Measuring Community Health Improvement Implementation
August 20, 2013, 1:30pm – 3pm

THANK YOU FOR JOINING US

Please stay tuned. The webinar will begin on time.
Please note that you will be placed on mute for some of this session. You may use the chat dialogue box at any time to contact IPHI staff.

This session will be recorded and available at:
IPHI’s website: www.iphionline.org

Measuring Community Health Improvement Implementation
August 20, 2013

HOUSEKEEPING

- Organizers will mute all phones during the presentation
- Q & A session at the end
  - You can ask questions through the chat option anytime during the presentation
  - At the end, we'll take live questions. Please use the raise hand option to be un-muted.
- Technical Issues
  312.850.4744
  kristin.monnard@iphionline.org
Webinar Presenters

Laurie Call
Director, Center for Community Capacity Development
Illinois Public Health Institute
Laurie.Call@iphionline.org
312.850.4744

Objectives

- Define IPLAN impact and outcome objectives for use in IPLAN.
- Understand how logic models can help develop strong plans.
- Understand how to develop measurable and meaningful impact and outcome objectives.
- Identify meaningful process measures.
- Identify tools and processes for monitoring and evaluating.

Variety of Requirements for Measuring Community Health Improvement

- Illinois Project for Local Assessment of Needs (IPLAN) – Certified Local Health Dept Administrative Code
- Public Health Accreditation Board (PHAB)
- IRS Requirements for Non-profit Hospitals-Community Health Needs Assessment (CHNA)
- Funders
- Etc.
The Certified Local Health Department Administrative Code Requires:

- At least one measurable **outcome objective** covering a five-year time frame related to each priority health need;
- At least one measurable **impact objective** related to each outcome objective; and
- At least one **proven intervention strategy** to address each impact objective.
- Evaluate programs and provide quality ... and provide feedback on inadequacies and changes needed to redirect programs and resources.

**IRS Requirements for CHNA**

**PHAB Standards**

5.2.2 L Produce a community health improvement plan as a result of the community health improvement process

1. Community health improvement plan dated within the last five years that includes:
   - Community health priorities, measurable objectives, improvement strategies and performance measures with measurable and time-framed targets
   - Policy changes needed to accomplish health objectives
   - Individuals and organizations that have accepted responsibility for implementing strategies
   - Measurable health outcomes or indicators to monitor progress
   - Alignment between the community health improvement plan and the state and national priorities

Source: Field Standards and Measures, Version 1.0
PHAB Standards

5.2.4 A Monitor progress on implementation of strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners

1) Evaluation reports on progress made in implementing strategies in the community health improvement plan including:
   a) Monitoring of performance measures
   b) Progress related to health improvement indicators
2) Revised health improvement plan based on evaluation results

Source: PHAB Standards and Measures, Version 1.0

Poll Question 1
Which best describes the organization or group you represent?

1. Coalition
2. Community-Based Organization
3. Hospital
4. Local Health Department
5. State Health Department
6. Other

Poll Question 2:
What stage is your organization or group at with community health assessment and planning?

1. Completing our assessment; priorities not yet defined.
2. Completed assessment with priorities defined.
3. Developing our community health improvement plan for our priorities.
4. Implementing and monitoring our plan.
5. N/A
Poll Question 3:
Thinking of your last IPLAN/CHNA process, what percentage of overall time was spent on assessment vs. planning?

1. Less than 30% on assessment and the rest on planning.
2. 30-40% on assessment and 60-70% on planning
3. 50% on assessment and 50% on planning
4. 60-70% on assessment and 30-40% on planning
5. 71% or more on assessment and the rest on planning.
6. N/A

Need to Better Balance Time and Resources

Assessment
Planning

Planning is developing plans to address the priority, including:
- The exploration of barriers, resources, full understanding of the issue, outcomes and the strategies, interventions and activities we and our partners will implement to create the changes needed to include: detailed action plans, measurement plans, monitoring and oversight.
Priorities were selected based on having a picture of what is...

- Scope of the problem
- Impact of the problem
- Most vulnerable populations
- Why it is important to address to achieve vision
- What else is going on to address this issue?

Refer to the reports with data related to Priority Issue.

In some cases, more work on understanding the problem may be necessary.

Action planning to address priorities begins with the end in mind...

Current Status of the Priority Issue

What changes need to occur to achieve Vision?

Vision for the Future with Improvements Related to the Priority Issue

Desired Changes

- How does health status need to change?
- What determinants of health need to change?
- How must the environment change?
- What policies must be changed and/or adopted?
- What types of system changes are needed?
- What risk factors need to change?
- What behaviors must change? How and by whom?
- What knowledge or skill must be increased and by whom?
- What attitudes must change and by whom?
- What awareness must be created and with whom?
Levels of Goals/Objectives/Outcomes

<table>
<thead>
<tr>
<th>Short-Term</th>
<th>Intermediate</th>
<th>Long-Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually 1-2 years</td>
<td>Usually 2-5 years</td>
<td>5 years or greater</td>
</tr>
<tr>
<td>Changes in awareness, knowledge, and attitudes</td>
<td>Changes in skills, behavior, policy, and some system changes</td>
<td>Changes in determinants of health, risk factors, health status, systems</td>
</tr>
</tbody>
</table>

Begin with the end in mind...

Intermediate

Short-Term

Intermediate

Short-Term

Intermediate

Short-Term
Different Terminology Used

<table>
<thead>
<tr>
<th>Measure the program/ intervention (what we do)</th>
<th>Measure the results (change) of initial programs/ interventions</th>
<th>Measure the results (change) usually at least 3-5 years down the road</th>
<th>Measure the results (change) of overall efforts in relation to long-range impact (5 year or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output</td>
<td>Short-Term Objective</td>
<td>Impact Objective</td>
<td>Outcome Objective</td>
</tr>
<tr>
<td>Process Measure</td>
<td>Initial Objective</td>
<td>Intermediate Objective</td>
<td>Long-Term Objective</td>
</tr>
<tr>
<td>Process Objective</td>
<td>Process Objective</td>
<td>Intermediate Outcome</td>
<td>Long-Term Outcome</td>
</tr>
<tr>
<td>% of target population who completed at least 80% of smoking cessation classes</td>
<td>Increase in % of participants not smoking at 6 months</td>
<td>Decrease in % of population who smoked at 6 months</td>
<td>Decrease in lung cancer mortality</td>
</tr>
</tbody>
</table>

AFTER we are clear about the changes needed...

- Identify programs, strategies and interventions to create the desired changes (or achieve objectives).
- **Evidence-based strategies** – Strategies to address contributing factors and risk factors to achieve impact and ultimately outcome objectives. At least one proven intervention strategy should be defined for each impact objective.

Relationship, Strategy, Alignment...

Outcome Objectives (PLAN) | Impact Objectives (PLAN) | Proven Intervention Strategies (PLAN) | Evidence-based Interventions |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term</td>
<td>Short-Term</td>
<td>Evidence-based Interventions</td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td>Short-Term</td>
<td>Evidence-based Interventions</td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td>Short-Term</td>
<td>Evidence-based Interventions</td>
<td></td>
</tr>
</tbody>
</table>
We seek alignment with others focusing on the same priorities...

Alignment makes us stronger.

Align with other initiatives going on with the public health department, other organizations in the community and at the state and national level.

5 Key Elements to Collective Impact

- **COMMON AGENDA**
  - Common understanding of the problem
  - Shared vision for change

- **SHARED MEASUREMENT**
  - Collecting data and measuring results
  - Shared accountability

- **MUTUALLY REINFORCING ACTIVITIES**
  - Evidence-based/Evidence-informed approaches
  - Coordination through joint plan of action

- **CONTINUOUS COMMUNICATION**
  - Consistent and open communication
  - Clear decision making processes
  - Focus on building trust

- **BACKBONE SUPPORT**
  - Separate organization(s) with dedicated staff
  - Resources/skills to convene and coordinate


IPLAN Requirements
The Certified Local Health Department Administrative Code Requires:

- At least one measurable **outcome objective** covering a five-year time frame related to each priority health need;
- At least one measurable **impact objective** related to each outcome objective; and
- At least one **proven intervention strategy** to address each impact objective.
- Evaluate programs and provide quality ... and provide feedback on inadequacies and changes needed to redirect programs and resources.

---

**Process Objective**

- Desired level of change in a contributing factor.
  - **Direct contributing factors** – a scientifically established factor that directly affects the level of a risk factor
  - **Indirect contributing factors** – community-specific factor that directly affects the level of the direct contributing factor

- **Short-term** (1-2 years in length)
  - Usually the result of one or more programs or interventions.
  - Should address an impact objective

---

**IPLAN Impact Objectives**

- A goal for the level to which a health problem should be reduced.
- **Intermediate** (i.e., 2 to 3 years) in length of time
- Desired level of change in a risk factor.
  - **Risk factors** are direct causes and determinants which based on scientific evidence or theory, are thought to influence directly the level of a specific strategic issue/health problem.
  - Measurable related to each outcome objective.
  - Only occur after related short-term (process) objectives are achieved.
**Long-term PLAN Outcome Objectives**

- A goal for the level to which a health problem or condition should be reduced.
- **Long term** (five-year)
- Measurable related to each priority health need.
- Look to HP 2020 Objectives for guidance on establishing measures
- Only occur after short-term and intermediate objectives (process and impact objectives) are achieved.

---

**Examples of Impacts/Outcomes**

<table>
<thead>
<tr>
<th>Outcome Objective</th>
<th>Impact Objective</th>
<th>Example Adapted From</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2014, reduce the number of asthma hospitalizations in Will County by 15%, (762 hospitalizations).</td>
<td>By 2012, 25% of the Will County communities will pass ordinances to be smoke-free.</td>
<td>Will County</td>
</tr>
<tr>
<td>By 2016, reduce Kendall County death rate from heart disease from 144 per 100,000 to 138 per 100,000</td>
<td>By 2012, decrease the number of Kendall County adults who smoke from 22.3% to 21%.</td>
<td>Kendall County</td>
</tr>
<tr>
<td>By 2019, reduce by 10% the pregnancy rate among Vermillion County adolescent females aged 15-19 years of age</td>
<td>By 2017, increase by 10% the proportion of Vermillion County sexually active persons aged 15 to 19 years who use condoms to both effectively prevent pregnancy and provide barrier protection against disease.</td>
<td>Vermillion County</td>
</tr>
</tbody>
</table>

---

**Digging Deeper into Priority Issues**

**What are the underlying causes and factors?**

- **Risk factors** are direct causes and determinants, which based on scientific evidence or theory, are thought to influence directly the level of a specific strategic issue/health problem.
- **Direct contributing factors** - a scientifically established factor that directly affects the level of a risk factor
- **Indirect contributing factors** - community-specific factor that directly affects the level of the direct contributing factor
Poll 4
Have you ever used this tool?

1. Yes and I like it.
2. Yes and I am not crazy about it.
3. No and I might try it.
4. No and there is no way I am going to use it!
5. N/A
SMART Objectives

Specific – specify what is to be achieved, by how much, and by when
Measurable – make sure that the objective can be measured (i.e., data is or will be available to measure progress)
Achievable - set objectives that are feasible for the agency
Relevant - align objectives with the mission and vision of the agency
Time-oriented - establish a timeframe for achieving the objective

Measure of change, in what, by whom, by when

Degree of Change + Type of Change + Area of Change + Target Population + Time Frame

Examples:
10% decrease in smoking rates among 12-15 year olds in XYZ county by September 2015. (Baseline 32%)
20% increase in the number of residents in XYZ county with a medical home by January 2015. (Baseline 56%)

Logic Models as a Tool for Developing Strong Plans

Poll 5
What is your familiarity and use of logic models?
1. Zero – Don’t know how to use them or Just don’t like them at all.
2. Minimal – Have limited understanding and or use.
3. Moderate – Average knowledge; use now and then.
4. Extensive – Great deal of knowledge/understanding and use them for almost everything.
Logic Model Review

GOALS

INPUTS — STRATEGIES — ACTIVITIES — OUTPUTS — OUTCOMES

Assumptions

Short-term Outcomes
Intermediate Outcomes
Long-term Outcomes

STRA TE GIES
INPUTS
ACTIVITIES
OUTPUTS
OUTCOMES

Assumptions

Strategies

Inputs

Activities

Outputs

Outcomes

Indicators

Short-term Outcomes
Intermediate Outcomes
Long-term Outcomes

Logic Models and Evaluation Goals

Source: CDC Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide
Logic Models

- Label flipchart pages for sets of questions/ LM components
  1. If we got it right, what would it look like? (anticipated impacts, end in mind)
  2. Who is being helped? (target populations or those we serve)
  3. What rules need changed? (long-term outcomes, policy changes, changing the rules or nature of the game)
  4. Who would change and how? (intermediate outcomes, behavioral outcomes)
  5. What are the first things that need to change? (short-term outcomes, what needs to change now?)
  6. What must be done? (activities)
  7. What can be measured? (outputs, what can be counted)
  8. What can we do to make it happen? (inputs or resources, what do we need to make it happen)

Sample Logic Model

Identifying Meaningful PROCESS MEASURES
Process is a measure of what we do.

- Ultimately, what will give you the best information about what it is being implemented to address the priority?
- What will tell you if the program, intervention or activity is on track?
- What will you be able to report out on to show progress?

Considerations for Process Evaluations

- Transfers of Accountability
- Dose Delivered
- Dose Received (Exposure)
- Dose Received (Satisfaction)
- Access
- Staff Competency
- Reach (Participation rate)
- Recruitment
- Context

Questions for Process Evaluations

- Who have we reached through this intervention?
- What was delivered?
- How does that compare to what was planned?
- Have evidence-based practices been adhered to rigorously? If not, why?
- If someone were to try to replicate our process, would they be able to from our information?
- What barriers exist for our intended participants?
Additional Questions Related to Partnerships

- What inputs and activities are each partner responsible for?
- What outcomes will each partner measure?
- How well are the partners communicating?
- What is needed to improve the effectiveness of the partnership?

IMPACT AND OUTCOME MEASURES

Criteria for Choosing Outcomes to Measure

- Cost and burden of data collection
- Can program participants or others realistically provide the data?
- Can we track individuals through time?
- Are there any issues of confidentiality to take into account? How would we do it?
- Can we train data collectors and manage the data collection process for this type of data?
- Is the desired improvement cycle smaller or larger than the measurement cycle?
Criteria for Choosing Outcomes to Measure

- Is it reasonable to believe the program can influence the outcome in a non-trivial way, even though it can’t control it? (can you really impact community-wide change?)
- Would measurement of the outcome help identify program successes and help pinpoint and address problems or shortcomings?
- Will the program’s various stakeholders accept this as a valid outcome of the program?


Look at Your Set of Outcomes

- Do program outputs and initial, intermediate, and long-term outcomes relate to each other logically? (walk through and check “if-then” relationships)
- Do these relationships reflect the logic of the program—the sequence of influences and changes that program inputs, activities, and outputs are intended to set in motion?
- Do the longer-term outcomes represent meaningful benefits or changes in participants’ status, condition or quality of life?
- Have you identified potential negative outcomes of the program?


Identifying Indicators

- Determine the specific observable, measurable characteristic or change that will represent achievement of the outcome
- Determine the specific statistic(s) (e.g. number and percent attaining outcome) the program will calculate to summarize the level of achievement.
- You may need more than one indicator for an outcome.

Selecting Indicators for Outcomes

<table>
<thead>
<tr>
<th>Program</th>
<th>Outcome</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking cessation</td>
<td>Participants stop smoking</td>
<td># and % who report quitting</td>
</tr>
<tr>
<td></td>
<td></td>
<td># and % not relapsed at 6 months</td>
</tr>
<tr>
<td>Counseling for parents to reduce child abuse</td>
<td>Fewer cases of abuse</td>
<td># and % of families with no cases following program</td>
</tr>
<tr>
<td>6th grade tutorial program</td>
<td>Improved academic performance</td>
<td># and % of students who earn better grades after program</td>
</tr>
</tbody>
</table>

Outcome Measurement Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Sources</td>
</tr>
</tbody>
</table>

Source: University of Wisconsin-Extension, Program Development and Evaluation.

Hard to Measure Outcomes

- Anonymous participants
- Very short term service
- Very long term outcomes
- Reliability of participants to give accurate response
- Intangible outcomes
- Long term outcomes dependent on influencing action of others (not target group)
- Community level outcomes
- Activities that support other agencies/programs
- Programs preventing negative events
Poll 6:
Have you ever reached the point of measuring outcomes for community health improvement planning?

- Yes
- Close but not quite.
- No
- N/A

Developing Measurement and Monitoring Plans

Why do measurement systems fail?

1. Impose management measures on the performing group instead of allowing the group to establish the measures
2. Do not involve process owners and those who know the most about the process in developing the measurement systems
3. Treat measurement information and trends as private data and do not share the information with the group
4. Fail to recognize and reward performance improvement
5. Fear exposing good or bad performance. The group may be satisfied with the status quo and not want to upset anyone.
6. Improperly define the system or process to be measured
7. Spend too much time on data gathering and reporting and not enough time on analysis and action
8. Fail to consider customer requirements
Determining Measurement Needs

- What are you already doing to collect data, document your work etc.?
- What resources do you have?
- How often will you be able to come together to look at data?
- What existing reliable data do you already have?
- Where can you start measuring a couple indicators fairly easily and accurately?
- Where do you have measurement expertise, capacity and time?
- Others?

Infrastructure to Support Monitoring

- Evaluation and Monitoring Team
- Evaluation and Monitoring Focus/Expertise on Action Teams
- Oversight/Accountability Mechanism
- Plans for How Results Will be Used

Basic Monitoring Infrastructure

- Establish a team responsible for monitoring progress of activities and process data, objectives and outcome indicators
- Report out progress information to steering committee or governing committee and all partners:
  - monthly, every 3 months, every 6 months or annually
  - depending on when outcome and performance data are available.
  - Hold assessment sessions to discuss “how are we doing?”
  - What is going well? Why?
  - What is not going well? Why?
  - What changes or improvements are needed regarding the activities?
  - Develop a plan and implement changes or improvements

The key is to develop a monitoring process to provide continuous feedback to make changes/improvements when necessary.
### Sample Tool for Documenting Activity

Activity Trackers help:
- Create a norm; expectation.
- Integrate monitoring into existing processes.
- Provide basic tool to document all the activity going on related to a particular issue.
- Keep the focus of the committee/ action team on the priority issue.
- Identify improvement opportunities and successes.
- Provide structured opportunity for group problem-solving.

### Sample Tool

- Basic tool; easy to adapt.
- One place to record actions from all participating agencies and groups.
- Ability to track activity before measurement.
- Linked directly to outcome objectives.

### Sample Tool for Monitoring Evaluation Processes

- Simple Excel worksheet for each CHIP priority area.
- Aligns evaluation methods with CHIP priority areas.
- Documents evaluation findings specific to each priority area on an ongoing basis to enable quality improvement.
### Components in a Measurement Plan

- Process and outcome indicators
- Data sources for measuring the indicators
- Methods for measurement
- Person Responsible for Data
- Timing for measurement
- Baseline
- Target

### Measurement Plans

<table>
<thead>
<tr>
<th>No.</th>
<th>Process Indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Monitoring/Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Three key messages rolled out as a coordinated campaign by at least 5 key stakeholders at 15 message points.</td>
<td>Outreach materials, press releases, websites and other social media.</td>
<td>Survey</td>
<td>1. Analysis of message testing and development of final key messages.</td>
</tr>
<tr>
<td></td>
<td>At least 300 youth participate in a pre-post survey around rollout of key messages at 15 message points. to test knowledge of health risks. (survey results would be an impact/outcome measure)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Could be as simple as an excel spreadsheet with targets and measures
  or
• Something more complex and visually appealing
What is Program Sustainability Capacity?

- The ability to maintain programming and its benefits over time.
- Many things can affect sustainability capacity, such as financial and political climates, organizational setting, or the presence of effective evaluation.
Why is Program Sustainability Capacity Important?

- Programs of all sizes strive for sustainability
- Funding cycles and budget deficits make sustainability challenging
- There are factors that have been shown to contribute to stronger program sustainability and position efforts for long-term success

Program Sustainability Framework and Domain Descriptions

- POLITICAL SUPPORT: Internal and external political environments that support your program
- FUNDING STABILITY: Establishing a consistent financial base for your program
- PARTNERSHIPS: Cultivating connections between your program and its stakeholders
- ORGANIZATIONAL CAPACITY: Coordinating the internal support and resources needed to effectively manage your program
- PROGRAM EVALUATION: Enabling your program to inform planning and programmatic needs
- PROGRAM ADAPTATION: Taking actions that enable your program to respond to changing circumstances
- COMMUNICATIONS: Engaging stakeholders and the public about your program
- STRATEGIC PLANNING: Developing plans that guide your program’s direction

Websites for Sustainability Tools

Program Sustainability Assessment Tool
- https://sustaintool.org

Program Sustainability Plan

University of Washington in St. Louis
Brown School of Social Work
Resources

- University of Wisconsin-Extension Logic Model
  - http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html
- W.K. Kellogg Foundation Logic Model Development Guide
- W.K. Kellogg Foundation Program Evaluation Guide
- CDC Program Evaluation Guide
  - http://www.cdc.gov/eval/guide/
- New Zealand Ministry of Health: "How to Measure for Population Health" Guide
  - http://health-equity.pitt.edu/884/

Feedback

- Please complete the evaluation form.
- Your input is used to plan future offerings.

Thank You!

If you have training or technical assistance follow-up needs, contact:

Laurie Call, Director
Center for Community Capacity Development, IPHI
Laurie.Call@iphionline.org