 2009 from World Wide Web: http://www.northwestern.edu/ipr/publications/papers/mcc.pdf
4. Moore, M. (1994). *Community capacity assessment: A guide for developing an inventory of community-level assets and resources*. Santa Fe, NM: New Mexico Children, Youth and Families Department.
5. National Association of County and City Health Officials. (2001.) MAPP Framework: Phase 3: Four MAPP Assessments, Community Themes and Strengths Assessments. Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool. Washington, DC: National Association of County and City Health Officials.
6. Sharpe, P.A., Greaney, M.L., Lee, P.R., Royce, S.W. (March/April, May/June 2000). Asset-oriented community assessment. *Public Health Reports*, 205-211.
7. Wine, M., Ray, K. (2000). Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey. St. Paul: Amherst H. Wilder Foundation.

Recommended Practice Area 7:
Using Explicit Criteria and Processes to Set Priorities



PURPOSE/OVERVIEW: The aim of this practice area is to use clear criteria to set priority health goals and approaches for implementation. This involves establishing agreed-upon criteria (e.g., fit with community's vision; evidence of effectiveness) and processes (e.g., community involvement in ranking) to inform choices of what goals are addressed and approaches implemented.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify stakeholders' interests in the process of priority setting and planning for implementation
    - Assure participation in priority setting of those from diverse sectors and populations experiencing health disparities
    - Facilitate a dialogue about key stakeholders about their interests. Interests may include:
        - Hospital:
            - Process that people see as fair
            - Plan for implementation that includes priority approaches that are promising and feasible
        - Local health department:
            - Process that people see as open and participatory
            - Plan for implementation that includes priority approaches that are based on evidence of effectiveness
            - Community health plan that helps meet criteria for accreditation

- United Way:
  - Process that engages member agencies, as well as those they serve
  - Plan for implementation that includes priority approaches that address United Way focal areas (e.g., health, education)
- Community advisory board of local community health coalition:
  - Process that engages communities experiencing health disparities in a respectful and meaningful way
  - Plan for implementation that addresses community concerns and social determinants of health (e.g., approaches to improve education, jobs, housing, safety)

2. ___ Establish explicit criteria for setting priorities for community health issues to be addressed.
   - Criteria may include whether the issue is:
     - Consistent with the community's vision and goals
     - Of higher incidence/ prevalence/ magnitude
     - Severe (risk of morbidity/mortality)
     - Aligned with stakeholders' strengths/priorities
     - Important to the community, including those experiencing health disparities
     - In alignment with existing assets and resources for addressing the problem/goal
     - Synergistic with other community issues
     - Feasible to change

3. ___ Establish a process for engaging stakeholders and the broader community in setting priorities for community health issues. For example:
   - Review agreed-upon criteria for setting priority health goals
   - Discuss candidate community health issues
   - Facilitate a dialogue about why an issue is strategic and the consequences for addressing (not addressing) an issue
   - Rate each candidate health concern by importance and feasibility of producing improvement
   - Facilitate a group review and discussion of ratings and possible consolidation of issues
   - Rank order and select 3-5 priority issues
   - Hold a formal vote on final health issues by members of governance body

4. ___ Establish explicit criteria for selecting approaches or interventions to be used in implementation. Criteria may include:
   - Evidence-based approaches—data showing that the approach (and not something else) produced intended results in situations similar to the local context
   - Fit with the local context—i.e., available resources, timing, cultural practices
   - Feasibility of implementing and sustaining the approach/intervention long enough to make a difference
   - Fit with other community efforts and related priorities

5. ___ Establish a process for engaging stakeholders and the broader community in using the criteria to select priority strategies. For example:
   - Review agreed-upon criteria for selecting strategies/approaches
   - Discuss candidate approaches including the evidence base and fit with the community context [See CDC's *Guide to Community Preventive Services* http://www.thecommunityguide.org/ for evidence-based approaches by category (e.g., physical activity, tobacco, alcohol, violence); see links to databases of best practices, http://ctb.ku.edu/en/promisingapproach/Databases_Best_Practices.aspx]
   - Rate each candidate approach by importance in achieving the goal and feasibility of implementation
   - Facilitate a group review and discussion of ratings and potential synergy among approaches

- Rank order and select priority approaches/interventions necessary to achieve the goals
- Hold a formal vote on final approaches/interventions by members of governance body

6. ___ Use the agreed-upon criteria and process to identify and consolidate a list of priority health issues
   - Review agreed-upon criteria (e.g., including fit with community's vision and goals, incidence/prevalence, severity, etc.)
   - Identify several priority health issues to be addressed (e.g., prevent cardiovascular diseases/chronic diseases; increase access to health services/screenings; reduce disparities in infant mortality; promote early childhood education)
   - Consolidate list of issues using common factors for multiple issues (e.g., increase healthy nutrition, physical activity, access to health screenings/services; etc.)

7. ___ Once issues have been prioritized, use the agreed-upon criteria and process to identify and coordinate priority strategies for addressing those issues
   - Review agreed-upon criteria (e.g., including evidence/practice base for candidate strategies, fit with resources and barriers to implementation, etc.)
   - Identify several priority strategies for implementation for each issue (e.g., modifying opportunities for physical activity; enacting policies to increase costs of using tobacco products)
   - Plan to coordinate efforts to implement related interventions across different health issues

8. ___ Assess the fit of the proposed health issues and approaches for implementation with other efforts to address related community health concerns
   - Note the overlap/gap between the proposed priority issues and approaches for implementation with other current/emerging efforts
   - Look to adjust, coordinate, and integrate efforts for maximum community benefit at lowest cost

9. ___ Engage the Community Advisory Board in making a formal decision about priority goal areas and approaches for implementation

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of using explicit criteria and processes to set priorities:

Health District of Northern Larimer County – Fort Collins, Colorado

Every three years, Larimer County conducts a community health assessment and planning process to prioritize community-identified problems. Initially, assessment results were analyzed using the Hanlon Method. Criteria used for this prioritization included the extent of problem, the severity of the problem, and the amenability of the problem to remediation. However, Dr. Bruce Cooper, Medical Director for the Health District of Northern Larimer County, reported some seemingly irrational results that the Hanlon Method provided. In one of the early surveys, one of the issues that emerged from the Hanlon Method with highest rankings in terms of extent and severity was low rates of pap smears among women. However, Dr. Cooper shared that rates of mortality and morbidity rates from cervical cancer were extremely low, suggesting that there was a disconnect between what the Hanlon Method suggested as high priority health needs, and what was actually needed in the community.

In more recent years, the Health District of Northern Larimer County has customized criteria for setting priorities to better suit their local needs. They have combined the extent and severity components of the Hanlon Method with the use of epidemiological concepts and risk ratios to come up with attributable burden due to risk factors and preventable burden based on amenability of risk factors to change. This burden of disease estimate is used to generate an initial list of priority diseases, priority risk factors, and priority interventions. Several years ago, Larimer County also added community values to its set of criteria to ensure that prioritized problems addressed the top-of-mind concerns of the community. Additionally, the Board considers whether there are gaps in healthcare services in the community when setting priorities. For example, if there is a basic health need that no one else in the community is administering services for, that need may become a higher priority.

Larimer County gathers feedback from the community via multiple methods, including widely distributed community surveys and multiple focus groups with various target populations in the community. These focus groups include the general public, business leaders, key leaders (political leaders, large employers, administration from the University of Colorado), healthcare providers, mental health care providers, non-profit and health and human services agencies, and one focus group conducted in Spanish. During the focus groups, a facilitator seeks community feedback about top health concerns and possible solutions. Ultimately, Health District staff help synthesize rankings of burden of disease, risk factors, amenability of interventions, gaps in existing services, and qualitative information gathered from the community, and presents this data to the Health District Board for consideration and consensus-building.

A previous community health improvement implementation plan prioritized decreasing the rate of smoking. Remarkable progress has been made since 1995, when results of the health assessment survey showed that the rate of smoking was 18%. A survey conducted in 2010 showed a decline to 11.5% in the Northern Health District, and 11.9% in all of Larimer County.

Sources: Interview, Dr. Bruce Cooper, Health District of Northern Larimer County Medical Director, Interview, Sue Hewitt, Health District of Northern Larimer County Coordinator of Research and Evaluation, Interview, Jim Burdine, Dr.P.H., Texas A&M Health Science Center

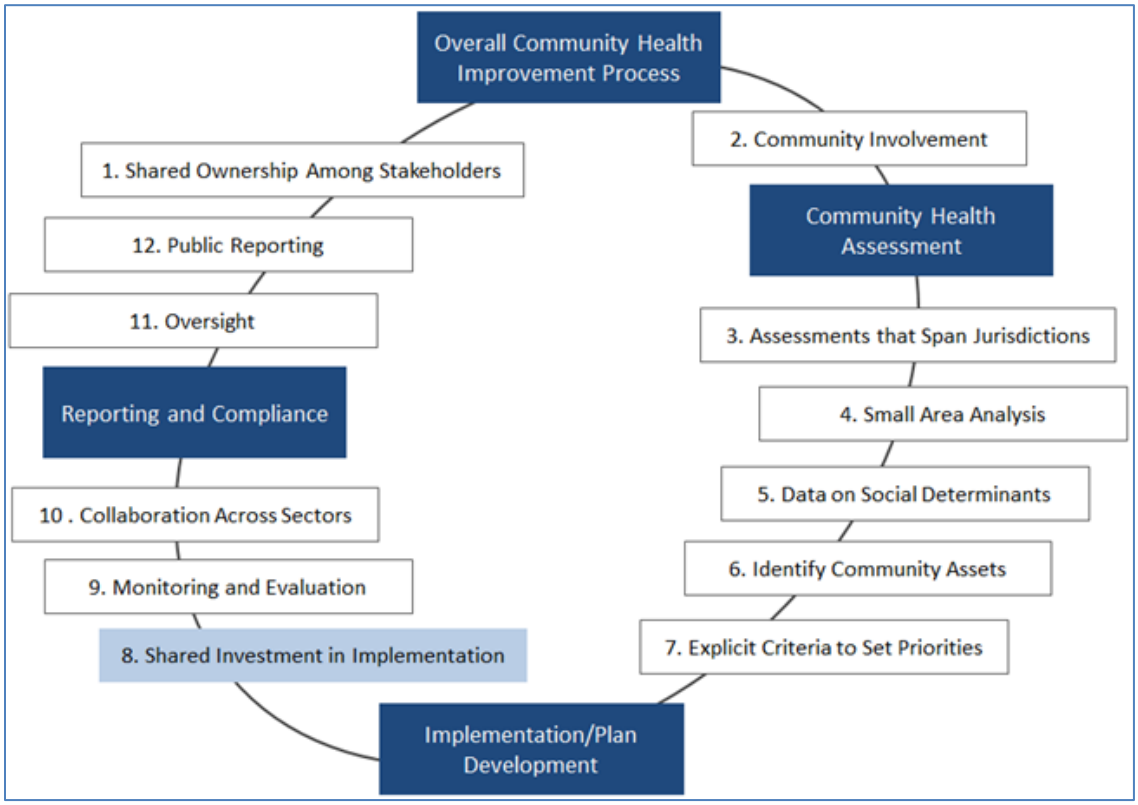
ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider having a smaller working group meet to draft criteria and review process and then engage community and key stakeholders in two, three-hour retreats to make decisions about priority issues and strategies.

QUESTIONS FOR REFLECTION: What are the biggest and most serious health issues in our community? What criteria and processes will be used to set priorities for health goals addressed and approaches implemented? How will we assure participation of the community and key stakeholders, including those from diverse sectors and populations most affected by health concerns? How will we ensure transparency regarding the prioritization process? Does the resulting plan include health goals seen as important to the community, as well as approaches sufficient to meet the prioritized goals?

SOURCES:

1. Catholic Health Association. (March 2011 Draft). Developing an Implementation Strategy, Step 5: Define and Validate Priorities. *Assessing and Addressing Community Health Needs*.
2. National Association of County and City Health Officials. (2001.) Phase 4: Strategic Issues and Phase 5: Formulating Goals and Strategies. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
3. Centers for Disease Control and Prevention. (2010). Action Step 7d: Complete the Community Health Improvement Planning Template *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
4. Association for Community Health Improvement. Step 4: Selecting Priorities. *Community Health Assessment Toolkit.*
5. Voluntary Hospitals of America (1994). Phase V: Establishing Priorities and Planning for Collaborative Action. *Community Health Assessment: A Process for Positive Change*. Texas: Voluntary Hospitals of America, Inc.
6. National Association of County & City Health Officials. (2008). Task 8: Select Standards; Task 9: Create Environmental Health Issue Profiles; Task 10: Rank the Environmental Health Issues; Task 11: Set Priorities for Action. *Protocol for Assessing Community Excellence in Environmental Health*.
7. HRSA Maternal and Child Health Needs Assessment Guide: Step 4: Setting 10 (or more) Priorities.

Recommended Practice Area 8:
Assuring Shared Investment and Commitments of Diverse Stakeholders



PURPOSE/OVERVIEW: The objective of this practice area is to create shared investment among diverse stakeholders in implementing the plan. It involves facilitating pledges of human and financial resources in implementing the plan from stakeholders/ organizations representing different sectors of the community. Legally-binding agreements can help assure follow through on commitments.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___Identify key stakeholders and support organizations whose commitments are important to successful implementation of the plan
   - Engage leadership/board from the hospital, local health department, United Way/human service agencies, Community advisory board of local community health coalition, etc.
   - Engage community members (e.g., through focus groups and forums)
   - Engage university/consultant organizations and others needed to support the CHI effort

2. ___ Assure participation of those from diverse sectors that can help address priority issues and those who can reach populations most affected by them
   - In addition to the hospital and local health department, engage local community health coalitions, United Way/human service agencies, business/worksites, education/ schools, parks and recreation, law enforcement, faith communities, and other relevant sectors

- Engage Community/ cultural/ advocacy organizations serving populations experiencing health disparities (e.g., African Americans, Latinos, Native Americans; women, people with disabilities)
- Arrange for community forums/listening sessions in the community and meetings with staff of key agencies
- Communicate adjustments in implementation based on feedback

3. ___ Determine stakeholders' and support organizations' potential contributions to implementation. These may include:
   - Hospital: Staff to assist in some implementation tasks
   - Local health department: Staff time, experience in implementing selected approaches
   - United Way: Relationships with member agencies with a variety of community assets and engagements with communities most affected
   - Community health coalition: Ongoing activities of action committees and community members engaged in implementing health promotion strategies
   - Community/ cultural/ advocacy organizations: Relationships and reach within communities experiencing health disparities
   - University/consultant organizations: technical assistance and evaluation services

4. ___ Identify key outputs and related activities that should result from implementation of the plan's strategies. These may include:
   - Outputs—Fully-implemented programs, policy changes, environmental changes, media communications, etc.
   - Activities—Action plans, Advocacy and social marketing efforts, Program implementation, etc.

5. ___ Develop and implement a comprehensive action plan for implementation
   - Develop action plans for each major activity (who will do what, with whom, by when, with what communication, with what requirements for resources)
   - Develop an overall action plan that integrates all major activities for implementation

6. ___ Identify human and financial resources needed and potentially available for this work and secure commitments from partners
   - Secure legally-binding financial commitments from partners for needed activities (e.g., for 50% time paid coordinator)
   - Apply for additional funding for implementation to local health foundation
   - Engage those organizations that have trusting relationships with communities with health disparities (e.g., faith communities)

7. ___ Establish an agreement among key stakeholders about their roles and responsibilities in this shared work of implementation
   - Depending on the context, there may be a continuum of formality to the agreements. For instance, once the process moves to implementation, the group will benefit from a more formal agreement (e.g., signed contract or scope of work) outlining responsibilities for all key parties. (This increased formality may be needed to attract resources necessary to implement identified interventions.)
   - Outline the key roles and responsibilities of organizations/individuals involved in implementing the agreed-upon activities (i.e., who will do what activities, with whom, by when, with what outputs or deliverables)

8. ___ Assess the fit of proposed implementation activities with other ongoing/planned community improvement efforts and attempt to coordinate and integrate efforts

- Note the fit/overlap/gap between the proposed implementation plan and other planned efforts
- Look to adjust, coordinate, and integrate efforts for maximum community benefit at lowest cost

9. ___ Engage the Community Advisory Board in making a formal decision about investments for implementing the community health improvement plan

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of assuring shared investment and commitments of diverse stakeholders:

Bread of Healing Clinic – Milwaukee, WI

The community has identified access to health care for the uninsured as a major issue in Milwaukee, WI. Professionals seeing this problem in their daily practice began collaborating to meet the needs of uninsured people in their community, establishing Bread of Healing Clinic in the Lindsay Heights Neighborhood, and later in 2 additional neighborhoods. This Clinic partners with multiple health organizations, faith communities, and grantmakers to ensure shared responsibility for serving the uninsured. Key partners and support organizations include: the Cross Lutheran Church, the Aurora Sinai Medical Center, the University of Wisconsin School of Medicine and Public Health, local foundations, and other local faith groups. The clinic has grown from humble beginnings (open one half-day each week) to now offering services six days per week through three clinic locations, supported by a full-time and volunteer administrative staff and an independent 501c3 status.

The Clinic prizes collaborations that support model programming, quality of care, and cost effectiveness through shared service delivery. Shared investment in the implementation plan helps to create a win-win situation for all partners: meeting community-determined needs by helping provide medical services to the uninsured, saving the local hospital money in ER visits by uninsured patients, providing excellent educational field opportunities for health professions students, and providing service opportunities for members of local faith communities.

The ongoing human and financial commitments of key stakeholders and establishment of legally-binding agreements has been critical to the sustainability of the Bread of Healing Clinic's efforts. For example, Aurora Sinai Medical Center funds the employment of the Clinic's full-time Director, while local faith groups provide fundraising and volunteer support. Local Foundations also provide assistance with other Clinic operations, such as the full-time pharmacist, who is then able to secure free or low-cost pharmaceuticals for distribution of more than one million dollars' worth of pharmaceutical products to in-need patients through 16 local free health clinics through their Medshare program. Additionally, largely due to efforts by Bread of Healing Clinic partners, free clinics are "at the table" of the Milwaukee Healthcare Partnership, keeping access to care for low-income residents on the local agenda.

Source: Dr. Tom Jackson, Board Member, Bread of Healing Clinic

ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider having a mix of informal memoranda of agreements between local organizations that can share staff and resources and reserve legally-binding agreements for those few organizations where money is exchanged.

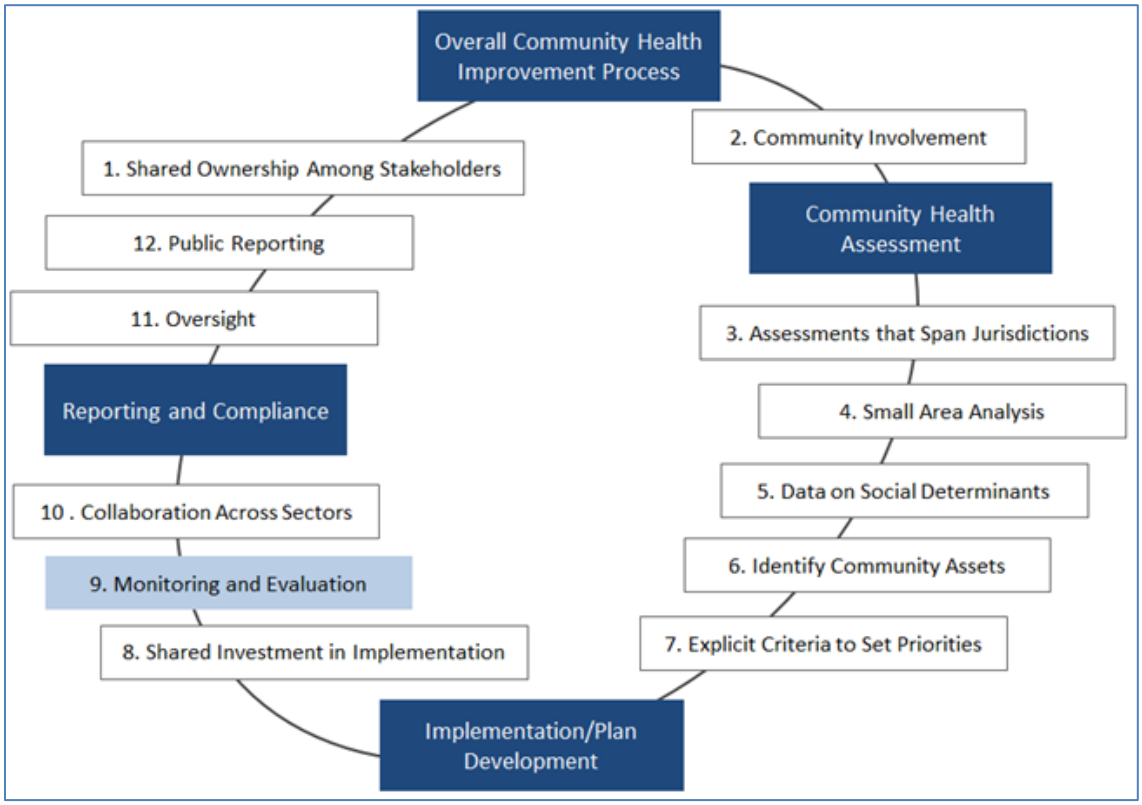
QUESTIONS FOR REFLECTION: What resources are needed from which individuals/organizations for implementation to be successful? How is each stakeholder's role spelled out in the action plan for implementation? How will they be engaged in this process to increase the chances of their

investment? What types of agreements will optimize participation and follow through on commitments in this shared work?

SOURCES:

1. Catholic Health Association. (March 2011 Draft). Developing an Implementation Strategy, Steps 1-8. *Assessing and Addressing Community Health Needs* (85-107).
2. National Association of County and City Health Officials. (2001.) MAPP Framework: Phase 1: Organize for Success/ Partnership Development; Phase 2: Visioning; Phase 6: Action Cycle. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
3. Centers for Disease Control and Prevention. (2010). Action Step 8: Build the Community Action Plan. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
4. Association for Community Health Improvement. Step 6: Planning for Action and Monitoring Progress. *Community Health Assessment Toolkit.*
5. Voluntary Hospitals of America (1994). Phase VI: Action and Evaluation. *Community Health Assessment: A Process for Positive Change* (77-80). Texas: Voluntary Hospitals of America, Inc.
6. National Association of County & City Health Officials. (2008). Task 12: Develop an Action Plan. *Protocol for Assessing Community Excellence in Environmental Health*.
7. U.S. Department of Health and Human Services. Phase IV: Developing a Comprehensive Intervention Plan. *Planned Approach to Community Health: Guide for the Local Coordinator.* Atlanta, GA: U.S. Department of Health and Human Services, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
8. HRSA Maternal and Child Health Needs Assessment Guide: Design Programs and Allocate Resources.

Recommended Practice Area 9:
Participatory Monitoring and Evaluation of Community Health Improvement Efforts



PURPOSE/OVERVIEW: The aim of this practice area is to engage stakeholders in design and use of the monitoring and evaluation system. It involves engaging stakeholders with diverse interests in selecting key evaluation questions and methods and using the information to examine what it is happening, what it means, and implications for adjustments. Although named later in the cycle, this practice area's emphasis on ongoing organizational learning and accountability makes it integral to all phases of the community health improvement process.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify key stakeholders in the monitoring and evaluation process and their criteria for success for the community health improvement effort
   - Engage key stakeholders (i.e., leadership/board from the hospital, local health department, United Way, community advisory board of local community health coalition, etc.) in a dialogue about "what success would look like and how we would know it"
   - Identify criteria for success of the CHI effort. For example:
     - Meeting milestones in the process (e.g., completing community health assessment)
     - Achieving environmental and policy changes related to priority goals (e.g. expanding opportunities for physical activity, expanding tobacco-free zones)
     - Improvements in incidence/prevalence of key behaviors (e.g., % reporting regular engagement in physical activity)
     - Outcomes (e.g., % of children/adults overweight)

2. ___ Assure participation in the evaluation of those in diverse sectors and groups who can help understand, improve, and assure transparency of the effort
    - In addition to the hospital and local health department, engage local community health coalitions, United Way/human service agencies, business/ worksites, education/ schools, parks and recreation, law enforcement, faith communities, and other relevant sectors in reviewing reports.

3. ___ Facilitate dialogue to determine stakeholders' interests and reporting needs from the monitoring and evaluation system. For example:
    - Hospital reporting needs: Data on performance measures (e.g., completion of community assessment, implementation plan, other milestones)
    - Local health department reporting needs: Data on performance measures (e.g., completion of community assessment, environmental and policy changes resulting from implementation of strategies, etc.) and documentation of activities that meet accreditation standards
    - United Way reporting needs: Documented implementation of interventions and their effects on community-level outcomes for UWA goal areas (e.g., health, education)
    - Community advisory board of local community health coalition reporting needs: Evidence of community participation in reviewing the data and considering its meaning and implications for improvement; Particular attention to data on effects of efforts on reducing health inequities

4. ___ Identify key evaluation questions, measures, and methods to be used
    - Using the logic model or framework for the CHI initiative, facilitate a dialogue about evaluation questions, measures, and methods
        - Example Evaluation Questions:
            1) To what extent does the community health improvement effort meet proposed performance measures (e.g., milestones for assessment, etc.)?
            2) To what extent does the community health improvement effort implement proposed policy and environmental changes?
            3) How do policy and environmental changes contribute to improvements in targeted objectives (e.g., reduce tobacco use; promote physical activity, healthy nutrition, and access to health services)?
            4) How are policy and environmental changes associated with changes in population-level behavioral outcomes (e.g., reported 30-day use of tobacco products)?
        - Example Evaluation Measures:
            - Environmental and policy changes related to objectives
            - Incidence/prevalence of key behaviors (e.g., % reporting regular engagement in physical activity, eating fruits and vegetables, tobacco use)
            - Outcomes (e.g., % of children/adults overweight; other relevant HP 2020 indicators)
        - Example Evaluation Methods:
            - Review and synthesis of archival data of community-level indicators
            - Behavioral surveys
            - Key informant interviews
            - Focus groups

5. ___ Identify human and financial resources needed for the evaluation and secure commitments/ agreements about sharing roles, responsibilities, and data
    - Secure commitments of financial resources for monitoring and evaluation activities
    - Engage university/consulting partners to help design and implement participatory evaluation

- Develop a signed MOA that outlines the key roles and responsibilities of organizations/individuals in implementing the agreed-upon monitoring and evaluation activities (i.e., who will do what activities, with whom, by when, with what outputs or deliverables, with what communication with whom)

6. ___ Collect and analyze the data using systematic methods
   - Implement activities for data collection
   - Provide descriptive data (e.g., rates, frequency, changes over time) and visual displays of information (e.g., graphs) related to each evaluation question
   - Implement methods to assure the quality of the data (e.g., reliability, validity)

7. ___ Engage stakeholders in dialogue about what the results mean and their implications for adjustment
   - Arrange for brief (e.g., 1/2 day) and regular (e.g., twice yearly) retreats to review emerging data for key evaluation questions
   - Prepare and facilitative collaborative review of data summaries and graphs of key findings
   - Focus the participatory review on three questions—What are we seeing (in the data)? What does it mean? What are the implications for adjustment in the CHI initiative?

8. ___ Develop and implement a communications plan to make transparent and public the results and accomplishments of the CHI initiative
   - Make the report of evaluation results publically available
   - Establish public comment/feedback period for draft evaluation reports
   - Communicate accomplishments to the broader community and honor those champions who helped bring them about
   - Report where results fell short of goals and plans for improving outcomes

9. ___ Indicate how stakeholders' involvement in monitoring and evaluation will be sustained
   - Indicate how the evaluation team will assure meaningful roles, appropriate responsibilities, adequate resources, minimal risks, and rewards for those doing this work

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of using participatory approaches in monitoring and evaluation of community health improvement efforts:

Brazos Valley Health Partnership – Brazos Valley, Texas

The Brazos Valley Health Partnership engages community stakeholders in participatory evaluation and planning efforts. A community advisory board gives input on designing the research questions, reviewing research ideas, and reviewing grant proposals. The Partnership also reaches out to key stakeholders, such as the Brazos County Council of Government, to ensure their interests are considered. The community health assessment conducted by the Partnership includes the 8 counties around College Station, Texas. In 2010, they conducted 3500 household surveys, extensive discussion groups, and secondary data analysis. Community members were involved in every stage of the research, from the design through implementation.

An essential element of their efforts involves communicating results back to the communities (for example, by sharing results with the Chamber of Commerce over a pancake breakfast). The Partnership conducted regional health summits to share assessment results and plan for next steps. These summits were one-half to three-quarters of a day long and ranged from 150 to 200 participants. Cross-sectional buy-in included the Brazos County Council of Government, health care providers, United Way and other non-profit organizations,

regional hospitals, chambers of commerce, public health departments, and the NAACP. Research findings were presented, and then small breakout groups were formed on 8 to 10 topics related to key findings. These groups would organize into task groups, and spend six to eight weeks identifying best practices, project plans, and possible grant applications in those areas. All of the task groups then reassembled to share their findings and prioritize plans for implementation. Many stakeholders, including the local Mental Health/Mental Retardation Association, actively use the community assessment information to guide their planning for program implementation. Recently prioritized issues have included food availability and transportation.

Britt Allen, the Chair of the Brazos Valley Health Partnership, noted how valuable their partnership with the Center for Community Health Development at Texas A&M has been, and shared that "the key thing is that the information is used to actually do something!"

The Partnership is already planning how to improve their next community health assessment, including putting information a format that communities can use more easily.

Sources: Britt Allen, Chair, Brazos Valley Health Partnership, and Jim Burdine, Dr.P.H., Texas A&M Health Science Center School of Rural Public Health.

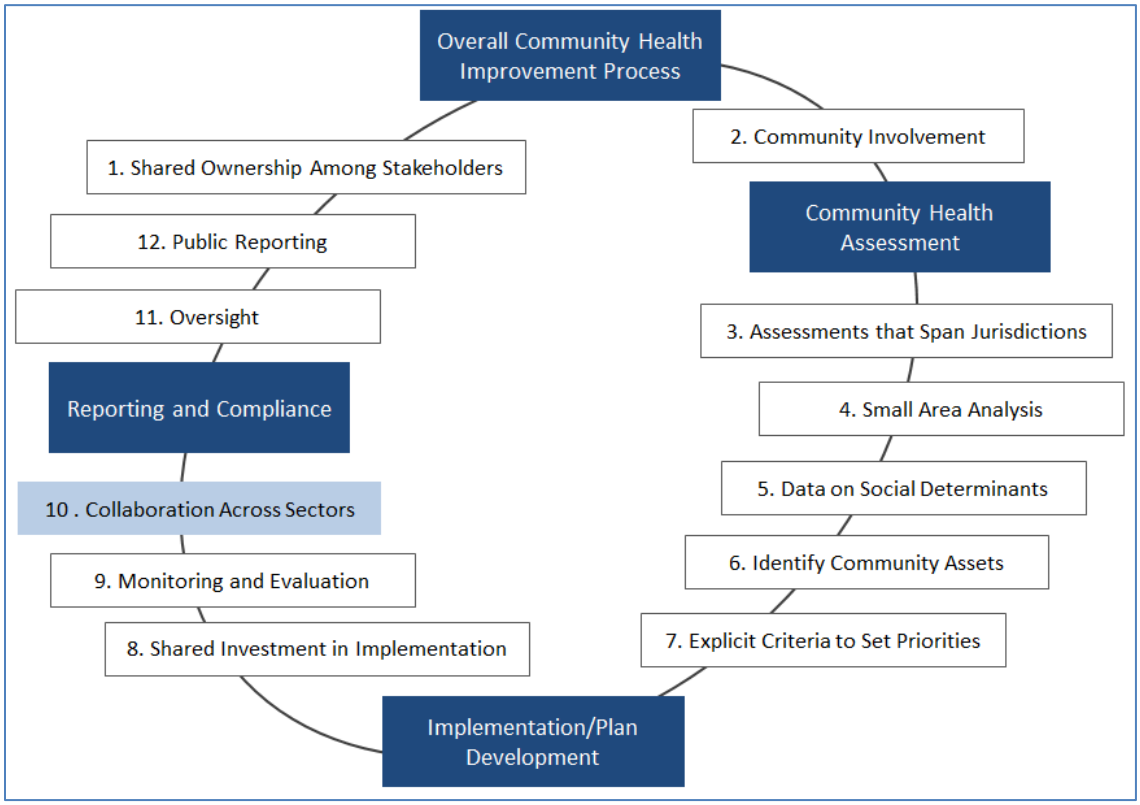
ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider identifying priority evaluation measures and methods and sharing responsibilities for them among existing staff of key stakeholders.

QUESTIONS FOR REFLECTION: What would success look like for the community health improvement effort, and how would we know it? What are the diverse stakeholders' interests and reporting needs? How well do the proposed evaluation measures and methods help answer key evaluation questions? How will we assure participation from diverse stakeholders in dialogue about what the results/findings mean and their implications for adjustment? How openly and effectively will key findings/accomplishments be communicated to diverse stakeholders and the broader community?

SOURCES:

1. Catholic Health Association. (March 2011 Draft). CHNA Step 6: Document and Communicate Results; Implementation Strategy, Step 8: Update and Sustain the Implementation Strategy. *Assessing and Addressing Community Health Needs* (85-107).
2. National Association of County and City Health Officials. (2001.) Phase 6: Action Cycle. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
3. Association for Community Health Improvement. Step 5: Documenting and Communicating Results; Step 6: Planning for Action and Monitoring Progress. *Community Health Assessment Toolkit.*
4. Centers for Disease Control and Prevention. (2010). Action Step 8: Build the Community Action Plan, Track Your Progress; Evaluation and Reassessment. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
5. Voluntary Hospitals of America (1994). Phase IV: Synthesis and Communication of Information; Phase VI: Action and Evaluation. *Community Health Assessment: A Process for Positive Change* (77-80). Texas: Voluntary Hospitals of America, Inc.

Recommended Practice Area 10:
Collaborating Across Sectors to Implement Comprehensive Strategies



PURPOSE/OVERVIEW: The aim of this practice area is to assure ongoing collaboration among diverse stakeholders from different sectors in implementing comprehensive strategies for community health improvement. It involves sharing risks, resources, and responsibilities among those doing the work. There is particular attention to engaging diverse stakeholders from multiple sectors—government, business, education, health, human services, faith communities—that can implement comprehensive strategies and reach those with health disparities.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify key stakeholders across multiple sectors of the community whose organizations can contribute to addressing priority issues and related strategies
   - Engage leadership/board from the hospital, local health department, United Way/human service agencies, community advisory board of local community health coalition, government, law enforcement, transportation, business, etc.
   - Encourage participation in implementation from those diverse sectors that can help implement strategies and populations most affected by priority issues

2. ___ Determine stakeholders' interests/wants and offers for implementation. *See Recommended Practice #1, Key Task #4.*

3. ___ Develop a plan for implementing priority strategies that engages multiple sectors of the community to collaboratively:
   - Review the priority strategies with attention to evidence base for achieving intended results, available resources, timing, and competing/ complementary priorities
   - Develop an action plan for activities related to each priority strategy (i.e., who will do what activities, with whom, by when, with what communication with whom)
   - Select and train implementers
   - Assure technical support for full implementations of each strategy
   - Monitor and obtain feedback on implementation and results

4. ___ Identify human and financial resources needed to implement priority strategies and secure commitments *(See Recommended Practice #1, Key Strategy #6)*

5. ___ Establish a memorandum of agreement to integrate and coordinate roles and responsibilities for implementation among key stakeholders
   - Develop a signed MOA that outlines the key roles and responsibilities of organizations/individuals from different sectors (e.g., hospital, health department, business, government--parks and recreation, law enforcement)
   - Develop an action plan that integrates agreed-upon activities for implementation (i.e., who will do what activities, with whom, by when, with what outputs or deliverables, with what communication with whom)

6. ___ Assess the readiness of key organizations/individuals to fulfill their implementation responsibilities and build capacity to work together across diverse sectors (*See Recommended Practice #1, Key Task #8)*

7. ___ Establish/engage the governance and organizational structure for making decisions, managing, and supporting the work *(See Recommended Practice #1, Key Task #10)*

8. ___ Indicate how stakeholders' involvement from diverse sectors will be sustained long enough for implementation to achieve improvement in community health outcomes *(See Recommended Practice #1, Key Task #11)*

EXAMPLE OF THIS PRACTICE AREA: Below is an example of collaborating across sectors to implement comprehensive strategies:

Bell Hill Healthy Community Initiative, UMass Memorial Medical Center – Worcester, Massachusetts

The UMass Memorial Medical Center has engaged diverse community stakeholders in partnerships addressing issues of local concern in Bell Hill, a low income neighborhood located adjacent to the UMass Memorial main campus. Key priority areas undertaken include: 1) improved environmental conditions; 2) improved access to care for residents; 3) improved dental health; 4) lack of access to healthy foods; and 5) neighborhood revitalization/affordable housing. UMass Memorial has partnered with diverse groups to develop innovative implementation strategies. Partners include the local government, the faith-based community, the local health department, local schools, law enforcement, the regional environmental council, local neighborhood groups, the East Side Community Development Corporation, NeighborWorks

Homeownership Center, Massachusetts Housing Partnership, and the State Department of Housing and Community Development.

Some key achievements of these inter-sectorial partnerships include:

- A youth empowerment model in which the Regional Environmental Council trains youth to test for lead contamination and work to provide lead remediation (with funds from the local health department)
- A Care Mobile that visits local schools and a park and helps connect children and adults with needed services and a medical home
- Physician care to elderly residents living in a Worcester Housing Authority subsidized high-rise housing unit
- Preventive dental screenings in two local elementary schools (where the free and reduced lunch rate is 92 percent)
- A youth employment program in which local youth built a community garden on the parsonage of the Christ Baptist Church
- A neighborhood revitalization initiative that has leveraged over four million dollars to transform abandoned buildings into affordable homes and assist first-time homeowners with financial training and loan assistance

A key to these successful efforts has been the collaboration of diverse stakeholders from various community sectors who are committed to improving quality of life for residents in Worcester.

Source: Mónica Escobar Lowell, Vice President, Community Relations, UMass Memorial Health Center.

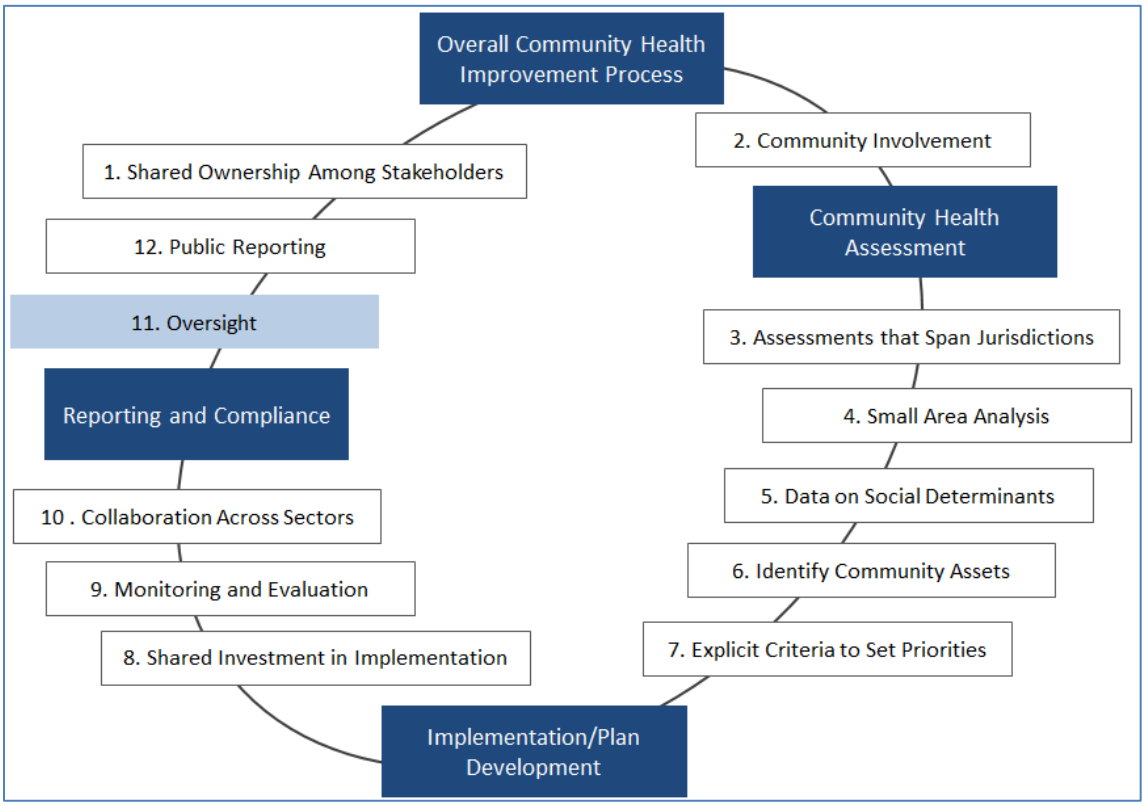
ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application of this practice area in low-resource contexts, consider identifying priority implementation activities and sharing responsibilities for them among existing staff of key stakeholders.

QUESTIONS FOR REFLECTION: What stakeholders from which community sectors can help implement priority strategies in the action plan? What are stakeholders' interests and offers for implementation? How will they share risks, resources, and responsibilities for their work together? How will we assure participation from diverse sectors that can help implement the comprehensive strategies, and from populations most affected by them? What would ongoing and effective collaboration look like, and how would we know it (e.g., sustained engagement in implementation)?

SOURCES:

1. Catholic Health Association. (March 2011 Draft). Developing an Implementation Strategy, Steps 1-8. *Assessing and Addressing Community Health Needs* (85-107).
2. National Association of County and City Health Officials. (2001.) Phase 5: Goals / Strategies; Phase 6: Action Cycle. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
3. Centers for Disease Control and Prevention. (2010). Action Step 7d: Complete the Community Health Improvement Planning Template; Action Step 8: Build the Community Action Plan, Track Your Progress. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
4. Association for Community Health Improvement. Step 6: Planning for Action and Monitoring Progress. *Community Health Assessment Toolkit.*
5. Voluntary Hospitals of America (1994). Phase V: Establishing Priorities and Planning for Collaborative Action; Phase VI: Action and Evaluation. *Community Health Assessment: A Process for Positive Change*. Texas: Voluntary Hospitals of America, Inc.

Recommended Practice Area 11:
Establishing Oversight Mechanisms



PURPOSE/OVERVIEW: The aim of this practice area is to ensure that a broad group is engaged in monitoring implementation of the plan—at organizational, local, and regional levels. It puts in place operating procedures to assure oversight of community health improvement efforts.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Recruit independent and competent leadership for the oversight group
   - Enlist those with the collaborative skills and experience to support the oversight effort

2. ___ Define the group's purpose and level of oversight.
   - For example:
     - Coordinating and supervisory function
     - Provide a strategic perspective
     - Monitor improvement efforts to assure a coherent, effective, and efficient effort
     - Critique and question implementation to ensure quality and fairness
     - Look for efficiencies and assess results
     - Provide advice and support for evidence-based interventions to be implemented
     - Use a whole-of-the-community approach that integrates efforts under a single, comprehensive plan
     - Identify levels of oversight appropriate to the context (e.g., local city/county, state, region)

3. ___ Establish the governance and organizational structure for making decisions, managing, and supporting the work of the oversight committee.

- Form a Community Advisory Board to include members with independent status, decision making authority, and appreciation for the community health improvement process
- Clarify rules for decision making
- Arrange for needed technical support (e.g., from university/consulting partners)
- Assure that institutional partners reflect the economic, social and cultural characteristics of the region

4. ___ Develop clear roles and responsibilities for the oversight group
   - Develop rules for meetings, participation, decision making, and other operational functions
   - Address key questions for the group, including: What are the limits of everyone's authority? How and when are we expected to work together? On which issues is decision-making shared? With whom? What are the lines of communication?

5. ___ Build group members' understanding of shared goals, strategies, and reporting requirements
   - Provide orientation and technical briefing to oversight group to enhance understanding of priority health issues, social determinants or upstream factors contributing to the problem, priority strategies for addressing issues, and performance measures to be reported in monitoring and evaluation

6. ____ Assess the oversight committee's readiness to fulfill their responsibilities and provide training, coaching, and tools to build capacity as needed. (*See Recommended Practice #1, Key Task #8)*

7. ___ Review data from the monitoring and evaluation system as part of oversight
   - Review data from the monitoring and evaluation system—including those for key evaluation questions related to success
   - Establish a time schedule and format for reviewing information (e.g., quarterly meetings to assess progress; annual oversight retreat for fuller review)
   - Some key questions for oversight—Does implementation lead to intended outputs and outcomes? Does it address identified needs? Does implementation need to be adjusted to meet current needs or changes in the situation?

8. ___ Indicate how oversight process will be sustained throughout the community health improvement effort
   - Indicate how the group will assure meaningful roles, appropriate responsibilities, adequate resources, minimal risks, and rewards for those providing oversight

9. ___ Develop a communications and formal reporting plan to stakeholders and the public that assures transparency about the plan and progress in implementation
   - Disseminate copies of the final plan and progress reports to city and county agencies and community-based organizations
   - Develop formal mechanisms to inform and encourage involvement of key leaders (e.g., department heads, staff) and the community, including those from groups experiencing health disparities, in reviewing progress reports

10. ___ Develop incentives for success and celebrate accomplishments through rewards and recognition
    - Make continued access to grants/resources contingent on performance
    - Provide public recognition of the CHI effort, including accomplishments and areas for improvement
    - Honor champions for community health improvement

EXAMPLE OF THIS PRACTICE AREA: Below is an example from the field of establishing oversight mechanisms:

Advancing the State of the Art in Community Benefit (ASACB)

From 2002 – 2006, 70 hospitals from Arizona, California, Nevada, and Texas participated in a multi-state demonstration project entitled "Advancing the State of the Art in Community Benefit," which developed and field tested a set of standards for community benefit programming. These included institutional policy measures focused on establishing governance, management, and operations metrics to foster strong oversight and institutional engagement. These measures are included in the table below.

Table: Advancing the State of the Art in Community Benefit (ASACB) Institutional Policy Measures

1. Establish a board-level committee to provide oversight and policy guidance for all charitable services and activities supported by the hospital.
2. Specific roles and responsibilities of CB committee are clearly documented and used as guides for decision making.
3. Establish explicit guidelines for recruitment of members of CB committee that address competencies related to the Core Principles.
4. Establish explicit criteria and process used by CB committee and staff to select priority program areas of focus.
5. Establish formal mechanisms to integrate CB planning and budgeting with organizational strategic planning to ensure continuity and proactive investment.
6. Ensure that senior leader (e.g., president, CEO) is directly accountable for CB performance.
7. Establish a formal mechanism that requires periodic verbal and written staff report to trustees of progress towards identified measurable objectives.
8. Revise job description(s) to outline specific responsibilities and competencies needed for CB staff. Establish minimum 1 FTE dedicated time for ongoing CB management.
9. Include language in job description that gives CB managers the authority to make design changes in program activities to align with Core Principles.
10. Develop formal documentation to ensure that senior managers who supervise CB staff have appropriate competencies and support application of Core Principles.
11. Develop formal mechanisms to inform and encourage involvement of key leaders and employees.
12. Develop formal plans that outline strategies to be implemented for a minimum of three years.
13. Engage and leverage the expertise of local public health agencies and academic institutions.
14. Develop and document strategy to seek periodic input from diverse community stakeholders on proposed CB activities.

Image Source: Barnett, Kevin. (2009). Beyond the Numerical Tally: Quality and Stewardship in Community Benefit. Public Health Institute. Retrieved from: http://www.communityhlth.org/communityhlth/files/files_projects/PHI_ASACB_policybrief_Feb09.pdf

Since the conclusion of this demonstration project, a variety of health systems across the country have implemented (or are in the process of implementing) these standards, including Aurora Health Care, Catholic Healthcare West, UMASS Memorial Health System, and Trinity Health. An example of Catholic Healthcare West's implementation of Policy #6 listed above (ensuring that senior leadership is directly accountable for community benefits performance) is that they have changed the title of their hospital presidents to "Service Area Leaders," reflecting job responsibilities that transcend hospital walls. To see Catholic Healthcare West's

full Community Benefit Policy and Procedure, visit: http://www.communityhlth.org/communityhlth/files/files_projects/CHWPP3_45REVISED.pdf.

For more governance/ decision-making sample resource documents, visit: http://www.communityhlth.org/communityhlth/projects/asacb/asacbtools.html.

Sources: Barnett, Kevin. (2009). Beyond the Numerical Tally: Quality and Stewardship in Community Benefit. Public Health Institute. Retrieved from: http://www.communityhlth.org/communityhlth/files/files_projects/PHI_ASACB_policybrief_Feb09.pdf
Interview: Eileen Barsi, Catholic Healthcare West.

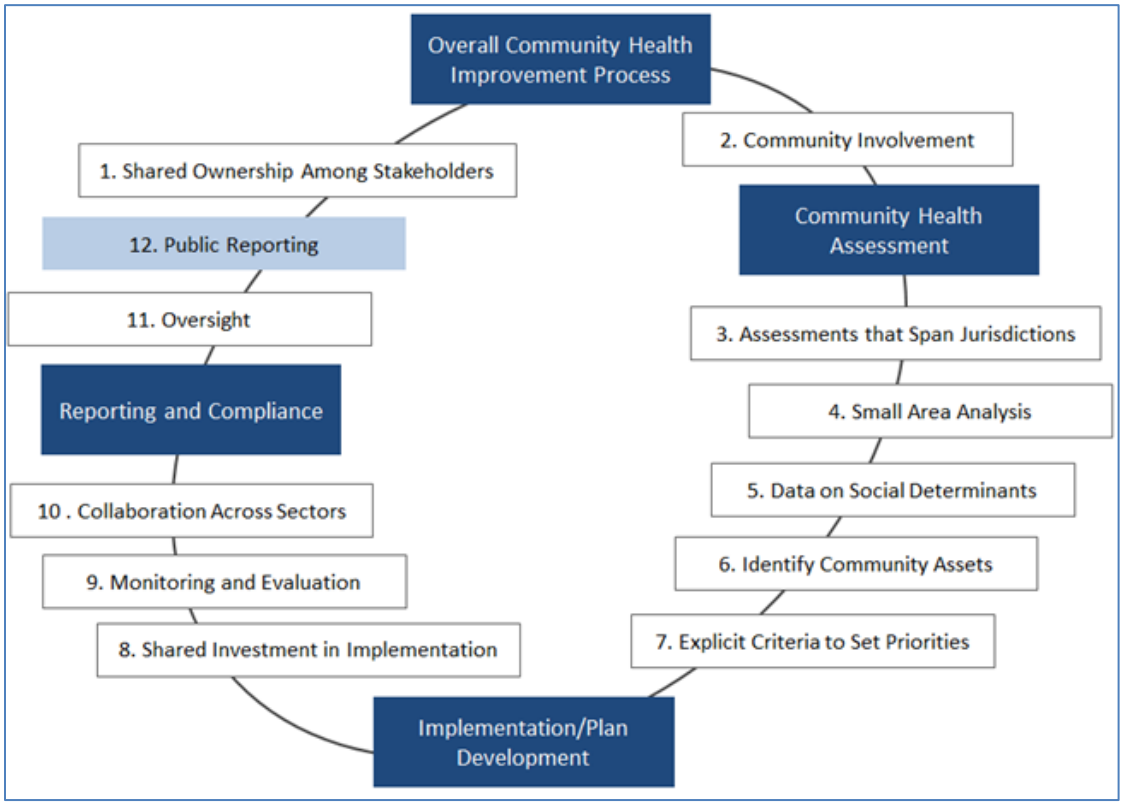
ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application in low-resource contexts, consider engaging in regional or cross-jurisdiction groups for oversight, or create one overarching oversight group for all objectives.

QUESTIONS FOR REFLECTION: Who are the key stakeholders in local/regional oversight of the community health improvement effort? Is this group inclusive of those implementing plans and affected by them? How are decisions to be made, and by whom? How do we build a culture of collaboration and accountability among stakeholders? What internal and external mechanisms are needed for proper oversight? How do we stay focused on what matters and use the information to improve performance? How do we make outcomes matter?

SOURCES:

1. Catholic Health Association. (March 2011 Draft). Developing an Implementation Strategy, Steps 1-8. *Assessing and Addressing Community Health Needs* (85-107).
2. Centers for Disease Control and Prevention. (2010). Action Step 1: Assemble The Community Team. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
3. National Association of County and City Health Officials. (2001.) Phase 6: Action Cycle. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
4. Association for Community Health Improvement. Step 6: Planning for Action and Monitoring Progress. *Community Health Assessment Toolkit.*
5. Voluntary Hospitals of America (1994). Phase VI: Action and Evaluation. *Community Health Assessment: A Process for Positive Change* (77-80). Texas: Voluntary Hospitals of America, Inc.
6. National Association of County & City Health Officials. (2008). Task 13: Evaluate progress and plan for the future. *Protocol for Assessing Community Excellence in Environmental Health* (64-65).
7. HRSA Maternal and Child Health Needs Assessment Guide: Design Programs and Allocate Resources.
8. U.S. Department of Health and Human Services. Phase IV: Developing a Comprehensive Intervention Plan; Phase V: Evaluating PATCH . *Planned Approach to Community Health: Guide for the Local Coordinator.* Atlanta, GA: U.S. Department of Health and Human Services, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
9. Association for Community Health Improvement. (2006). Advancing the State of Art in Community Benefit Model Institutional Policies. Retrieved from: http://www.communityhlth.org/communityhlth/projects/asacb/asacbmeasures.html
10. Barnett, Kevin. (2009). Beyond the Numerical Tally: Quality and Stewardship in Community Benefit. Public Health Institute. Retrieved from: http://www.communityhlth.org/communityhlth/files/files_projects/PHI_ASACB_policybrief_Feb09.pdf

Recommended Practice Area 12:
Creating Formal Public Reporting Processes



PURPOSE/OVERVIEW: The aim of this practice area is to communicate publically and openly progress in implementation and achieving intended results. It involves creating a communications plan to increase public awareness, accountability, and support for making progress toward community health improvement.

KEY TASKS AND RECOMMENDED IMPLEMENTATION:

1. ___ Identify and engage a communications planning group for the public reporting effort
   - Put together a representative group of stakeholders and advocates that can develop a communications plan to reach, inform, and influence key audiences and the general public

2. ___ Define the aim of the public reporting process
   - Identify the aims with stakeholders, which may include:
     - Compliance with reporting requirements
     - Public awareness, accountability, and support for making progress toward community health improvement

3. ___ Collect information from those who would benefit from and contribute to the public reporting effort
   - Conduct interviews, listening sessions or public forums, talk with groups who are most affected by the issue to plan public reporting

- Determine what they know about the CHI effort, how important particular types of information are to them, what benefits they see for reporting, what the costs are

4. ___ Identify and prioritize target audience(s) for key messages and types of information
   - Determine to whom you want the messages to speak
   - Some candidate audiences—General public, federal regulatory agencies, funders, partners, policy makers
   - Consider geographic areas or scope, and readiness of audiences to act in response to messages

5. ___ Understand the interests and preferred communications of target audience(s)
   - What will different audiences care about being addressed in messages from the CHI effort?
   - How do audiences obtain information of importance to them (i.e., preferred forms of media/communication)?
   - Are there strategic moments or best timing for maximum reach with communications?

6. ___Tailor or adapt your message to each target group
   - Identify sources of information that are influential, determine the mode of delivery, craft the information and message
   - Make the information more relevant to what the audience already understands and cares about
   - Make it easy for the audience to understand and use the information

7. ___ Plan an ongoing communications campaign with annual reports
   - Identify core components and strategies of your campaign, for instance:
     - Develop memorable messages about the CHI effort
     - Communicate messages through channels that reach prioritized groups
     - Engage trusted and persuasive intermediaries (e.g., community leaders, clergy)
     - Make it easy for audiences to respond with intended actions (e.g., that the public sends letters to public officials and other indicators of support for additional improvement efforts)
     - Integrate annual reports and other aspects of the communication plan with the CHI implementation plan

8. ___ Test communications and public reports with audiences during development
   - Use focus groups from targeted audiences to develop and refine components of the communications plan
   - Clarify messages based on feedback
   - Adjust plan based on effects, satisfaction with efforts, and costs in time and money

9. ___ Assess and address public opinion about the CHI effort
   - Assess public opinion about the CHI initiative through surveys, public forums, and focus groups
   - Address public opinion (including opposition) about the CHI initiative through education programs, presentations, public forums, and websites
   - Use the media to share messages about priority health issues and how the CHI initiative is addressing them

10. ___ Educate public officials about priority issues and CHI efforts
    - Identify current/potential champions of the CHI initiative among legislators, public officials, policy makers, etc.
    - Educate policy makers about the priority issues and CHI effort
    - Mobilize partners and those affected by the priority health issues and the CHI initiative to address them

11. ___ Implement the communications and reporting campaign
    - Communicate information about the results, what you are seeing and what it means, explaining the meaning and implications of the results for the audience
    - Develop action plans for implementing each component of the campaign (e.g., who will do what, with whom, by when, with what intended results)

12. ___ Encourage audiences to use reports to further efforts
    - Conduct sense making sessions in which the report is used to reflect systematically on what results we are seeing, what it means, and implications for adjustment
    - Provide communications that are easy to understand and create opportunities for input for quality improvement
    - Use the information to make adjustments

EXAMPLES OF THIS PRACTICE AREA**:** Below are examples from the field of public reporting processes:

Example 1: State of Massachusetts Attorney General's Office

The State of Massachusetts Attorney General's Office encourages transparency and accountability among non-profit hospitals and HMOs through public reporting. The Attorney General's Office has developed Community Benefits Guidelines for how non-profit hospitals should develop and report on the benefits and programs they provide to the public as part of their commitment to the communities they serve. These Guidelines contain expectations related to assessing health care needs of communities, planning programs with community partners, and reporting. Since 2001, these reports have been made publicly available in an online database from the Community Benefits website, enabling the public to more readily access information about community benefits efforts.

Sources: Lois Johnson, JD, and website of the Attorney General of the State of Massachusetts

Example 2: New York's Community Service Plan

In April of 2008, the New York Department of Health launched the Public Health Prevention Agenda for the Healthiest State. The Prevention Agenda established 10 public health priorities and sought to integrate traditional medical services with public health interventions to stimulate positive behavioral changes to improve health status. An important part of the Prevention Agenda is the process for formal public reporting that the New York Department of Health introduced, which requires hospitals, local health departments, and health care and community partners to document their efforts in a Community Service Plan (CSP). The New York Department of Health released guidelines for creating Community Service Plans, which included the organization's mission statement, a description of the service area they support, plans for public participation, an assessment of public health priorities, a three year plan of action for addressing priorities from the Prevention Agenda, and a description of changes Impacting community health and access to services. The New York Department of Health also recommends that hospitals disseminate a written summary of the CSP to the public and encourages hospitals to post information on their organization's website so that it is readily accessible by the public. The goal of the Community Service Plan public reporting is that by working with community health partners to develop a collaborative approach, all participants will be better able to meet the needs of their community while avoiding duplicative efforts and achieving economies of scale.

Source: New York Department of Health CSP Guidelines

ADAPTATION OF THIS PRACTICE AREA FOR RESOURCES/CONTEXT: For application in low-resource contexts, look for low-cost methods of communication, perhaps using free media and informal methods.

QUESTIONS FOR REFLECTION: How will the CHI initiative provide transparency in a public reporting process? What are optimal roles for oversight groups in coordinating and integrating reporting at local, state and regional levels? How can media and advocacy organizations increase public awareness, accountability, and support for making progress toward community health improvement?

SOURCES:

1. Catholic Health Association. (March 2011 Draft). Developing an Implementation Strategy, Steps 1-8. *Assessing and Addressing Community Health Needs* (85-107).
2. Centers for Disease Control and Prevention. (2010). Action Step 1: Assemble The Community Team. *Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs* (8-10). Atlanta: U.S. Department of Health and Human Services.
3. National Association of County and City Health Officials. (2001.) Phase 6: Action Cycle. *Mobilizing for Action through Planning and Partnerships: Web-based Framework Tool*. Washington, DC: National Association of County and City Health Officials.
4. Association for Community Health Improvement. Step 6: Planning for Action and Monitoring Progress. *Community Health Assessment Toolkit.*
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7. HRSA Maternal and Child Health Needs Assessment Guide: Design Programs and Allocate Resources.
8. Hibbard J, S. (2010). *Best Practices in Public Reporting No. 1: How To Effectively Present Health Care Performance Data To Consumers*. AHRQ Publication No. 10-0082-EF, May 2010, Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from: http://www.ahrq.gov/qual/pubrptguide1.htm
9. Hibbard J, S.(2010) *Best Practices in Public Reporting No. 2: Maximizing Consumer Understanding of Public Comparative Quality Reports: Effective Use of Explanatory Information*. AHRQ Publication No. 10-0082-EF, Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from: http://www.ahrq.gov/qual/pubrptguide2.htm
10. Hibbard J, S. (2010). *Best Practices in Public Reporting No. 3: How to Maximize Public Awareness and Use of Comparative Quality Reports Through Effective Promotion and Dissemination Strategies*. AHRQ Publication No. 10-0082-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from: http://www.ahrq.gov/qual/pubrptguide3.htm

Epilogue

Shared responsibility--pulling in the same direction:

Our common purpose is to create conditions that assure the health and well-being of all those living in our communities. We are in this together—whether our base for contribution is a hospital, health department, business, government agency, non-profit organization, or as a community member.

"…Too late, alas, now for the apt quotation

About a love that's proved by steady gazing

Not at each other but in the same direction…"

--Poet Seamus Heaney, "Album"

Let us cast our gaze in the same direction. Working together, we can enhance the critical and challenging work of community health improvement.

Acknowledgments

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We also appreciate those in the field who provided expert guidance and examples of effective implementation of practices to enhance community health improvement. These interviewees included: Chris Abarca (Florida Department of Public Health), Britt Allen (Brazos Valley Health Partnership), Eileen Barsi (Catholic Healthcare West), Jim Burdine (Texas A&M Health Science Center), Liza Corso (CDC), Teresa Daub (CDC), Debbie Hull (Mercy and Memorial Hospitals), Tom Jackson (Bread of Healing Clinic), Julia Joh Elligers (NACCHO), Diane Littlefield (Sierra Health Foundation), Gianfranco Pezzino (Kansas Health Institute), Cindy Samuelson (Kansas Hospital Association), Edie Snethen (Kansas Association of Local Health Departments), Melody Stafford (Three Rivers Health Clinic), Julie Trocchio (Catholic Health Association), James Walton (Project Access Dallas), Bruce Cooper (Health District of Northern Larimer County), and Sue Hewitt (Health District of Northern Larimer County). Thanks also to those who provided a critical review of this report during a written comment period following a presentation in Atlanta.

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Appendix: Supports for Implementation from the Community Tool Box

This Appendix provides links to supports for implementation from the Community Tool Box for each of the 12 recommended practice areas. The Community Tool Box is a free 7,000 page resource for promoting community health and development, available in English http://ctb.ku.edu/ and Spanish http://ctb.ku.edu/es.

Recommended Practice Area 1:
Assuring Shared Ownership of the Process among Stakeholders

1. Community Tool Box, *Chapter 18, Section 2: Participatory Approaches to Planning Community Interventions.* KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/sub_section_main_1143.aspx
2. Community Tool Box, *Chapter 24, Section 3: Promoting Coordination, Cooperative Agreements, and Collaborative Agreements Among Agencies.* KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/sub_section_main_1229.aspx
3. Community Tool Box, *Toolkit 15: Improving Organizational Management and Development*. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/dothework/tools_tk_content_page_294.aspx
4. Community Tool Box, *Toolkit 2: Creating and Maintaining Coalitions and Partnerships*. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/dothework/tools_tk_content_page_72.aspx
5. Community Tool Box, *Chapter 7, Section 6: Involving Key Influentials in the Initiative*. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/sub_section_main_1083.aspx
6. Community Tool Box, Chapter 2, Section 13: MAPP: Mobilizing for Action through Planning and Partnerships. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/chapter2_section13_main.aspx

Recommended Practice Area 2:
Assuring Ongoing Involvement of Community Members

1. Community Tool Box, Chapter 7, Section 2: Promoting Participation Among Diverse Groups. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/sub_section_main_1079.aspx
2. Community Tool Box, *Chapter 7, Section 7: Involving People Most Affected by the Problem*. KU Work Group for Community Health and Development, University of Kansas. Retrieved from: http://ctb.ku.edu/en/tablecontents/sub_section_main_1084.aspx
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Using Small Area Analysis to Identify Communities with Health Disparities

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Recommended Practice Area 5:
Collecting and Using Information on Social Determinants of Health

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Collecting Information on Community Assets

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Recommended Practice Area 7:
Using Explicit Criteria and Processes to Set Priorities

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Recommended Practice Area 8:
Assuring Shared Investment and Commitments of Diverse Stakeholders

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Recommended Practice Area 9:
Participatory Monitoring and Evaluation of Community Health Improvement Efforts

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Recommended Practice Area 10:
Collaborating Across Sectors to Implement Comprehensive Strategies

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Recommended Practice Area 11:
Establishing Oversight Mechanisms

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Recommended Practice Area 12:
Creating Formal Public Reporting Processes

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OVERALL CONDITIONS THAT MAY AFFECT SUCCESSFUL IMPLEMENTATION:
For guiding questions and supports to enhance implementation in your context, see http://ctb.ku.edu/en/promisingapproach/tools_bp_sub_section_17.aspx